Suicide Prevention: Exploring Aboriginal understandings of suicides from a Social and Emotional Wellbeing Framework

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ABSTRACT

The purpose of this research (PhD) was to explore Aboriginal understandings of suicide from a Social and Emotional Wellbeing (holistic) Framework through the establishment of traditional yarning style approaches to interviews and focus groups. Culturally this framework fits well with an Indigenous holistic view of health, connection to land, culture, spirituality, family, and community. These are important to Aboriginal people and can impact on their wellbeing. This research was undertaken in consultation with up to 55 Aboriginal residents across Toowoomba Darling Downs and South West regions of Queensland classified as rural, remote, semi-urban and urban Aboriginal communities.

There is a need for additional research into understandings and definitions of suicidal behaviour for Aboriginal and Torres Strait Islander people and their communities (Suicide Prevention Australia, 2009a; 2014b). The loss of a life from suicide impacts considerably on the family and the wider community, which in turn disrupts social and emotional wellbeing - mental health (De Leo et al., 2011) of Aboriginal people. As the social and emotional well-being (SEWB) and mental health problems are not completely recognised or understood from an Aboriginal perspective within the broader health care system.

It is evident that suicides among Aboriginal and Torres Strait Islanders are much more frequent in comparison to other Queenslanders, for Aboriginal and Torres Strait Islanders suicide rates are 50 percent higher (Kõlves, Potts & De Leo, 2015). Not only are these high rates characteristic of the interplay of both risk and protective factors but broader social, economic and historic factors affecting social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islanders are also important. Evidence suggests improving social and emotional wellbeing of people results in a reduction in suicides for Aboriginal and Torres Strait Islanders (Queensland Mental Health Commission, 2015).

This research set out to attain a comprehensive understanding of suicides from an Aboriginal perspective. This incorporated undertaking a historical and contemporary analysis of the literature on suicide across the broader population – internationally and nationally to determine when suicides primarily occurred in Australian Aboriginal populations. In addition further historical understanding of suicides in each Aboriginal community was also important in appreciating the historical and cultural context of communities where Aboriginal people currently resided. Aboriginal participants including females and males, young people (18 years and over), middle-aged people and elders residing within each of the communities participated in pre-arranged face to face semi-structured interviews and focus groups. Thematic analysis of the data achieved a number of themes (Italics) and subthemes: Suicide, Community – underlying issues and substance misuse, Young people – relationships and help-seeking, mental health – services and awareness and Culture – cultural perspectives, social, lifestyle and leadership.

In conclusion suicide in Aboriginal communities is on the rise accompanied by intergenerational trauma, substance misuse, poverty, disempowerment, disengagement and disadvantage within the larger social and health context. Historically suicide and self-harm did not appear to exist prior to the 1960s; and there is a difference in understandings and shifts in attitudes towards suicides today. The negative effects from emotional distress, violence, self-harm, substance abuse, anti-social behaviour, behavioural and disciplinary problems are all compounded by the ongoing experiences of social and economic disadvantages further impacting on the risk of social and emotional wellbeing of Aboriginal people and their communities.

Certification Page

This thesis is entirely the work of Raelene Ward except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

Student and supervisors signatures of endorsement are held at USQ.

Principal Supervisor: Professor Don Gorman

Associate Supervisor: Dr John Williams-Mozley

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STRUCTURE OF CHAPTERS

The structure of this thesis will be presented in the following format:

Chapter 1 This 'Introduction' provides the reader with background information about the researcher in context to the topic of suicide in Aboriginal communities. The researcher has coordinated a number of research projects and programs prior to this research in the area of Aboriginal health, suicide, social and emotional wellbeing, capacity building and mental health. From a professional point of view, the researcher has received a number of academic achievements and continues to contribute to new knowledge in this area in particular through this PhD journey. Furthermore a section on keeping research on track is important both culturally and ethically in understanding the historical research processes undertaken with Indigenous people and their communities, and how some of the learnings from the past influence how research should be done today that is culturally appropriate and embedded into current research practices. As well a section on cultural and ethical considerations for the purpose of this research will outline effective and appropriate community consultation and engagement processes in line with Aboriginal community protocols.

Chapter 2 This Chapter on 'Social and Emotional Wellbeing (Mental Health)' provides the reader with background information pertaining to social and emotional wellbeing (SEWB), what it means from an Aboriginal perspective and as it stands in contrast to western understandings of mental health. It incorporates historical information relevant to understanding colonisation and government policies and how these affected and continue to impact SEWB (mental health) of Aboriginal and Torres Strait Islander people. It includes a section on Helen Milroy's work illustrating a multidimensional model of health and wellbeing from an Aboriginal perspective, enabling the reader to better understand a holistic approach to SEWB including broader elements of health and wellbeing.

Chapter 3 This chapter provides an overview of the context and significance of this research from an Australian and Aboriginal perspective as it provides a historical background to colonialism with reference to the 1967 Referendum in positioning Aboriginal rights the development of the first National Aboriginal Health Strategy (1989). This document was instrumental in positioning the future direction of Indigenous health within Australian. It is imperative to have a historical understanding of these within the context of Australia including the development of current Government policies and reports over time that provide insight into Indigenous health and mental health, in particular those that focus on mental health reform and suicide prevention. The following Government reports and policies to be discussed are 1967 Referendum, National Aboriginal Health Strategy (1989), Royal Commission into Aboriginal Deaths in Custody' (RCIADIC) (1991), Burdekin Report (1993), 'Ways Forward' Report (1985), Queensland Mental Health Plan (2008), Queensland Mental Health Commission (2013), Suicide prevention developments in Australia as well as the collection of suicide data. These have been instrumental in shaping Indigenous health and mental health services, programs and funding over time in Australia.

Chapter 4 This Chapter provides a 'History of Australian suicides' a review of the literature that is pertinent, current and includes classic literature works that provide historical insights into the context of the issues among Aboriginal and Torres Strait Islander people. The information is in part framed by a chronological understanding of the reports in this field of study which is offered as a table in the Chapter. This is an important framing because it allows an understanding of how suicide prevention evolved over time and whether or not these strategies have been taken up by and have had positive impact within Aboriginal communities. The Chapter concludes with an understanding of the most effective strategies in use within Aboriginal communities as

ascertained from the literature and research participant interviews and thus lays down the platform for the dialogue of risk and protective factors to be discussed in Chapter 5.

Chapter 5 This chapter provides the reader with information on risk and protective factors relevant to the broader community and the difference between 'risk factors' and 'warning signs' generally and for suicide. Additionally, an overview of risk and protective factors for Indigenous suicides provides insight into specific areas of difference. Understanding why someone takes their own life is complex and there are various factors that contribute to a person's decision to no longer live. Furthermore, insights into social determinants for Aboriginal health are relevant in allowing the reader to better understand Aboriginal communities from a social and economic perspective and how these relate to suicides in rural and remote communities.

Chapter 6 This chapter provides a review of the literature that is pertinent, current and includes classic literature works that provide historical insights into the context of the issues among Aboriginal and Torres Strait Islander people. Furthermore, the review of the literature provides a broad range of interdisciplinary and scholarly views and perspectives on the issue of Aboriginal and Torres Strait Islander understanding of suicide.

Chapter 7 This chapter provides the reader with background information about Aboriginal & Torres Strait Islander Youth Suicide commencing with the most current statistics which illustrate a distressing picture of the high rates occurring among young Indigenous people in Australia but more disturbingly across the world. Within Queensland there are two organizations that have the responsibility for protecting and promoting the rights, interests and wellbeing of young people these include Commission for Children and Young People and Child Guardian (CCYPCG), whereas, the Secretariat of National Aboriginal and Islander Child Care (SNAICC), have a specific focus of advocating on

behalf of Aboriginal and Torres Strait Islander children, young people and families. Additional areas of focus particularly in relation to Aboriginal suicides are psychological distress, sport in youth suicide and the collection of Indigenous suicide data in Australia.

Chapter 8 This chapter provides background information and discussion on the following areas: qualitative research methodology, planning of the research activities: information sessions, consent, recruitment, interviews and focus groups, risk and benefits and limitations of the research. Processes undertaken in the data analysis phase through the use of thematic analysis will be outlined. Furthermore, a description of the research methods used in relation to ethics, participants, and processes for gaining informed consent. Data collection was obtained in the form of digitally recorded interviews and focus groups with all participants across each of the communities in preparation for transcriptions and analysis.

Chapter 9 This chapter provides a profile of each community incorporating both traditional and contemporary information relevant to specific Aboriginal populations across the 'Darling Downs and South West Queensland. Additionally, a historical overview of Indigenous health in Queensland will be provided. Furthermore, historical and contemporary accounts will be the focus from a traditional owner's perspective pertaining to each community. This information was obtained through archival accounts that were available at the time of this review. Each community was also described in relation to their Aboriginal Medical Service providing insight into what services were provided.

Chapter 10 This Chapter will provide an overview of the findings from the research. Participants' comments highlighted from individual transcripts in the form of an excerpt are provided within each theme. In describing the layout of this Chapter individual excerpts are written as a quote in inverted commas with an identification record number

as follows (i.e. Participant Interview/Focus group DS95) for the purpose of maintaining confidentiality, accuracy and anonymity. Each identification number is unique and does not allow for participants to be identified or known within the conversations. The following themes and sub-themes identified are 1. Suicide (overarching theme), 2. Community – underlying issues and substance misuse, 3. Young people – relationships and help-seeking, 4. Mental health – services and awareness, 5. Culture – cultural perspectives, social, lifestyle and leadership.

Chapter 11 'Discussion of Suicide in Aboriginal communities' this chapter provides the reader with contextual information pertaining to rural, remote communities including semi- urban and urban communities relevant to this research. As well the researcher has captured from the findings and understandings of Aboriginal participants an overview of Aboriginal suicides from a social and emotional wellbeing framework, for instance each element of the framework was aligned to what communities said about suicides in their region. Towards the end of this chapter a historical review of the literature on suicide from as far back as possible - the 18th Century highlights a number of theorists from this period.

Chapter 12 This final Chapter will provide a conclusion bringing the whole thesis together by summarising the main points of discussion as well as highlighting the limitations observed and experienced in undertaking this particular research with local and regional Aboriginal communities as well as a number of recommendations for the future of this research into Aboriginal suicide.

CHAPTER 1 INTRODUCTION TO THE RESEARCH

The term, ‘Aboriginal and Torres Strait Islander’ and ‘Indigenous’ will be used throughout this entire thesis and in accordance with referenced articles. While only Aboriginal people were recruited and participated in this study, Torres Strait Islander people were not excluded if they showed an interest in the research.

This chapter provides the reader with background information about the researcher in context to the topic of suicide in Aboriginal communities. This chapter positions the researcher within a range of research projects and programs prior to this research. From a personal and professional point of view, a number of academic achievements in the area of Aboriginal health, suicide, social and emotional wellbeing and mental health contribute to new knowledge and moreover to this PhD journey. Additionally, a section on keeping research on track is included and is important for both culturally and ethically understanding the historical research processes undertaken with Indigenous people and their communities. Learning’s from the past influence how research should be done today within culturally appropriate and embedded research practices. As well a section on cultural and ethical considerations for the purpose of this research will be outlined through effective and appropriate community consultation and engagement processes in line with Aboriginal community protocols.

1.1 Positioning the Aboriginal researcher within the research

My name is Raelene Ward; I am an Aboriginal woman, a descendent from the Kunja people on my grandfather’s side, who are the custodians of the land for and some areas surrounding Cunnamulla; my Grandmother is a descendant of the Kooma people a neighbouring language group also located in South West Queensland. I graduated with my first degree, a Bachelor of Nursing in 1997 proceeding with a Masters in Health in 2010 with a focus on suicide prevention. My Masters research was ‘In the event of a

crisis, what services are accessed and available to Aboriginal communities who have been affected by suicide and/or self-harm?' Additionally, further studies at a PhD level warranted similar consideration to explore Aboriginal understandings of suicides from a Social and Emotional Wellbeing Framework in the context of four communities.

1.2 Contributions to suicide prevention

My previous involvement included coordinating a three-year suicide prevention project (2007- 2009) Building Bridges: Learning from the Experts funded by the National Suicide Prevention Strategy (NSPS) and auspice by the Australasian Centre for Rural and Remote Mental Health formerly known as the Centre for Rural and Remote Mental Health, Queensland (CRRMHQ, 2009). This project required a collaborative approach by working in partnership with several Indigenous communities across Queensland and including key stakeholders of Aboriginal Community Controlled Health Organization's; Universities; Royal Flying Doctor Service and Queensland Health Districts. Building Bridges was one of many projects funded under the National Suicide Prevention Strategy (NSPS) within Australia focusing on suicide prevention in Aboriginal communities. The purpose of the project was to build on the experience and knowledge from other Aboriginal communities by extending effective local responses to self-harm and suicidal behaviours (CRRMHQ, 2009). This was previously explored and successfully implemented in one Aboriginal community of Yarrabah, located in Northern Queensland. Outcomes and learning's from Yarrabah were pivotal to this project and future research. Initiatives such as knowledge sharing were facilitated through men's groups in collaboration with other Aboriginal communities. The Building Bridges Project (2007-2009) highlighted a number of key outcomes and learning's as identified by the experiences of Aboriginal people in the southern community. One of the key learning's identified from this community was little to no experience with establishing men's groups

and in facilitating empowerment and strength based initiatives as modified from the Northern communities of Queensland This community had originated from a different starting point in comparison to other communities and the composition of the community was much different in quite profound ways. For instance, differences in community dynamics and connectedness existed and varied across many of the communities involved. As a result, there was a need for the National Suicide Prevention Strategy project to connect and build a foundation based on what the community required rather than building on what existed in other communities. To build this foundation, it was essential to focus on building relationships within the local Aboriginal and non-Aboriginal community and identify opportunities to link in with established local services, organizations, local events and meetings. Efforts to engage local Aboriginal men were extremely challenging. Other issues of relevance were, Aboriginal people were seen and classed as a minority group whereas Aboriginal people in the North were seen and classed as a majority group in communities. These key learning's have informed and contributed to future research regarding Aboriginal communities and suicide prevention in Queensland (CRRMHQ, 2009).

At the completion of the suicide project in 2009, I continued to work in similar areas as a consultant for the Centre for Rural and Remote Mental Health Queensland (CRRMHQ) with the task of facilitating a number projects predominantly in rural and remote communities through community engagement processes with the aim of building capacity of rural and remote communities in responding to and preventing suicide. Within the same year I was awarded the Suicide Prevention Australia (SPA) LIFE Award – Indigenous Category, for the unique and creative health program, service partnership encompassing the holistic and social view of health (physical, emotional, cultural and spiritual), wellbeing of Indigenous individuals and communities in promoting suicide

prevention across the Darling Downs and South West Queensland. Annually, these Awards are held in conjunction with International World Suicide Prevention Day, by recognizing the outstanding contribution to suicide prevention in Australia. In 2010 I returned to the University of Southern Queensland at the Centre for Rural and Remote Area Health as an Indigenous Nurse Research Fellow, primarily undertaking research with, for and about Aboriginal and Torres Strait Islander people and communities. This position was one of a kind in Queensland and solely funded by the Office of the Chief Nurse Officer (OCNO) in Queensland Health. Towards the end of 2013 future prospects in relation to my position as an Indigenous Nurse Research Fellow was not promising due to a lack of funding. Nevertheless in 2014 I was successful in securing a position within USQ School of Nursing and Midwifery as a Lecturer while facilitating a number of research projects.

1.3 Focus of the study

Qualitative research methods comprising of information sessions, qualitative interviewing and focus groups were utilized because they were considered appropriate and sensitive to the cultural and language differences that exist in Aboriginal communities. The purpose of the research study is to explore Aboriginal understandings of suicide including the cultural, behavioural, and social aspects in rural, remote, semi-urban and urban Aboriginal communities named as Cunnamulla, Charleville, Oakey and Toowoomba. This research study focused on achieving a better understanding of Aboriginal suicides from a social and emotional wellbeing framework. The overall aim is to achieve an understanding of historical and contemporary perspectives towards suicide, views and/or opinions of Aboriginal people, the level of impact from suicides on people and communities, service provision and accessibility, and additional factors contributing to suicides. This research contributes to a new body of knowledge and research into suicide

prevention specific to Aboriginal people within the identified communities. There have been a number of research projects implemented across these regions focusing on suicide and mental health, targeting vulnerable populations' in particular Aboriginal people and farmers where suicides are concentrated. Separately each of the research projects had a unique focus but overall an emphasis was on building the capacity of local people within communities to address suicide and mental health issues across rural and remote communities. Predominantly suicide prevention projects concentrated on the broader population by incorporating mainstream approaches to suicide prevention, however when it comes to dealing with suicide within Aboriginal community's literature is limited, particularly so for these regions in Queensland (Suicide Prevention Australia 2008). Suicide Prevention Australia (2008) in their position statement, assert that suicides in Indigenous communities is significantly higher than that of the non-Indigenous population, and understandings and definitions of both suicide and self-harming behaviours from an Indigenous perspective required further research. Consequently, this research explored Aboriginal understandings of suicides in collaboration with local Aboriginal people. In designing this research, a number of research questions were identified for eliciting information from participants.

1.4 Goal of the research

The overall goal of this research was to explore Aboriginal understandings of suicides from a social and emotional wellbeing framework.

1.5 Objectives for the research

- Understand historical and contemporary perspectives of Aboriginal communities
- Understand how suicides impact on Aboriginal people and communities
- Understand Aboriginal views and awareness of suicide
- Understand health service provision and where people access help

- Understand social and emotional wellbeing factors contributing to suicide

1.6 Research questions

The research questions designed for the research enabled suicide to be explored in a holistic framework through the establishment of face to face interviews and focus groups. The research questions encompass:

1. What do Aboriginal people understand about suicides?
    - What is the view or opinion of Aboriginal people?
    - What awareness do Aboriginal people have about suicides?
    - Who do Aboriginal people talk to and/or seek help from?

2. How do we understand Aboriginal suicides in the context of social and emotional wellbeing? The question here is to explore Social & Emotional Wellbeing of people generally in the wider Aboriginal community who have been affected by suicides.

Further to this, Aboriginal participants required for this research were individuals, family members, interested groups and the broader community, were encouraged to participate if they were 18 years of age or over and identified as either Aboriginal or Torres Strait Islander people. They were asked;

3. What happens in the community when a suicide occurs?

- How do suicides impact physically?
- How do suicides impact socially?
- How do suicides impact emotionally?
- How do suicides impact mentally and psychologically?
- How do suicides impact culturally?

For each identified community, the aim was to undertake a historical and contemporary analysis of the literature to better understand each community separately including

dynamics within communities; service provision and accessibility of services. This question wasn't different to Question 2, other than written in a way to ensure that focus was maintained and that nothing vital was overlooked. When undertaking the research these questions were asked in a way that was inclusive and relevant to Aboriginal people and their communities. Comprehensively the aim was to attain a broader understanding of suicides from an Aboriginal perspective from within the identified communities.

4. Undertake a historical analysis of the communities?
5. How do suicides' impact on the community?
6. How do suicides' impact on services?

An adequate understanding of Aboriginal suicides in Aboriginal communities requires an appreciation of the historical, the culture and the context of communities of where Aboriginal people reside.

1.7 Keeping Research on Track

In the early stages of the research plan ethics approval was sought. In accordance with research guidelines a research proposal was prepared and submitted for candidature to the University of Southern Queensland in 2011. Upon the proposal being accepted a candidature presentation was prepared and delivered to a number of university academics and the wider community across the region. Towards the middle of 2012 an ethics application was prepared for the Human Research Ethics Committee (HREC) at the University of Southern Queensland (USQ) requiring a number of amendments over time to the application with final approval gained towards the end of 2012. The approval number for this research is HR No. H12REA147.

Historically, attempts into researching Indigenous people and communities regarding their health has not been the most favourable process with many not even aware that this was taking place with them or on them. Across Australia, Indigenous populations

have been subjected to research since the 19th century for the purpose of anthropological research, resulting in the collection of data, often without their knowledge or consent. Research data obtained had no intention of addressing the poor status or living standards of Indigenous people and their communities. Indigenous Australians have been subjugated to improper and unethical research that exposed them as a race and population, being vulnerable to disrespectful research experiments, invasive examinations, procedures, objectified, scrutinized and inaccurately represented. Majority of this research did not confer any benefits to Indigenous people and their communities. The 1970s saw the development of improved dialogue supporting the need for research protocols that were designed and led by Indigenous people and based on their cultural values and morals of community control, consultation and consent as well as the intellectual ownership of data and application of improved health outcomes. By the 1980s, the articulation and development of national ethical guidelines pertaining to research with Indigenous people and communities became a living document endorsed by the National Health and Medical Research Council (NHMRC) of Australia. There were two main key areas of focus for these guidelines: ensure that Indigenous people and communities maintain control and ownership of their data by building capacity of Indigenous researchers through education and training opportunities of a research focus as well as identifying and describing effective research questions applicable to them and their communities (Department of Health 2008, p. 61-63; De la Barra et al, 2009 p. 2). Informed by these discussions, there has been a growing consensus over the past ten years, both within Australia and internationally, that research is more likely to have a long-term impact in improving the health of Indigenous people if it evaluates the impact of health programs rather than simply describing health problems, involves Indigenous researchers in all stages of the research, and builds capacity among Indigenous researchers presently and in the future.

1.8 Community engagement processes

This research required the researcher to build on established relationships, connect with people and communities, consult and engage people regarding a number of issues or concerns that affect people's health and wellbeing by exploring the situations in which they were confronted and experiencing. The need for a planned process was developed and implemented with identified groups of people and stakeholders that supported community people to be informed and involved in the development of policy directions resulting in increased awareness and understanding. It is important that community are involved in a number of different ways allowing them to be considered in the decision-making process. This is evident in the collaborative efforts and partnerships established which create opportunities and strengthen the empowerment of community to evolve and manage change (Cavaye, 2001; Fredericks & Ward, 2014; 2018).

In the case of Aboriginal & Torres Strait Islander research, The National Health & Medical Research Council (NHMRC) in their 'Keeping Research on Track' (2006) for researchers and Indigenous people and communities when planning and conducting research. In the beginning relationships between Aboriginal and Torres Strait Islander people and researchers, namely white researchers has often been one sided and not for the benefit of Aboriginal and Torres Strait Islander peoples. The research community has taken a number of twists and turns over time (MHMRC, 2006; Department of Health, 2008).

This document facilitates a greater understanding about health research ethics and to decide whether the research is relevant, ethical and appropriate. The main points for noting identified from this document was the importance of researchers to change their ways in how they conducted research, how they build research capacity and ensure the rights of Aboriginal and Torres Strait Islander peoples are respected and supported in the research process as participants. In the commissioning of research Aboriginal and

Torres Strait Islander peoples have a right to be involved and question any research being proposed in their communities "to say 'no' up front, to say 'yes', and to discuss a different focus for the research, to request more time to talk about the proposal, to expect that cultural values are respected, to have input into the research agenda, to check on the researcher's track record, to expect that the way things are done in communities and organizations is respected during the research process, to negotiate a formal research agreement, and to delay and stop the research" (Department of Health 2008, p. 61-63)

Building a rapport and connection with Aboriginal and Torres Strait Islander peoples before the research begins and in the planning stages is essential for effective partnerships to develop. This is supported by the steps outlined in the Keeping Research on Track (2006) document and confirms that the research is appropriate and meets the needs and goals of communities. This in turn respects the values of Aboriginal and Torres Strait Islander cultures and traditions or otherwise may jeopardize the ethics and quality of the research being proposed.

1.9 Cultural and Ethical considerations

Culturally and ethically, 'Keeping Research on Track' (2006) guides effective consultation and engagement protocols with Aboriginal and Torres Strait Islander people (Department of Health, 2008; Fredericks & Ward, 2014; 2018). Throughout this research the key steps were embedded to guide the researcher in upholding the principles and practices that are inherently required when working with Aboriginal and Torres Strait Islander people and their communities (NHMRC, 2006). Building relationships is about Aboriginal people and researchers talking with one another more importantly it's about Aboriginal people talking about their values and ways of doing things such as being aware and adhering to Aboriginal community protocols. It is also about Aboriginal people identifying if researchers and the team have the knowledge, skills and experience in doing the

research. Based upon this then relationships begin to evolve where Aboriginal people feel safe to proceed with the proposed research (NHMRC, 2006; Department of Health, 2008; Fredericks & Ward, 2014; 2018).

Involvement from Aboriginal people in the research may require changes to processes, outcomes and even in framing the research question or to not proceed with the research. Conceptualization – thinking relates to the time to explore all possibilities and to ensure that everyone understands each other and gets the most out of the research by shaping research to meet the needs of Aboriginal people and communities. What requires consideration is the focus of the research, research team, steering committees or advisory committees which highlights the need for Aboriginal involvement with the continuous development and maintenance of relationships. Development and approval is about establishing formal agreements between Aboriginal people, communities, organizations and researchers about what the research will look like and feel like and to ensure that everyone understands what is being proposed (NHMRC, 2006; Department of Health, 2008; Fredericks & Ward, 2014; 2018).

A letter of support from a community group or organization is also required and working together in developing the ethics application. Data collection and management is where information is collected during the research in the form of health records, people, Australian Bureau of Statistics, interview and focus groups to name some. It's about managing the data collected from the process or participants ensuring participants are fully informed, consent is provided, and that the information is kept private and where required de-identified. Analysis - looking at the meaning, analysing the data to see what it is showing and what it means. This means that both the researcher and Aboriginal people interpret the data collected from each perspective more importantly what the data means to the Aboriginal community and organizations involved. The rights of Aboriginal

people in this process are to understand what the processes are for analysis, what the role of the community is in analysis and interpretation, whether the community agrees with what researcher's say, if the findings are relevant to community and what happens if the community disagrees (NHMRC, 2006; Department of Health, 2008; Fredericks & Ward, 2014; 2018).

Report writing is about telling the story from the findings, what are the lessons learnt, discussions and recommendations. It is important that the information being presented is done in a culturally appropriate way and acknowledges the contribution from community, authorship and preserving the intellectual property of Aboriginal people and communities. Dissemination - sharing the results with community, organizations, and policy makers and funding bodies. This can be done through community meetings – providing feedback sessions, stakeholder meetings, conferences and publication in journals. Learning from our experience is about taking a step back and looking at what has occurred in the research process from a community and organization perspective. Learning from the lessons in the field in how to improve and do things differently. It's also about identifying future research questions and considering if and how knowledge will be transferred or translated into communities, programs, practice and policy (NHMRC, 2006; Department of Health, 2008; Fredericks & Ward, 2014; 2018).

From the outset the researcher consulted and planned engagement activities with participants within communities through the efforts of local Aboriginal Medical Services (AMS's) including other health, mental health and community service providers in line with the community protocols required throughout this research journey. The researcher worked in collaboration with each of the identified Aboriginal Medical Services adhering to Aboriginal protocols whilst planning and undertaking research with Aboriginal people and their communities. Protocols were respected and preserved throughout the entire

research journey. Participants recruited in this research were Aboriginal adults 18 years and over residing in any of the four identified communities. The researcher's intention was to gain a comprehensive understanding of suicides from an Aboriginal perspective to inform future research, policy and practices into suicide prevention in particular the expansion of the National Indigenous Suicide Prevention Strategy developed in 2013 (Department of Health, 2010; 2013).

This research contributes to the new body of knowledge and research into further understandings about Aboriginal suicides across two regions the Darling Downs and South West Queensland. Emphasis on this research and what it means to Aboriginal people is important for this region given the context of communities, and service provision, most importantly accessibility of health and mental health services. There is a vast amount of literature on suicide focusing on the broader population incorporating mainstream approaches into suicide prevention activities. As for the identified regions, literature and data pertaining to suicide prevention in these Aboriginal communities is progressing (Suicide Prevention Australia, 2008). The types and amount of research conducted in Australia on Indigenous suicides in the beginning was scarce but over time has increased and has been the focus of a number of organizations, government bodies, researchers and communities. Suicide Prevention Australia (2008) confirm that suicides in Indigenous communities is significantly higher than that of the non-Indigenous population, and that understandings and definitions of suicide and self-harming behaviours from Indigenous perspectives requires further research.

CHAPTER 2 SOCIAL AND EMOTIONAL WELLBEING (MENTAL HEALTH)

Introduction

This chapter provides the reader with background information pertaining to social and emotional wellbeing (SEWB), what it means from an Aboriginal perspective and how it stands in contrast to western understandings of mental health. This Chapter incorporates historical information relevant to understanding the impacts from colonization and Australian government designed policies and how these continue to impact social and emotional wellbeing (mental health) of Aboriginal and Torres Strait Islander people.

Health and wellbeing for every person is a requirement for life and living as human beings and encompass physical, social, emotional, mental and psychological aspects that require balance for individuals, family and groups to be able to live a positively satisfying quality of life (WHO, 1986; National Aboriginal Health Strategy, 1989). This broader definition of health is not too dissimilar to Indigenous understandings of health and wellbeing. Health and wellbeing from an Indigenous perspective is wrapped around the understanding of whole of life view meaning its cyclical – life-death-life and holistic because it achieves optimal conditions in physical, social, emotional, cultural, spiritual and psychological aspects for health and wellbeing (National Aboriginal Health Strategy, 1989). Acknowledging the strengths, resilience, and diversity of Aboriginal and Torres Strait Islander people and communities including the differences in cultures and histories is imperative in establishing relationships and achieving sustainable outcomes in social and emotional wellbeing. What contributes to social and emotional wellbeing is the freedom and capacity to communicate desires and express how an individual is feeling and adapting to difficult and challenging situations, being compassionate and kind to each other and being able to relate to others facilitates better problem-solving approaches (Social & Emotional Well Being Framework, 2009).

2.1 Social and Emotional Wellbeing

The term social and emotional wellbeing is the preferred terminology used by many Aboriginal and Torres Strait Islander people to describe their health and mental health in a holistic way revealing integral relationships to aspects of social and emotional wellbeing. Social and emotional wellbeing and Aboriginal culture are interrelated and connect people with land, culture and spirit. Family and community is everything to Aboriginal and Torres Strait Islander culture and people and when aspects of social and emotional wellbeing are out of balance these can impact on their overall wellbeing (Australian Health Ministers, 2003). For example, Aboriginal and Torres Strait Islander people's poor social and emotional wellbeing has been linked to past effects of colonization and government policies such as loss of traditional lands, forced separation of families and loss of cultural identity (Mindframe, 2015). Prior to colonization, traditional Aboriginal culture provided and supported Aboriginal people with optimal conditions for mental health through physical, social, emotional, cultural and spiritual aspects of wellbeing. Traditionally mental health from an Aboriginal cultural perspective was understood collectively and linked to "all aspects of life – community, spirituality, culture and country" (Parker, 2010; Parker & Milroy, 2014, p. 3). Aboriginal culture and tradition provided for the distribution of rules and relationships and kinship defined social order. For example, men and women knew their roles and responsibilities in their communities. Children and young people were cared for by their extended kinship, sheltering them from stressful situations. Aboriginal meaning and understanding of life was facilitated through their own experiences of connection to country and their dreamtime. Spirituality created a sense of comfort and connection for Aboriginal people as well as a place of need when in crisis or dealing with grief and loss (Parker, 2010; 2012).

In Australia's Aboriginal and Torres Strait Islander communities' distress in all forms is a manifestation of the true history of what Aboriginal and Torres Strait Islander people experienced (National Mental Health Commission, 2017). Aboriginal and Torres Strait Islander people continue to experience negative effects in lifestyle of living in poverty with high rates of unemployment, incarceration, hospitalization and diseases. Aboriginal and Torres Strait Islander people are disadvantaged and alienated from many aspects of mainstream due to degrees of discrimination and racism that is either hidden or obvious to people. These types of negative experiences support the claim that Aboriginal and Torres Strait Islander people do not access health and specialist related services and programs the way they are proposed and hospitalized more often than their counterparts (Dudgeon et al., 2014c; National Mental Health Commission, 2017). In 2008, 31 per cent of Aboriginal and Torres Strait Islander young people aged over 15 years were reported to have significant high levels of psychological distress relating to trauma and grief (Mindframe, 2015). Across all communities Aboriginal and Torres Strait Islander people are confronted with a great deal of grief and loss due to high rates of morbidity and mortality, incarceration either in juvenile detention or jail and high rates of hospitalization (The Australian Bureau of Statistics, 2010; Mindframe, 2015).

Many of the stressors experienced by Aboriginal and Torres Strait Islander people are becoming evident through further research in trying to understand the historical and contemporary impacts that influence the everyday lives of Aboriginal and Torres Strait Islander people and their communities. In comparison to the general population, Aboriginal and Torres Strait Islander people report experiencing at least one stressor (83%) more than their counterparts (57%) in a twelve-month period (Aboriginal & Torres Strait Islander Health Performance Framework Report, 2006). There are a number of stressors in which Aboriginal and Torres Strait Islander people are confronted with each

and every day such as violence, drug and alcohol abuse, mental health related problems, continuous grief and loss, poverty and financial worries (Aboriginal & Torres Strait Islander Health Performance Framework Report, 2006).

Social and emotional wellbeing problems and mental disorders are being more recognized and at higher rates for Aboriginal and Torres Strait Islander people who require services and programs to be more culturally appropriate and safe. Effective assessment and diagnosis will result in culturally appropriate treatment as long as clinicians and health professionals recognize the impact culture and spirituality have on the development and presentation of social and emotional wellbeing and mental health problems. Aboriginal and Torres Strait Islander people believe that mental health and mental illness focus too much on problems and do not properly describe all the factors that make up and influence wellbeing and the best way to understand these is to think of mental health and mental illness as part of a person's social and emotional wellbeing (ATSISPEP, 2015). Aboriginal health in the broader sense cannot be understood or improved without appreciating the historical and contemporary journey of Aboriginal and Torres Strait Islander people.

For the Australian population, there has been on average 2,415 (12075 deaths in total over the last five years) suicides each year since 2010, equivalent to almost seven (7) deaths from suicide each and every day (Suicide Prevention Australia, 2014b). The most recent data indicates the number of suicides in 2012 was 2,535 (11.2 per 100,000) equivalent to almost eight (8) deaths from suicide per day. It’s the highest it’s been over the last 10 years. For Indigenous populations suicide is the 5th leading cause of death (Suicide Prevention Australia, 2014b) and the leading cause of deaths for males and young people between 15 and 24 years (Davies-Simon, 2011; Statistics, 2010b), young people being most susceptible (Suicide Prevention Australia, 2014b). Suicide for

Indigenous women under the age of 25 years is nearly five times higher in comparison to non-Indigenous women (Pink & Albion, 2008; Silburn, 2010). In addition, for each Indigenous female suicide there were roughly 5 - 6 suicides for males (Silburn, 2010).

For Aboriginal and Torres Strait Islander males and females the age-standardized death rate for suicides was twice as high, with rates 4 – 5 times that of non-Indigenous Australians (Suicide Prevention Australia, 2014b). In spite of the high incidence of suicides there is a need for more research into understandings and defining suicidal behaviour specific to Aboriginal and Torres Strait Islander people and their communities (Suicide Prevention Australia, 2009a; 2014b). The loss of a life from suicide impacts considerably on the family and the wider community, which in turn disrupts social and emotional wellbeing - mental health (De Leo et al., 2011). Therefore, achieving an adequate understanding of Aboriginal suicides in Aboriginal communities requires an appreciation of the history, the culture and the context of communities where Aboriginal people reside.

2.2 Aboriginal multi-dimensional model of health and wellbeing

Helen Milroy an Aboriginal Psychologist created 'The Dance of Life' (2006) illustrating a multi-dimensional model of health and wellbeing from an Aboriginal perspective. The painting is the last in a series and encompasses a number of dimensions. The final painting brings several dimensions together to reflect the delicate balance of life within the universe. These dimensions include the biological or physical dimension, the psychological or emotional dimension, the social dimension, the spiritual dimension and finally but most importantly, the cultural dimension (Milroy, 2006). Within each dimension there are additional layers to consider, including the historical context, the traditional and contemporary view as well as our gaps in knowledge. The potential solutions for healing and restoration of wellbeing come from considering additional factors encompassing

issues of symptom presentation and service delivery, such as education and training, policy, the socio-political context and international perspective (Milroy, 2006).

Milroy's (2006) creative and theorized construction of Aboriginal life in the Dance of Life points to the ideal state of Aboriginal health and well- being. The dimensions which she has mapped in her painting show the complexity of how all aspects of Aboriginal life are interconnected but this creative work also sets the direction for the ways in which Aboriginal health and well-being can be achieved to arrest the appalling downward trends of Aboriginal health. The answers to having Aboriginal health and well-being are perhaps beyond health systems alone and holistic approaches do acknowledge there are limits to compartmentalizing the issues experienced by Aboriginal families and communities. Milroy's work assists in framing this research in the following ways: Being on, with and in country is a foundational first step. The health of the country equates to the heath of the people. To be well means to have connection with country (AIATSIS, 2009); Aboriginal health and wellness is dependent upon positive life experiences which have been nurtured and supported. This is strongest when this is a collective experience- a whole of family, a whole of community experience; the wholeness of families builds healthy communities and fortifies well-being; Aboriginal spirituality is real. It is alive, and it is timeless. There are protective qualities for Aboriginal health and well-being in the practices and traditions of Aboriginal spirituality;

From a psychological viewpoint, having an effective support network, certain amount of creative behaviour and conditions that promote a sense of personal involvement contribute to human health and wellbeing. While the persistence of traditional practices and extended family systems form the basis for resilience of Aboriginal communities there have been important and pervasive cultural changes affecting families, children and youth, and, with them, exposure to domestic violence, substance misuse, suicide and

self-harm, and other sources of risk (Cooperative Research Centre for Aboriginal Health 2006; Mental Health Commission, 2013). Therefore, it is important to ensure there is a good support network surrounding individuals and families in being able to overcome difficult situations, being able to deal with conflict effectively that creates a sense of empowerment and strength to rise above historical pasts (South Australian Health Partnership, 2005 p.2).

A holistic approach to social and emotional well-being can be understood by recognizing the range of factors that can impact positively and negatively on health, growth and development. It is important to understand the Aboriginal and Torres Strait Islander definition of health in this context. The National and Aboriginal Community Controlled Health Organization (NACCHO) recognize that optimal conditions for health and well-being require a holistic and whole-of-life view of health, referring to the social, emotional and cultural well-being of the whole community (AIHW, 2009).

The maintenance and revival of Aboriginal cultural practices and traditions means Aboriginal health and well-being thrives and not just survives. My interpretations of Milroy's (2006) work resonates with the voices of the research participants interviewed for this research (Chapter 11) and are critical to considerations for building and re-building Aboriginal health and well-being. To dance into life this way allows Aboriginal people out of the horrors of the time warp that sees Aboriginal people's lives step forward then step back, step forward, then back. Holistic approaches to Aboriginal health contribute to decolonization- to the deleterious and inter-generational effect of colonization spoken to in this chapter. What will be key is understanding Aboriginal mental health and well-being from Aboriginal perspectives and being knowledgeable about colonization and its' generational impacts on Aboriginal lives – the dispossession of lands, the fracturing of families, the decimation of cultures and the continued de-

valuing of Aboriginal worth. All of these factors contribute to Aboriginal ill-health. Aboriginal people however have shown enormous resilience in surviving. It is from this basis, knowledge of colonization and strategies for de-colonization together with an understanding of what makes Aboriginal people resilient and a commitment to hearing and involving Aboriginal people in their own health matters that a healthier future can be realized in practice. The next chapter outlines the historical context influential to the development of policy as steps forward in building Aboriginal health and well-being.

CHAPTER 3 - BACKGROUND

Introduction

This chapter provides an overview of the context and significance of this research from an Australian and Aboriginal perspective as it provides a historical background to colonialism with reference to the 1967 Referendum in positioning Aboriginal rights the development of the first National Aboriginal Health Strategy (1989). This document was instrumental in positioning the future direction of Indigenous health within Australian. It is imperative to have a historical understanding of these within the context of Australia including the development of current Government policies and reports over time that provide insight into Indigenous health and mental health, in particular those that focus on mental health reform and suicide prevention. The following Government reports and policies to be discussed are 1967 Referendum, National Aboriginal Health Strategy (1989), Royal Commission into Aboriginal Deaths in Custody' (RCIADIC) (1991), Burdekin Report (1993), 'Ways Forward' Report (1985), Queensland Mental Health Plan (2008), Queensland Mental Health Commission (2013), Suicide prevention developments in Australia as well as the collection of suicide data. These have been instrumental in shaping Indigenous health and mental health services, programs and funding over time in Australia.

3.1 Context and significance of the research

According to Georgaratos (2015), Australia's First Peoples are suiciding at the world's highest rates and are the fifth leading cause of all Aboriginal and Torres Strait Islander deaths particularly, deaths for young people. Historically, suicide and self-harm were not evident in traditional Aboriginal and Torres Strait Islander societies however some researchers dispute this saying suicides did exist but were not obvious or evident in numbers as they appear today (Parker, 2010; 2012). Suicides over time have become

increasingly obvious, more publicized and identified as a huge public and social health concern in Australia. Suicides account for more than five per cent (5%) of all Aboriginal and Torres Strait Islander deaths (Mental Health Commission, 2013), indicating 1 in 20 Aboriginal and Torres Strait Islander people will die from suicide on average equating to over 100 people dying from suicide. There are no words possible to express or describe a person or loved one to suicide but the loss of a child is unimaginable and to think a child planned and deliberately is even more incomprehensible. Unfortunately this is a reality of today and occurring in many Indigenous communities throughout Australia. Indigenous males 15-19 years are more than 4 times more likely to die by suicide whereas Indigenous females are nearly 6 times more likely to also die from suicide. More disturbingly Indigenous children under 14 years of age are nearly 8 times more likely to die by suicide (ATSISPEP, 2015; Georgaratos, 2015). While these numbers (refer to Appendix 1 figure 1.0) reflect that Indigenous suicide is of significant concern and gaining momentum as a serious public health issue, that is not a simple solution to fix and increasingly these figures are likely to underestimate the true scale of the problem (ATSISPEP, 2015). The 2011 Census data, from Australian Bureau of Statistics (2014), report there were 713,600 (3% of the total Australian population) Aboriginal and Torres Strait Islander people residing in Australia in 2014. The largest numbers of Aboriginal and Torres Strait Islander people were from New South Wales and the highest percentage of Aboriginal and Torres Strait Islander people were in the Northern Territory. Aboriginal and Torres Strait Islander populations have a much younger cohort than the overall Australian population. As for Queensland there were 203,045, Aboriginal and Torres Strait Islander people, representing a total of 4.3% of the state/territory (Australian Bureau of Statistics, 2014).

3.2 1967 Referendum – Rights for Aboriginal people

The Australian Government in 1967 held a referendum which altered the Australian constitution in which more than 90 per cent of voters in Australia had voted YES to count and include Aboriginal and Torres Strait Islander people's in the census which in turn essentially gave the power back to the Australian Government to establish laws for Aboriginal and Torres Strait Islander people. Prior to 1967, Aboriginal and Torres Strait Islander people were not counted as citizens and treated as foreigners, classified as part of the flora and fauna act. Aboriginal and Torres Strait Islander people did not have the same rights and were controlled by state governments – they could not vote in state elections, could not marry who they wanted, could not move freely without permission, own property wherever they chose, be legal guardian of their children, receive the same pay as others for the same work and drink alcohol without prejudice (Mayer, 2002). For Queensland, this practice of control continued until the mid-1980s (Tatz, 2011), State governments designed and controlled the laws for Aboriginal and Torres Strait Islander people and these were different depending on which state you resided. From 1962, Aboriginal and Torres Strait Islander people were eventually given the right to vote across all state elections - Queensland was the last state to authorize the right to vote (Reconciliation Australia, nd).

The Native Title Act (1993) was a legal dismissal of the original belief of terra nullius (the belief that pre-colonial Australia was unoccupied) meaning that Australian society now recognized that Aboriginal people originally owned the land. This meant that the Indigenous people could claim ownership and gain access to their traditional sacred sites and on 9 September 2000, Matt Foley, the Queensland Attorney-General, ceremoniously returned the Wakka Wakka, Warra and Jarowair people the ownership of the initiation site of the Meringindan Aboriginal Reserve. Like the rest of Australia, relationships

between white and Indigenous Australians on the Darling Downs are being repaired and a mutual understanding of cultures is being gained. The acknowledgment of the lie of terra nullius as well as Prime Minister Kevin Rudd's 'Sorry' speech (recognizing the wrongdoings committed against Aboriginal people) in 2008 were steps toward the ultimate goal of reconciliation between Australia's Indigenous and Non-Indigenous people (Reconciliation Australia, nd).

3.3 The National Aboriginal Health Strategy (1989)

Over time, Aboriginal and Torres Strait Islander health saw a number of policies and plans designed and implemented in Australia and one of the first ones created for the purpose of Aboriginal health was the National Plan for Aboriginal Health in 1989 with the Australian Government endorsing the plan in 1990. The strategy was planned with a number of guiding principles in mind: an understanding that Aboriginal health is holistic encompassing different dimensions - physical, emotional, spiritual, social, economic and cultural, the idea that a person's health is not separate from the community's health and incorporates Aboriginal religion on the belief that the cycle is life-death-life. Self-determination is expressed in Aboriginal health through the notion of Aboriginal Community Control whereby, Aboriginal health services are provided in a culturally appropriate way. The high level of disadvantage experienced in Aboriginal communities is the result of economic, social, cultural and religious oppression since implementation of non-Aboriginal governments. To address Aboriginal health needs a collaborative effort across all sectors of government and the wider community is necessary. Unequal power relationships between Governments and Aboriginal Community Controlled Health sector due to a lack of understanding and respect for Aboriginal people, history, culture, society, intelligence, human rights and sovereignty – resulting in diminishing, devaluing, contradicting or ignoring the expertise of Aboriginal people – these are inherently

embedded since colonial oppression (Mayer, 2002). The original plan failed to meet a number of goals – it was never effectively implemented, was grossly underfunded, the establishment of an Aboriginal council to oversee implementation lacked political support, equity in accessing health services was not achieved and lastly Aboriginal health status appeared unequal to the rest of Australia and gaps still exist in health (Mayer, 2002). While failing to achieve its objectives, the development of the National Aboriginal Health Strategy (1989) confirm that consultation with Aboriginal and Torres Strait Islander people at the time had occurred but with little emphasis (Ward, 2015). One of the key learning's from this strategy was the importance for health programs to be community owned, community driven and evaluated by local Aboriginal people. Otherwise, community support and participation would not emerge and benefits to communities would be limited (Ward & Gorman, 2010).

3.4 Indigenous Policy Background

Currently within Australia there are limited resources available delivering mental health assessments specifically for Aboriginal and Torres Strait Islander people at the primary health care level with the support of culturally appropriate guidelines, policy and practices for mental health (Adams et al., 2014). However in recent times, mental health service provision under the auspice of government policies and programs continue to provide services that are not culturally appropriate or specific to Indigenous people and are underutilized. Within the broader health system mental health services are delivered within a framework that does not effectively respond to the needs of Aboriginal and Torres Strait Islander people and services are based on the basis of inherent ethnocentrism thus leading to widespread systemic failure to respond to the needs of Indigenous people (Dudgeon et al., 2014a). In response, the National Aboriginal Health Strategy (1989) identify that mainstream design and control mental health services to serve the wider

population rather than becoming accustomed to Aboriginal and Torres Strait Islander cultural values, beliefs and lore, resulting in mental health and psychological distress not being adequately assessed, diagnosed or treated promptly (NAHSWP, 1989).

3.5 Health & Mental health, Government reports and policy

It is necessary to have a breadth of understanding of the key events and reports that have been instrumental in the development of Indigenous health in Australia over time and today. An overview of the following reports 'National Aboriginal Health Strategy (NAHS) (1989)'; 'Royal Commission into Aboriginal Deaths in Custody (RCIADIC) (1991)'; 'The Burdekin Report (1993)'; 'Ways Forward' Report (1985); 'Queensland Plan for Mental Health (2008)'; 'Queensland Mental Health Commission (2013)' will be discussed.

Between 1987 and 1995 the Australian government conducted a number of enquiries and consultations with key Aboriginal and Torres Strait Islander people and stakeholders regarding the knowledge and understanding of mental health professionals on the history, culture and society of Aboriginal and Torres Strait Islander people. It was identified that there was little knowledge and understanding which effectively affected their assessment, diagnosis and treatment in applying culturally appropriate care. Furthermore, appropriate social and emotional mental health support was lacking and Aboriginal and Torres Strait Islander people believe they do not receive adequate services from mainstream mental health service providers (Kelly, Dudgeon, Gee & Glaskin, 2009)

A number of Government reports were chosen for discussion in this chapter as they had a national focus on Aboriginal and Torres Strait Islander people's health and mental health. The role and advice these reports put forth is one of the focal points of this chapter. A number of major national reports relating to Indigenous mental health services

in the 1990s included the Royal Commission into Aboriginal Deaths in Custody (1991), the Burdekin Report on Human Rights (1993) and the 'Ways Forward' (1985) report. The main outcomes highlighted across these reports were the need to improve and increase mental health services and programs to Indigenous people. The Royal Commission into Aboriginal Deaths in Custody similarly to the Burdekin Report considered a number of topics that significantly affect the mental health of Indigenous people within Australia such as the historical experiences and the impact from colonization. The above reports also prepared a number of recommendations for future mental health service, program and policy direction for Indigenous people. It was also identified that mental health professionals were repeatedly misdiagnosing and inappropriately treating Indigenous people's mental health because they simply had little understanding of Indigenous cultures and societies while acknowledging there were two different groups. For that reason, Indigenous understandings of mental health must be considered as two separate groups (Aboriginal and Torres Strait Islanders) different from each other and even more so from westernized understandings of mental health. This suggests that Indigenous people's health and mental wellbeing cannot be understood as the same as all other Australians because of their unique culture and experiences of being dispossessed. In 1999, a Queensland Mental Health Services branch aimed to enhance and change the delivery of mental health services in their region by evaluating the effectiveness of cultural safety and Indigenous access to mental health services, while implementing State and National Mental Health policies and plans (Eley et al, 2006).

3.6 Royal Commission into Aboriginal Deaths in Custody (RCIADIC, 1991)

A Royal Commission was held into Aboriginal Deaths in Custody by Prime Minister Bob Hawke in 1987, resulting from growing public concern that Aboriginal deaths in custody which "were too common and public explanations were too elusive" (Tatz, 2011, p. 4).

The public started campaigning about the conspiracies, corruption, murders and cover-ups carried out in remote community police cells and prisons which led to a massive enquiry into 99 Aboriginal deaths between 1980 and 1989. What became evident from the enquiry was that Aboriginality – was a significant and dominant part of Aboriginal people being in custody and dying in custody. Consequently, there are "laws and regulations in place now ensuring the care of Aboriginal people in police custody - watch-houses and prisons to prevent future suicides" (Tatz, 2011, p. 4).

Some of the major findings investigated by the Royal Commission into Aboriginal Deaths in Custody (1991) were established links involving substance misuse and mental health disorders and the high number of Aboriginal and Torres Strait Islander people identified historically as children who had been forcibly removed from their natural mothers, families and communities. Since then the Commission acknowledges the effects from being forcibly removed as a child and now as an adult, experiencing additional effects of dislocation from culture, trauma, racism, discrimination, alienation, exclusion and on-going stress. Stressors of being disadvantaged were contributing factors that influenced mental health problems, substance misuse and suicide for Aboriginal and Torres Strait Islander peoples (Dudgeon et al, 2010). The Royal Commission Report (1991) into Aboriginal Deaths in Custody also identified a number of recommendations associated with Aboriginal mental health as

> "substantial expansion in Aboriginal mental health services within the framework of the development, on the basis of community consultation, of a new mental health policy; there be close scrutiny by those developing the national policy of the number of models that exist for such expansion; Aboriginal people be fully involved in the policy development and implementation process and the linking or integrating of mental health services for Aboriginal people with local health and

other support services be a feature of current and expanded Aboriginal Mental Health services" (Ward & Gorman, 2010, p. 5).

3.7 The Burdekin Report (Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, 1993)

The Burdekin Report (1993), focused on specific issues affecting the mental health of Aboriginal and Torres Strait Islander people that encompass historical perspectives such as the significance of colonization and current approaches implemented when diagnosing and treating mental illness and consideration of Aboriginal perspectives on mental health problems. Findings report there is little knowledge and understanding on the incidence or occurrence of mental illness, effects relating to separation and dispossession and social and economic disadvantage all continue to add to widespread mental health problems. Similar to the findings of the Aboriginal Deaths in Custody report, mental health professionals had little understanding of Aboriginal and Torres Strait Islander culture and society and failed to diagnose and provide effective treatment. As a result, health professionals were not only limited in their knowledge and understanding of Aboriginal and Torres Strait Islander culture and people but were rarely confronted with Aboriginal and Torres Strait Islander people presenting with grief and loss issues and emotional and psychological distress. Aboriginal and Torres Strait Islander mental health does not equate to the same understanding as the wider population, because of their unique culture and personal experiences of dispossession (Ward & Gorman, 2010).

3.8 'Ways Forward' - National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report by Swan and Raphael, 1995.

Swan and Raphael (1995) conducted an investigation into the mental health of Aboriginal and Torres Strait Islander communities and found there was a high level of mental health problems (self-harm, suicide, substance abuse, domestic violence, child abuse, disadvantage, trauma and grief) that were not identified or addressed (Swan & Raphael,

1995). Many of these problems contributed to accumulative risk factors and were viewed overwhelming for many Aboriginal and Torres Strait Islander people. Similarly to the previous two reports (Aboriginal Deaths in Custody; Burdekin Report), the same observation was being reiterated that mainstream mental health services were not adequate, were not delivered in a culturally appropriate and holistic way in recognition of cultural values, beliefs and spirituality. However, what was different from the previous reports was the connection between mental health, wellbeing and physical health, indicating that mental health problems resulted from the overall poor health status in accumulation to grief and loss and additional issues. This supports the need for responsible decision-making that must reside with Aboriginal and Torres Strait Islander people when designing and implementing mental health services and programs that enable the uptake of these services by their own because of the connection to Aboriginal and Torres Strait Islander culture and wellbeing. At the time of this report, mental health was newly recognized and the validity of the information provided is questionable particularly the prevalence rates of mental health issues being reported in Aboriginal and Torres Strait Islander populations and communities (Morice, 1979). The sharing of this information was imperative to this report simply to inform mainstream service providers and mental health professionals to avoid compromising access and promoting the level of intervention required by Aboriginal and Torres Strait Islander people (Westerman, 2004; Hunter, 1993).

3.9 The Health Care System - Queensland Plan for Mental Health 2007-2017

The vision for mental health across Queensland for the period 2007 – 2017 was to improve mental health and facilitate access to a “comprehensive, recovery-oriented mental health system” (Queensland Government, 2008 p. 2) for the whole population. A coordinated approach was adopted through the delivering of a wide range of services

that would focus on promotion, prevention and recovery of mental health for individuals while addressing the level of impact on families and communities so those people can actively take part in their community and broader society. Through this plan the establishment of relationships, partnerships and community links within and across community and hospital settings both public and private for the whole population was a key focus (Queensland Government, 2008). Meeting the mental health needs of all Queensland's was a priority and making sure that the complexity of factors that influence mental health was being addressed. The primary focus of the Health Service Districts within Queensland was to ensure that holistic care was delivered to those people suffering from severe types of mental illnesses and disorders that were effective and responsive.

In relation to the Toowoomba District Mental Health Service provides a range of services across Toowoomba Darling Downs and South West Queensland communities to a wide range of mental health consumers in rural, remote and regional communities, which include the identified communities in this research. In the early 1990s the Queensland wide service on the background of the National Mental Health Plan designed and implemented a research project exploring the effectiveness of the delivery of mental health services targeting Aboriginal and Torres Strait Islander consumers, carers and communities across the region (Eley & Hunter, 2006). The main purpose of the research project was to identify pertinent issues that contribute to the lack or no access to mental health services in order of meeting the needs of Aboriginal and Torres Strait Islander people and communities. Evidence from this research supports and endorses what preceding research have found, full attendance and participation from Aboriginal and Torres Strait Islander people and communities in the design and implementation of mental health services, health care and treatment that is culturally appropriate and

culturally safe is the upmost priority. This extends to the employment of Aboriginal and Torres Strait Islander health professionals who have the ability to relate to any Aboriginal and Torres Strait Islander person because they are professionally committed, culturally aware and respectively considerate of Indigenous and non-Indigenous people (Eley & Hunter, 2006; Ward & Gorman, 2010).

3.10 Queensland Mental Health Commission (2013) – Mental Health Reform

The Queensland Mental Health Commission in their discussion paper titled 'Suicide Prevention in Queensland: continuing the conversation' (2015), highlighted a need for an improved approach to suicide prevention by continuing the conversation with Queenslanders about how and what an action should look like. This was based on national consultations conducted with stakeholders, community representatives, and government and non-government agencies about evidence that works to reduce suicide and the impact on Queenslanders. "While the suicide rates have been relatively stable in Queensland at around 13.3 per 100,000 people between 2009 - 2013 they continue to be higher than the 10.9 per 100,000 national rates" (Queensland Mental Health Commission, 2015, p. 3).

The Queensland Suicide Prevention Action Plan overarching goal is to reduce suicide and the impact on Queenslanders by changing the conversation and providing support and services in a more effective way through four (4) priority areas: 1. 'Stronger community resilience and capacity' by raising awareness and reducing stigma within communities, acknowledging when someone needs help, providing support and assistance to those bereaved by suicide, guiding and enhancing local solutions within communities; 2. 'Improve service system responses and capacity' recognizing and responding efficiently and appropriately to those at risk of suicide, providing holistic assessment, support, treatment and care to those at risk of suicide, decreasing access

to lethal means and providing support to workers and first responders of suicide; 3. ‘Focus support to vulnerable groups’ improving access and availability and success of mainstream services and modifying services and programs that meet the needs and position of at risk groups; 4. ‘A stronger more accessible evidence base’ through available research on what works, facilitating appropriate access to relevant and applicable data informing localized responses and lastly embracing the knowledge of those who have experienced suicide. For the purpose of this research Priority Area 3 ‘Focused support for vulnerable groups’ focuses on Aboriginal and Torres Strait Islander people and people living in rural and remote communities is of particular relevance. Additionally, the lesbian, gay, bisexual, transgender and intersex community are also included in this priority area. It is evident that suicides among Aboriginal and Torres Strait Islanders are much more frequent in comparison to other Queenslanders, for Aboriginal and Torres Strait Islanders suicide rates are 50 percent higher (Kloves, Potts & De Leo, 2015). Not only are these high rates characteristic of the interplay of both risk and protective factors but broader social, economic and historic factors affecting social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islanders are also important. Evidence suggests improving social and emotional wellbeing of people results in a reduction in suicides for Aboriginal and Torres Strait Islanders (Queensland Mental Health Commission, 2015). Suicides in remote communities were two times higher and for regional communities, were 28 percent higher. Some of the social, environmental and financial factors contributing to the wellbeing of rural and remote communities are “limited employment or education opportunities, social and geographic isolation, economic hardship and uncertainty” (Queensland Mental Health Commission, 2015, p. 11).

People residing in these communities are less likely to seek help, receive treatment or access support due to a lack of information in being able to access available quality

services. Other significant stressors adding to this mix for rural and remote communities is relationship breakdowns and conflict, substance misuse, income and work opportunities. Recognizing the diversity that exists in and across communities of Queensland, particularly the community strengths and weaknesses is important as not all rural and remote communities are precisely the same. However, being familiar with these differences will establish better community partnerships and encourage community participation in early planning and support effective co-ordination of activities. This is essential to achieving a collective community response to high suicide rates relevant to rural and remote communities (Queensland Mental Health Commission, 2015).

CHAPTER 4 – AUSTRALIAN SUICIDE PREVENTION DEVELOPMENTS

Introduction

In the first instance, suicide prevention strategies are considered in terms of the mainstream population and then secondly the suicide prevention strategies focused within Aboriginal communities are discussed. The information is in part framed by a chronological understanding of the reports in this field of study which is offered as a table in the Chapter. This is an important framing because it allows an understanding of how suicide prevention evolved over time and whether or not these strategies have been taken up by and have had positive impact within Aboriginal communities. The Chapter concludes with an understanding of the most effective strategies in use within Aboriginal communities as ascertained from the literature and research participant interviews and thus lays down the platform for the dialogue of risk and protective factors to be discussed in Chapter 5.

4.1 What is being done to prevent suicide?

The Department of Human Services and Health introduced the 'Here for Life' plan addressing the higher risk populations of youth suicide. Australia in 1995 was one of the first countries to develop the National Youth Suicide Prevention Strategy (NYSPS) and was the first country to adopt a coordinated approach towards preventing suicide (Senate Community Affairs References Committee, 2010, p. 5; Department of Health, 2014). Due to the growing body of evidence regarding community concerns internationally the Australian Government during the 1980s and 1990s aimed to explore the risk associated with suicidal behaviours occurring across the whole-life-span by launching the National Youth Suicide Prevention Strategy in 1999. The National Youth Suicide Prevention Strategy (NSPS) broadened their focus to cover the whole of life span continuum. This Strategy would take the focus of a transformed focus in the development of the 'Living is

for Everyone' (LIFE) (2011) Framework. This framework evolved into a national action plan with the aim of preventing suicide while promoting mental health and resilience. The Council of Australian Governments (COAG) in 2006 supported a National Action Plan on Mental Health requiring superfluous funding to expand suicide prevention programs targeting high risk populations (Senate Community Affairs References Committee, 2010; Department of Health, 2014) to reduce suicide risk and mortality while building individual and community resilience (Lifeline Australia, 2011). The key purpose of the National Suicide Prevention Strategy (NSPS) was to

> "build individual resilience and the capacity for self-help; improve community strength, resilience and capacity in suicide prevention by providing targeted suicide prevention activities; implement standards and quality in suicide prevention; take a coordinated approach to suicide prevention and improve the evidence base and understanding of suicide prevention" (Senate Community Affairs References Committee, 2010, p 20; Department of Health, 2014).

In Queensland a cross-Government initiative for suicide prevention evolved out of the Queensland Government Youth Suicide Prevention Strategy 1997-2002 (QGYSPS) with a focus on preventing self-harming behaviours among youth while reducing the impact on families and communities through a coordinated approach by incorporating life sustaining strategies. In 2003, the Queensland Government Suicide Prevention Strategy 2003-2008 (QGSPS) was the first developed by the Queensland Government incorporating a comprehensive whole of Government approach by embracing a whole of life approach to high risk populations across Queensland. From 2011, a whole of Government and whole of community approach became the focus of the Queensland Government Suicide Prevention Action Plan: Taking Action to Prevent Suicide in

Queensland by guiding the development of agencies across Queensland to take action (De Leo et al, 2011; Lifeline Australia, 2011).

Table of major reports in Indigenous Health & Suicide prevention in Australia		
Name of report	**Author/s**	**Date**
National Aboriginal Health Strategy	National Aboriginal Health Strategy Working Party	1989
Royal Commission Into Aboriginal Deaths In Custody	Patrick Dodson, Hal Wooten, and Elliott Johnston	1991
Burdekin Report (Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness	Brian Burdekin, Dame Margaret Guilfoyle and David Hall	1993
'Ways Forward' - National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report by Swan and Raphael	Pat Swan and Beverley Raphael	1995
The Hidden Toll: Suicide in Australia	Senate Community Affairs Reference Committee	2010
Suicides in the NT, Gone Too Soon: A Report Into Youth Suicide in the Northern Territory	Legislative Assembly of the Northern Territory	2012

Suicide and Suicide Prevention in Australia: Breaking the silence	Lifeline Australia and Suicide Prevention Australia	
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy	Department of Health and Ageing	2013
A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention	National Mental Health Commission	2013
One World Connected: An assessment of Australia's progress in suicide prevention	Suicide Prevention Australia	2014

In the development of a National Aboriginal and Torres Strait Islander suicide prevention strategy in 2010, the Senate Community Affairs References Committee (2010) established a number of recommendations. These are developing the capacity of communities and community organizations to provide local leadership and resources to enable Aboriginal and Torres Strait Islander peoples to take on the challenge of preventing suicide; provide postvention support to families and communities bereaved through suicide; base the strategy on evidence that provides professional support for effective practice; and support the uptake of resources from all levels of government (Department of Health, 2013).

4.2 Collection of Australian suicide data

The collection of Australian suicide data is the responsibility of each State and Territory to collect and register deaths occurring in their jurisdiction to the Registrars of Births, Deaths and Marriages (RBDM). The registration process is different for each State and Territory regarding the role and responsibilities of Registrars of Births, Deaths and Marriages and coroners. A number of documents must be completed by the medical practitioner or coroner in identifying the cause of death. The Australian Bureau of Statistics explains coronial processes in determining the intent of a death (whether intentional self-harm, accidental, homicide, undetermined intent) are especially important for statistics on suicide deaths because information on intent is necessary to complete the coding under ICD-10 coding rules (De Leo, 2011, p. 18). Indigenous suicides before 1971 were difficult to determine in a great deal of the literature due to the inconsistencies on the collection of data of Indigenous people in Australia which continues to be practiced in the state of Victoria and Tasmania (Elliott-Farrelly, 2005a; Pink & Allbion, 2008). However, since 1990 for the state of Queensland work has been progressing in rectifying this problem through the establishment of a Queensland Suicide Register (QSR). The Queensland Suicide Register has established a comprehensive database of suicides occurring across Queensland including Indigenous suicides. De Leo et al., (2011) report from 1998 it was mandatory to record ethnicity in death notifications however up until that time Indigenous suicides were based upon information gathered from health professionals and relatives or at the discretion of the coroner, which supports the argument of Indigenous suicides being underreported. Furthermore, in determining a death it is difficult at times to establish the exact circumstances or the alignment of coroners in their investigation due to the transient lifestyle of many Indigenous people (Hanssens, 2007a).

4.3 Australian Institute of Suicide Research and Prevention

The Australian Institute of Suicide Research and Prevention (AISRAP) located at Griffith University has a primary responsibility for the collection of suicide data of Queensland's adult population. Whereas, the Queensland Family and Child Commission (QFCC) are mandated to collect data on Queensland's children and young people up to 16 years of age. The identification of Indigenous suicide data in mainstream institutions has the potential to be misinterpreted and misrepresented which has historically been problematic and this trend continues. A suicide that fails to be identified as Indigenous, particularly from a health or legal professional perspective, may be reliant upon factors that draw on knowledge about Aboriginal identities and relationships with Aboriginal peoples that are historically limiting. For example, identifying Aboriginal peoples only in terms of physical features and skin colour undermines Aboriginal understandings which do not rely on these markers. Alternately, negative historical relationships between the police (investigating a suicide) and Aboriginal people may be informed by authoritative approaches that are unhelpful to elucidating the full knowledge of Aboriginal deaths in any given community. Aboriginal people have mechanisms, in relationships with police, to protect family and community from further harm. Mainstream authorities are not held in high esteem for the protection of Aboriginal people, community and values hence the problematic nature of collecting data about Aboriginal deaths by suicide.

CHAPTER 5 - RISK AND PROTECTIVE FACTORS FOR SUICIDE

Introduction

This chapter provides the reader with information on risk and protective factors relevant to the broader community and the difference between 'risk factors' and 'warning signs' generally and for suicide. Additionally, an overview of risk and protective factors for Indigenous suicides provides insight into specific areas of difference. Understanding why someone takes their own life is complex and there are various factors that contribute to a person's decision to no longer live. Furthermore, insights into social determinants for Aboriginal health are relevant in allowing the reader to better understand Aboriginal communities from a social and economic perspective and how these relate to suicides in rural and remote communities.

5.1 Risk factors as opposed to Warning signs

There is a shared misunderstanding that every person who suicides or attempts had an underlying mental health illness or problem, although there is a strong connection between mental health and suicide and suicide attempts these are influenced by different risk and protective factors. A person's actions are influenced by protective factors (coping skills, social attachments, connection and sense of purpose) which build capacity to cope with difficult situations in life (stresses, crisis) as well as building the resilience of individuals (Queensland Mental Health Commission, 2015) (refer to Appendix 1 figure 1.12). Risk and protective factors can be classified as things that can be adjusted or not, and are referred to in some literature as modifiable or non-modifiable. Risk and protective factors are not the only things taken into consideration with regard to suicide, for instance, some people present with risk factors and some don't and as such requires further in-depth assessment. Evidence indicates there are general socioeconomic and demographic trends or risk factors in rural and remote areas that contribute to an

increased suicide rate when compared to city areas. These risk factors include such things social and economic marginalization, social isolation, economic hardship/unemployment, easier access to means that lead to death and reduced access to support services and education facilities. A clear distinction must be achieved from the outset of what a 'risk factor' is and what a 'warning sign' is since people make the common mistake of thinking that risk factors are warning signs indicating that someone is going to suicide. These two are very different definitions. Warning signs for instance indicate an immediate risk of suicide, whereas risk factors indicate someone is at heightened risk for suicide, but indicate little or nothing about immediate risk (Rudd et al., 2006). Chapter four (4) provides information pertaining to risk and protective factors of suicide for non-Indigenous peoples. Additional risk and protective factors for Indigenous suicides are also provided. Understanding why someone takes their own life is complex and there are various factors that contribute to a person's decision to no longer live. These factors are identified from a whole of population viewpoint with the intention of highlighting factors that further contribute to Aboriginal and Torres Strait Islander suicides, separate from non-Indigenous populations. The Suicide Prevention Resource Centre (2015) report 'risk factors are not warning signs' whereas, Response Ability (2005a; 2014b) report 'a warning sign is different from a risk factor'. Warning signs may indicate that a problem is already present whereas risk factors more than likely indicate that a problem is going to occur. It is difficult to predict who is at risk of suicide however some signs may be evident when someone is thinking about ending their life. On the other hand, some people present with risk factors, but it does not essentially mean that the person will have difficulties. A build-up of multiple risk factors will undoubtedly increase someone's chance of developing harmful mental health issues (Response Ability, 2005; 2014) (refer to Appendix 1 figure 1.11). Whereas, Living Is for Everyone (LIFE) website (2015) in Fact sheet 4 uses the term 'persuade' in reference to risk and

protective factors indicating that these factors either influence or convince someone to end their life which is different to what was mentioned earlier, for example, these factors can sometimes exist on presentation or not and would not be the only sign that someone wanted to end their life. Reference is also made to risk factors increasing vulnerability of someone wanting to end their life and protective factors reducing vulnerability (Suicide Prevention Australia, 2015).

A single risk factor does not influence a person to suicide or attempt to suicide nor does it mean that risk factors alone will determine that someone is suicidal. However, a combination of risk factors and a lack of protective factors exist for an individual who is at risk. Risk factors that occur at particular times, when in crisis, have greater impact on those at risk for instance “loss of job, relationship breakdown and/or intoxication” (Queensland Mental Health Commission, 2015, p. 3). Additionally, childhood trauma, abuse (physical, sexual), family situations and personality characteristics have cumulative effects that also influence suicide and suicide attempts.

5.2 Risk and Protective Factors for Indigenous suicide

For an Indigenous person, risk and protective factors influencing mental health that continue to impact on individuals, families and communities in context to surroundings are potentially workplaces and schools, social, cultural and recreational environments, income and social opportunities, personal health practices, and access to a range of health and other services (Zubrick et al., 2010). It is evident that experiences of risk factors that are interrelated and cumulative generate negative effects on Aboriginal and Torres Strait Islander people’s social and emotional wellbeing (Kazdin & Kagan, 1994). For example, an individual risk factor is ineffective on its own however, when combined with other risk factors can have a strong effect on people. Continual contact with combined risk factors over time results in negative cumulative effects. The kind of risk

factors impacting Aboriginal and Torres Strait Islander people's social and emotional wellbeing are things like grieving the loss of a family member or relative through death or trauma, physical and emotional abuse from traumatic events and/or through domestic violence resulting in family breakdown, being removed from family and community through historical policies resulting in cultural dislocation, exposure to drug and alcohol abuse, racist or discriminatory processes and experiencing disadvantaged on social and economic levels (SHRG, 2004). Protective factors are things that increase the strength and resilience of Aboriginal and Torres Strait Islander people to rise above when faced with diverse challenges. Connection to land, culture, spirituality, ancestry family and community are recognized as key factors that protect people from experiencing highly stressful situations at the individual, family and community level (Zubrick et al., 2010).

Many Aboriginal and Torres Strait Islander people identify with and are confronted with racism and/or discrimination throughout their lifetime. The type of racism and discrimination impacting Aboriginal and Torres Strait Islander wellbeing is inherited systemically or institutionally occurring within policies, procedures and laws that specifically disadvantage groups and/or limit their rights as an individual resulting in unfair outcomes and unfair discrimination (Krieger, 1999). Stressful life events or circumstances can cause negatively cause effects for people enduring unfavorable events that impact on individuals and families capacity to function as a whole unit in a fulfilling and useful way (Zubrick et al, 2010).

Risk factors continue to demonstrate how cumulative and widespread negative impacts are and interrelated in situations of family violence, substance misuse and mental health. Protective factors enhance people's resilience and may serve to counterbalance risk factors. These factors may evolve from bio-psychosocial, environmental or socio-cultural in nature providing an opportunity to consider these factors from different perspectives.

Risk factors affecting social and emotional wellbeing include “unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage” (SHRG, 2004, p. 9). Protective factors contributing to positive aspects of social and emotional wellbeing include connection to land, culture, spirituality, ancestry and family and community. These aspects provide people with the ability to be resilient and heal from difficult circumstances. Despite rates of mental health problems and suicides being higher in rural communities than cities supports the notion that there are additional contributing factors to suicide and mental health and the reasons for someone to take their own life are very complex.

5.3 Social determinants of Aboriginal health

Despite similar rates of reported mental disorders, higher suicide rates in rural areas compared to metropolitan areas suggest that factors other than mental health may also be contributors and/or catalysts to rural suicide. According to the LIFE Framework (2011) a number of factors contribute to the high suicide rates in rural and remote areas such as economic and financial hardship changes in the economy and extreme climate events have a direct effect on many people in rural and remote communities; easier access to means that lead to immediate death, firearms and other means of suicide may be more available in rural and remote areas; social isolation: many people living in rural and remote communities are socially isolated with less face-to-face contact with services, family, friends and support networks. Less help-seeking: many rural people are resilient and resourceful, and have a strong sense of self-sufficiency; this may discourage them from seeking help in difficult times. Risk factors, or vulnerabilities, experienced in rural compared to urban areas require rural communities to implement and plan initiatives. Applying interventions that address social determinants of health to such diverse

populations and complex communities requires a population health approach and closer examination of both mainstream and Indigenous specific initiatives (CCRMHQ, 2010). A population health approach is about reviewing and understanding what occurs in the daily lives of people that affect their health, mental health and social and emotional wellbeing. To address and support the promotion of population health approaches specific to social and emotional wellbeing aspects of biological, psychological, social, environmental and economic factors must be recognized to be effective at the individual, family and community levels.

Making changes to the conditions that affect social and emotional wellbeing, therefore, generally requires long-term sustained effort across multiple sectors of the community. Effective interventions are not confined to traditional health or mental health services and domains. Interventions in all sectors of the community and at all levels can enhance social emotional and spiritual wellbeing. This requires widespread recognition of the interrelatedness of the domains of life and an understanding that the responsibility for social emotional and spiritual wellbeing, along with the benefits, reside in all sectors of the community. These benefits will become increasingly evident over time, as they comprise a long-term investment in social emotional and spiritual wellbeing (CCRMHQ, 2010). It is essential to acknowledge the central role of the Ottawa Charter for Health Promotion to Achieve Health for All by the Year 2000 and Beyond (WHO, 1986) within a population health approach. The Ottawa Charter was adopted at the First International Conference on Health Promotion in 1986 and was a basis for development of the Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO, 1997) and Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005). The Ottawa Charter defines health promotion as: the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and

social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Health promotion is not just the responsibility of the health sector, but it goes beyond healthy life-styles to well-being (CCRMHQ, 2013, p. 6).

5.4 Suicides and research in rural and remote communities

When comparing suicides rates between city and rural Australian communities generally suicide rates are reportedly higher in rural communities than in urban communities (Lifeline Australia, 2011; Cantor & Slater, 1997; Fraser et al, 2005b; Miller & Burns, 2008; Page et al, 2007; Page & Fragar, 2002; Phillips, 2009). Suicides in Australian rural and remote communities are continually increasing among marginalized groups of high risk populations for Indigenous people, youth and older disadvantaged males (Lifeline Australia, 2011; Caldwell et al, 2004; Hirsch, 2006; Morrell et al, 1999; Phillips, 2009; Taylor et al, 2005b). This is also evident among farmers in rural and remote communities in which two-thirds of suicides occurred in the age group 55 years and over and youth 15 – 24 years of age. It's been reported that people living in rural communities are 30 – 50 percent more likely to suicide than in urban communities. For farmers these increases are related to accessibility of firearms and pesticides. A study conducted by Dudley and colleagues (1988, p. 77) found that "suicides increased as much as 12-fold in towns with fewer than 4000 people; males aged between 15-24 years have proven to be most at risk" (Dudley et al, 1998; Page et al, 2007 as cited in Living is for Everyone, 2011). This is supported by a more recent study conducted by Alston (2010) and Phillips (2009) that suicides do increase because of rurality (Kõlves et al, 2012) - meaning the more remote you are the more at risk you are of suicide.

Statistically suicides are believed to be underestimated in rural communities similarly in many other population groups, in addition to actual figures being significantly higher than what is reported and registered. The Australian Institute for Suicide Research and Prevention data confirm that suicide rates are higher in rural communities for both males and females (Kõlves et al, 2009). Some of the challenges around this is being able to determine the proper intent of deaths (drowning, drug overdose, single vehicle and driver accidents), where they are classified as accidental or unspecified (Lifeline Australia, 2011). Regardless of whether you reside in rural remote communities or city dwellings the level of risk associated with suicide is minimal unless there are a combination of risk factors which obviously heightens further risks for suicide (Taylor et al, 2005a). Furthermore, not only is a combination of risk factors heightening the risk of suicide in rural communities but socio-economic status particularly of males establishes a strong connection between these factors (Page et al, 2002).

For men in rural communities some of the relatable risk factors are masculinity, stoic attitudes, connection to land and 'broad shouldered' behaviours – men masking mental health issues – playing many of their issues, problems down as not important. Additional contributors to suicide that hinder people accessing services is depression and social stigma when seeking help – and people genuinely have concerns about confidentiality, drought-related trauma, finances, substance misuse, isolation, violence and access to education regarding mental health. Despite similar rates of reported mental disorders, higher suicide rates in rural compared to metropolitan areas suggest that factors other than mental health may also be contributors and/or catalysts to rural suicide. In rural and remote communities the effects from drought and flood do negatively impact on people's health and wellbeing however, they should not be seen as the only factors contributing to the high rates of suicide (Suicide Prevention Australia, 2009).

Furthermore, rural communities may experience, to varying degrees, the stresses of the closure, restructuring and withdrawal of essential services such as banking, schools, hospitals, government offices, transport and employment services as well as the effects of workforce migration, social fragmentation, and an ageing population. Agricultural communities, which typically comprise many rural areas, may also experience stress caused by long work hours, the responsibility of caring for crops and animals, and the financial, psychological, and emotional impacts of drought conditions, climate change and farming crises. Research shows that the gradual depopulation of a number of rural areas has also resulted in the loss of primary relationships and increased loneliness for many rural residents, particularly young men. The effects of these circumstances are known to greatly contribute to broader socio-cultural, (mental) health, economic, and service-related problems and conditions, which in turn place individuals at greater risk of suicide and self-harm. Across cities and in regional and remote localities suicides are multifaceted and linked to many complex situations relating to issues in relationships, legal, physical, mental, impact on farmers and drought (Alston, 2010; Macintyre et al, 2002;Thacore & Varma, 2000). Evident in rural and remote communities is the association of suicide with higher levels of drinking, higher levels of mortality in younger year's higher hospital admissions relating to harm and violence among Indigenous populations (Cantor & Slater, 1997; Miller et al, 2010; Hunter, 1991; Ollapallil et al, 2008; Phillips, 2009; Pridmore & Fujiyama, 2009; Procter, 2005).

Similarly, suicides in metropolitan areas against suicides that occur in rural areas (regional and remote) are multi-faceted (Alston, 2010; Macintyre et al, 2002); often associated with relationship breakdowns, legal issues, physical and mental illnesses, as well as issues more directly related to farming, such as the impact of drought, can all be connected to suicide in these areas (Thacore & Varma, 2000). High-risk alcohol

consumption has been linked to an increased vulnerability to suicide, especially in rural areas, where there are corresponding high rates of alcohol consumption and suicide (Cantor & Slater, 1997; Miller et al, 2010). A study investigating the impact of socio-economic status on suicide found stronger associations between rural residency, lower socio-economic status and suicide, especially among males (Page et al, 2002). The higher rates of premature death due to external causes (which includes deaths attributed to suicide) experienced in Indigenous communities, many of which are located in remote areas of Australia, have been reported by different researchers (Hunter, 1991; Ollapallil et al, 2008; Phillips, 2009; Pridmore & Fujiyama, 2009; Procter, 2005). Indeed, Procter (2005) reports that between 1998 and 2001, 16% of Indigenous deaths were attributed to 'external causes', compared to 6% of general population deaths; more specifically, "premature death due to deliberate self-harm accounted for 33% of male deaths and 15% of female deaths (Procter, 2005, p. 237). These communities also experience higher rates of hospital admissions related to harm and violence, but it is uncertain how many admissions are directly related to self-harm or suicidal behaviours (Hunter, 2002; Ollapallil et al, 2008). However, as many remotely-located Indigenous communities do not have easy access to a hospital, there may be a significant under-reporting of these sorts of numbers. However, these self-harms and suicidal behaviours need to be understood within an Indigenous context. In this way, these performances can be read as a drastic response to certain stressful experiences (risk factors) and violence in the broader social and emotional context of cultural meaning, cultural identity, historical and current socioeconomic conditions (Procter, 2005, p. 238; for further reading on these issues please refer to Hunter et al, 2001 and Tatz, 2001). Self-harm can also have reasons deeply contextualised within culture in terms of 'sorry cuts' or 'anger cuts'; here, there may be no intention to die but desires to cope with seemingly unbearable pain, relieve stress, express rage or seek attention (Ollapallil et al. 2008).

To understand the risk and protective factors within Indigenous contexts requires further information and deep understanding. What is known and can be applied to the Indigenous context are socioeconomic factors, social isolation, and access to appropriate services. However, there are questions that remain unanswered. For example, to what extent are health services within remote and rural locations able to provide culturally appropriate service as a core feature of their delivery? Alternately, what role does the break down in culture have on the protective abilities of Aboriginal individuals and communities in the maintenance of health and wellbeing? Open, honest and continuous dialogue on risk and protective factors with the Aboriginal community is needed for unraveling this complexity. Such a strategy will provide practical, ethical, cultural guidance for dealing with suicide in remote and rural Aboriginal communities.

CHAPTER 6 - HISTORY OF AUSTRALIAN SUICIDES

Introduction

This chapter provides a review of the literature that is pertinent, current and includes classic literature works that provide historical insights into the context of the issues among Aboriginal and Torres Strait Islander people. Furthermore, the review of the literature provides a broad range of interdisciplinary and scholarly views and perspectives on the issue of Aboriginal and Torres Strait Islander understanding of suicide.

Suicides in Australia were evident as far back as the 1830's in a penal colony on Norfolk Island where convicts participated in a pattern of suicide by lottery progressing into the brutal and harsh conditions of bravery and solidarity (Hassan, 1992). The Australian colonies developed on the basis of English cultural and legal traditions, suicide and attempted suicide were regarded as criminal acts and, as such, suitable laws were embodied in the original criminal codes of the respective colonies. The process of altering the legal codes commenced in the late nineteenth century. In 1886, laws in Victoria were enacted to allow the performance of Christian burial rites for suicide victims and the forfeiture of property as a possible legal consequence of suicide was ended in 1878. This in turn has helped put to rest the English tradition of punishing the suicide through bodily mutilation, forfeiture of property and crossroad burial (Hassan, 1992, p. 35).

6.1 Historical context of Australian suicides

As reforms continued across the country community attitudes changed. Suicide was no longer treated as a crime from 1899 in Western Australia (1902) and Tasmania (1924) followed suit, however it would take more than a decade to occur in South Australia. In Tasmania 1979, Victoria 1967, Western Australia 1972 and Queensland 1979 crimes of suicide were abolished from the statute. In 1983 New South Wales and South Australia agreed that punishing those who suicided was inappropriate in a court of law. However,

this is not extended to those who assist or encourage someone to suicide. If a person was seen to assist or encourage they would be liable for imprisonment which varies from state to state. Under Australian law a coroner's inquest is held to determine a suicide based on the cause or circumstances surrounding the death either due to violence or under unusual or unknown circumstances. A coroner's verdict will fall into a category of: death due to natural causes; murder; accident; suicide; death due to undetermined cause or causes. Once a suicide is determined it is then classified by the Australian Bureau of Statistics. For instance, in a study conducted (Carr and Hassan1987), over a ten-year period (1972- 1981) deaths were classified as accidents or suicide. South Australia had the second highest proportion of suicides between 1972 and 1976 and the lowest proportion of undetermined deaths and had the highest proportion of suicides between 1977 and 1981. New South Wales between 1972 and 1976 reported the highest proportion of undetermined deaths, the highest proportion of suicides yet the lowest proportion of accidents. Categorizing unexpected deaths as a suicide was more likely the determination of South Australia's coroner rather than an unexpected death. However, for New South Wales (1972-76) undetermined or suicide was indicated as an accident. In the Northern Territory (1972-76) unexpected deaths were categorized as an accident rather than suicide. In Australia, for the period 1976-81 the proportion of suicides was consistently higher among males than females; this trend was consistent across the country. Though, for the period 1972-75 the amount of suicides was higher among females then males and more so in Queensland. It appears across the jurisdictions of Australia that inconsistencies were evident in how suicides were determined and classified and did result in the misinterpretation of data calling the accuracy and incidence of suicides within Australia into question. Australian research into suicide was predominantly undertaken by doctors of the medical profession and particular psychiatrists. Suicide studies at the time of Hassan's (1992) research were classified as

‘problem – orientated’ with emphasis on medical, mental health and suicide management. Up to the 1960’s, studies into suicide focused on relationships between suicides and migration and suicides and age, revealing that suicides increased with age and increased for young people and adolescents. Furthermore, there was a higher rate of older people completing suicide in comparison to higher rates of young people attempting suicide. From the 1980’s a focus on relationships between pre-existing psychiatric disorder/s and suicide were tested and scrutinized on the basis of methodology and theoretical positions. Studies conducted by psychiatrists and the medical profession viewed suicide as a form of psychiatric illness rather than from a socio-cultural perspective in accordance with Durkheim’s (15th April 1858 – 15th November 1917) theory and understanding. Over time variations in suicides were evident in relation to economic cycles including aspects of social change occurring. For instance, in the period (1880’s) of the land booms and speculative silver an increase in suicides was evident, similarly in the period (1890’s) increases relating to economic depression, collapse of the land booms, bank failure and the drought were also evident. In 1912, Knibbs (1910), the first sociologist researcher to study suicide in Australia examined trends in suicides between 1858 and 1910. Knibbs (1910) found fluctuations in suicides in the nineteenth century were described as 'probably social and related to, economic conditions as the most potent factors governing the phenomenon of suicide'. He disputes that any dramatic change in prosperity would diminish social regulations and consequently result in anomie as determined by Durkheim’s (15th April 1858 – 15th November 1917), theory, ‘one would expect that fluctuations in suicide rates would be associated with changes in social conditions which affect the degree of social integration within society’ (Hassan, 1992).

6.2 Historical context of Australian Indigenous suicides

For this section, a review was performed over a five-year period from 2004 - 2009 identifying and analysing the literature in relation to suicide within the Australian context. In “2004, 1661 males (16.8 per 100,000) and 437 females (4.3 per 100,000) died by suicide in Australia, a total of 2098 death (10.4 per 100,000). The highest suicide rates for males in 2004 were in the 30-34 years age group and for women in the 45-49 years age group. Suicide rates are approximately four times as high for men as they are for women. The rates of suicide for males peaked in 1998 at 27 per 100,000, but have declined to 16.8 in 2004. Female rates peaked at 11.1 per 100,000 in 1967, but declined to 4.3 per 100,000 in 2004. Many more people attempt than die by suicide. Up to 12% of people affected by mental illness take their own lives (compared with an average of 1.7% for the whole population” (Auseinet, 2007; Mindframe, 2007 as cited in Ward, 2010, p. 14). Between 2009 and 2010, there were between six (6) and seven (7) deaths per day as a result of suicides (Lifeline Australia, 2010; Suicide Prevention Australia, 2010), and are the leading cause of deaths amongst males in Australia. Deaths from suicides for Indigenous Australians are three to four times higher compared to the total population (Australian Bureau of Statistics, 2010b; Davies-Simon, 2011). Suicide for Indigenous women is roughly five times higher in comparison to non-Indigenous young women (Pink & Albion, 2008).

Since 1921 the rate of suicide has fluctuated considerably (refer to Appendix 1 figure 1.1), therefore it is important to look at the rate over time to see where these changes have occurred and what major events may have influenced these movements. The age-standardized death rate is the preferred measure to follow changes over time as it takes into account changes in the population size. For the total population, the suicide rate peaked in 1963, reaching 17.5 per 100 000 persons. However, for male suicide deaths

the highest rate occurred during the Great Depression of 1930 when the rate reached 28.1 deaths per 100,000, followed by 23.7 in 1963 and 23.6 in 1997. For females, the peak occurred in the 1960s when the rate rose above 10 deaths per 100,000. This increase among women in the 1960s has been attributed in part to the unrestricted availability of hypnotic and sedative drugs. Over the last decade there has been a gradual decline in male suicides, from 23.6 deaths per 100,000 (1997) to 14.9 deaths per 100,000 (2009). Suicides in 2007 were equal to 16.2 deaths per 100,000 and for 2008 they were equal to 16.7 deaths per 100,000. This increase could be attributed to improvements in data collection and reviews as discussed in limitations of suicide data. Data for 2008 and 2009 will be revised, mostly likely upwards; as a result, caution needs to be taken when interpreting the most recent data (Australian Bureau of Statistics, 2011).

For Aboriginal & Torres Strait Islander people the history of settlement in 1788 has not been a dignified progression encouraging or supporting free-thinking, rather the costs to Aboriginal & Torres Strait Islander people have been catastrophic. For example, Aboriginal and Torres Strait Islander peoples, “contact history has been one of ignominy and the mood has been miserable for the most part…..and these experiences have had profound implications for the collective and the individual” (Tatz, 2011, p. 1). In addressing the Canadian Royal Commission on Aboriginal Peoples in 1996, Chief Jean-Charles Pietacho of the Mingan First Nations group proclaims collective despair, or collective lack of hope, will lead us to collective suicide. “This type of suicide can take many forms, foreshadowed by many possible signs: identity crisis, loss of pride, every kind of dependence, denial of our customs and traditions, degradation of our environment, weakening of our language, abandonment of our struggle for our Aboriginal rights, our autonomy and our culture, uncaring acceptance of violence, passive

acknowledgement of lack of work and responsibilities, lack of respect for elders, envy of those who try to keep their heads up and who might succeed" (Tatz, 2011, p. 2).

Aboriginal & Torres Strait Islander people have been continually exposed to many Government policies since 1788 and experience negative effects from these even still in modern times. These effects have translated into immense difficulties when Aboriginal & Torres Strait Islander people try to access services and/or programs which are more often than not culturally mismatched and inappropriate. Language and communication barriers continue to exist in the simplest form. Many continue to feel helpless have low self-esteem, and struggle with power balances of largely non-Indigenous people in government orientated services on positions of authority and power (Westerman, 1997; Eckermann et al, 2010; Ward & Gorman, 2010).

Between 1788 and 1930 the period of the Protectionist Act evolved and commenced the control and power by government of Aboriginal and Torres Strait Islander people. For example, people were removed from their place of origin onto missionary controlled settlements called missions or reserves and imprisoned for undefined periods of time. Culturally for Aboriginal and Torres Strait Islander people this meant they had to forfeit any connection to land or country, their identity, family and community causing disruptions and conflict between other Aboriginal and Torres Strait Islander people and groups (Mullard, 2004; Eckermann et al, 2010; Ward & Gorman, 2010). One of the key outcomes of the government that took place was the direct action of removing Aboriginal children with fairer skin into institutions in which these children then would become known as 'ward of the state' and eventually recognized as the 'Stolen Generation'. The Protectionist Act in NSW in 1915 was rolled out to other States across Australia resulting in more children and families being judged and removed at the hands of government officials (Westerman, 1997; Ward & Gorman, 2010).

Under the direction and administration of Assimilation and Integration policies (1934 – 1972) Government appointed non-Indigenous staff were sanctioned to integrate and assimilate Aboriginal and Torres Strait Islander people into Non-Indigenous ways of living (Brock et al, 1999; Ward & Gorman, 2010). Rowley (1972) argues these policies were aimed at eradicating all 'full bloods' and was recognized as a form of genocide (Ward & Gorman, 2010). The lifestyle and living standards for Aboriginal people were not the same as other Australians and it became worse particularly where people would congregate on the fringes of towns known as fringe dwellers becoming reliant upon government and department bodies. The period of the 1950s saw the rise of compulsory education for all children including Aboriginal children regardless of their limitations, knowledge and boundaries. Aboriginal children largely at the time did not live amongst white Australian communities, had no boundaries, did not have an education and did not participate in general society. This in turn created much turmoil, difficult relationships, traditional lore and Western law and conflict between both populations.

In 1972 things would start to change for the better under the direction of the Whitlam government enforcing social reforms targeting funding and access for Aboriginal people. Social policy in the period 1788 to 1972 did not progress the problems or issues concerning Aboriginal people since the evolvement of the Royal Commission and Aboriginal Medical Services. On every social scale Aboriginal communities were recognized as most disadvantaged in regards to education, unemployment, higher mortality, morbidity and imprisonment (Westerman, 1997; Australian Human Rights' Commission, 2009; Ward & Gorman, 2010).

History dictates as far back as 1788 Aboriginal people continue to be disadvantaged on all levels of which many of these same social problems exist in today's society triggering negative impacts on their health and mental health status (Kahn et al, 1978; Radford,

1999; Blum & Harmon, 1992 & Australian Institute of Health and Welfare, 2002; Ward & Gorman, 2010). In 2009, the population for Aboriginal and Torres Strait Islander people was 2.4% of the total population roughly 500,000 people. In comparison to the Australian population, as Aboriginal and Torres Strait Islanders health and mental health needs, mortality rates, psychologically distress, suicides, self-harm and hospitalizations rise mental health services and programs must align to serve the needs of the whole community (Swan and Raphael, 1995; Kanowski & Jorm, 2009). In addition, information regarding mental health must equate to the literacy levels and cultural understandings of Aboriginal and Torres Strait Islander people.

6.3 Achieving an understanding of Australian Indigenous suicides

In traditional Aboriginal society and postcolonial time's suicide was not heard of, nor mentioned among the Aboriginal and Torres Strait Islander populations within Australia, even with the backdrop of government imposed policies that were racist and discriminatory creating widespread removal from communities, traditional land and families while denying people basic human rights and needs. It is also apparent that suicide rates before 1960 among Aboriginal and Torres Strait Islander people were below that of the non-Indigenous population (Hunter & Milroy, 2006; Hunter, 2001; 2007; Tatz, 2001). In Colin Tatz's (2000) book 'Aboriginal Suicide is different' there were no references in the literature of government records or archives pertaining to missions, government officials, anthropology, journals, fictitious stories, memoirs and art indicating that suicides in Aboriginal communities before the 1960s existed. This was evident in the work that Kidson and Jones did with Western Desert Aboriginal people in 1968 similarly in Cawte's (1987) work with Aboriginal people in Arnhem Land. Jones (1973) also reports in his work with tribal full-blood Aborigines there were no incidences of suicide in the 1970s (Tatz, 2011). Prior to the 1967 Referendum, Aboriginal and Torres Strait Islander

people were not recognized as people or part of the census which explains why there was little to no data on suicides, being normally recorded even before 1971. At the core of most sociological explanations for the high rates of suicide in the Indigenous Australian population is the historical dispossession of land and consequent marginalization and exclusion of Indigenous Australians from mainstream society (Hunter & Milroy, 2006; Hunter, 2001; 2007; Tatz, 2001). Until the 1970s, Indigenous Australians were subject to restrictions on travel, education, employment, living and marriage arrangements, and the forced removal of children to missions, orphanages and foster homes (Hunter & Milroy, 2006; Hunter, 2007; McKnight, 2002; Rowse, 1993). Undeniably, the inequalities experienced by Indigenous people have resulted in devastating effects on people's social, spiritual and cultural wellbeing. National recognition of Aboriginals as the first Australian inhabitants, and the reconciliation movement, began with the 1967 referendum, which granted Indigenous Australians citizenship and the right to vote; both rights from which Aboriginal Australians had been historically excluded (Hunter, 2007). The historical marginalization of Indigenous Australians has resulted in their disconnection from land, culture, religion, tradition and kinship groups (Folds, 1987; Hocking, 2002; Petchkovsky et al., 2004; Smith, 1999). This has led researchers to question whether Indigenous suicidal behaviours are more related to hopelessness, cultural disconnectedness and grief than specific risk factors, such as mental illness (Gorman, 2010; Hunter et al., 2001; Tatz, 2001).

The 2004 data across states and the Northern Territory reveal suicides contributed to 4.2 per cent of deaths for Aboriginal and Torres Strait Islander people in comparison to1.5 per cent of deaths for all other Australians (Auseinet, 2007). Suicide is significantly higher for Aboriginal and Torres Strait Islander men (2.8 times) and women (1.9 times) and evident among younger adult years. For instance, between 1990 and 1995 suicides

largely affected the 15-34 age groups for males and the 15-24 age groups for females. Data provided from 2005 records indicate Aboriginal and Torres Strait Islander suicides were 16.5 times more likely to die in custody than other Australians (ABS, 2007; Mindframe, 2007). This is illustrated in the data for the following states (Queensland, New South Wales, and South Australia & Western Australia) and Territory (Northern Territory) for the number of suicides for Aboriginal people (refer to Appendix 1 Figure 1.2; 1.3 and 1.4).

Properly identifying the accurate numbers of suicides for Aboriginal people is challenging because the data published by the Australian Bureau of Statistics (ABS) is only based on comparative low numbers across parts of the country, resulting in statistics being small. Therefore interpretations of the data require caution when analysing suicide rates. Methods for recording statistics for Aboriginal suicides and self-harming behaviours (Tatz, 1999; Harrison, 2001) is surrounded by complexity in the under-reporting of incidences, how suicides are reported and the length of time are different between states and territories. Identifying Indigenous status has always been an area of contention however, over time this has improved but problems are still evident in identifying Indigenous status in death records (Tatz, 1999; Australian Institute of Health & Welfare, 1999).

The rate of suicide for Aboriginal and Torres Strait Islander people residing in rural and remote communities is reportedly higher than in urban areas due to remoteness, poverty and the access and availability of firearms. Many rural and remote communities have larger populations of Aboriginal & Torres Strait Islander people suggesting rates of suicides are higher among males between the ages of 15-34 years. One of the key reasons contributing to these high rates is that young people are not seeking help or encouraged to do so in these communities (Mindframe, 2007). The differences between

suicides and attempted suicides are not only obvious for Non-Indigenous and Indigenous populations but the behaviours and characteristics of self-harm are not so obvious and are dissimilar. In addition, another aspect that was evident in some Aboriginal communities was the clustering of suicides, for example this was identified in Yarrabah Aboriginal community where clustering's happened at different points in time and in particular communities (Hunter et al., 2001).

In considering strategies to address these differences lies within understanding the social risks associated for Aboriginal & Torres Strait Islander people and their communities, for example, their lifestyle is different to Non-Indigenous people and it is imperative that Aboriginal & Torres Strait Islander people are not assessed, treated or classified within the same framework as Non-Indigenous people. Approaching Aboriginal & Torres Strait Islander people in a holistic way is key in addressing many of the social determinants affecting them today and requires a focus on the whole community rather than at an individual level (Hunter et al., 2001). Proctor (2005) in his work supports this in saying working with people at a community level in support of community based facilities and resources provides for the implementation of preventative measures which is needed when identifying people in crises or at risk of suicide. An example of this was observed in Yarrabah where local life promotion officers were accessed by community people. Providing education and training to local support workers would support and enhance young's people's sense of pride, culture, connection and belonging for that community and family. What is clear is the need to address suicide and self-harm in Aboriginal & Torres Strait Islander communities with a different approach that is not provided to the general population. This approach must be holistic in its delivery and culturally appropriate so that Aboriginal & Torres Strait Islander people can sensitively access services and programs as required. The development and design of culturally appropriate

services and programs are effectively implemented when differences between communities are identified ensuring that community specific strategies are reflective of Aboriginal & Torres Strait Islander people's needs (Elliot- Farrelly, 2004).

The Australian Institute of Suicide Research and Prevention (2015), report in 2014, 627 people committed suicide in Queensland; evidence tells us that for each suicide there is an estimate of 30 people attempting to suicide (SANE, 2014). Despite the fact that in Queensland the suicides rates are stable (13.3 per 100,000 from 2009 – 2013) they are higher than the national average (10.9 per 100,000). Almost three quarters of the suicides are males and are seen as the most disadvantaged and marginalized groups (Queensland Mental Health Commission, 2015). According to the Australian Bureau of Statistics (2015; 2013), for the period 2009-2013 the average number of deaths by suicide annually was 2,461. However, in 2013, this number had increased to 2,522 (6.9 deaths per day); for males 1,885 and females 637. The highest age-specific suicide rate for males in 2013 was 85 and above, followed by 45-49; 50-54-year age groups and the 80-84-year age group. Whereas for females the highest age-specific suicide rate for the same year was in the 40-44 age group, followed by the 50-54, 35-39 and 45-49 age groups and the 60-64 age group. In 2013, approximately 75% of people who died by suicide were males and 25% were females. Suicide is a prominent public and social health concern across Australia and throughout Queensland (De Leo, 2011; Australian Bureau of Statistics, 2015; 2013; Mindframe, 2014). In the state of Queensland, the total number of suicidal deaths in 2010 was 569 (425 males, 144 females), with 94% occurring before 75 years of age and the average age was 44 years. Between 2009-2010 Indigenous suicides was 70% higher in comparison to Non-Indigenous people. The prevalence of suicides in disadvantaged and rural and remote areas was twice as high compared to advantaged areas. In 2009, within the broader population in Australia, there

were approximately six (6) deaths a day as a result of suicides; however recent research indicates that there are seven (7) deaths per day as a result of suicides (Lifeline Australia & Suicide Prevention Australia, 2010), even so the rates are still extremely high, suicides are the leading cause of deaths amongst males in Australia but more importantly, the leading cause of all deaths for people between the ages of 15 and 24 years. Deaths from suicides for Indigenous Australians are three to four times higher compared to the total population (Australian Bureau of Statistics, 2010b; Davies-Simon, 2011) particularly for males aged 0–24 years and 25–34 years and what's more troubling is the suicide rates for young Indigenous women being roughly five times that of non-Indigenous young women (Pink & Allbion, 2008).

6.4 Contemporary understandings of Australian Indigenous suicides

Suicide rates within Indigenous populations throughout the world and are consistently higher. The burden of disease for mental illnesses was equally present in both Indigenous and non-Indigenous suicides with alcohol and substance abuse obvious in Indigenous suicide cases. In regard to mental health care via hospitalization in psychiatric wards was the experience of Indigenous people whereas; non-Indigenous people accessed care from their general practitioner. A commonly shared experience across Indigenous and non-Indigenous populations, of at least one major stressful life event were relationship issues. However, among Indigenous cases there were considerable differences in experiences of stressful life events: exposure to suicide in social group; bereavements; conflict situations and previous or current legal issues (De Leo, 2011). Gerry Georgatos (2013, p. 1), a journalist for the Independent Australia movement (2015), report that Australia's First Peoples are suiciding at the world's highest rates. As a race Aboriginal peoples endure horrific statistics for incarceration, homelessness and suicide incomparable with the rest of the Australia. Across Australia's population, 1.6 percent

dies by suicide whereas, for Indigenous people suicides equate to 4.2 percent of all deaths. The difference between Australia's national suicide rate and Indigenous people suicide rate is referred to as one of the world's worst hence for Aboriginal youth it appears to be the worst. The highest suicide rate for Aboriginal males is between 25 – 29 years with 91 deaths per 100,000 (22 deaths for non-Aboriginal people).

The Australian Bureau of Statistics refers to the standardized rate of suicide for Aboriginal males are two and half times higher and three and a half higher for females. Aboriginal and Torres Strait Islander youth (males) between 15 – 19 years suicide four and half times and females for the same age group suicide six times more than non-Aboriginal counterparts. The Northern Territory suicide rate between 2001 and 2006 was three and half times higher than nationally between 15 to 24 years. The suicide rate between 10 and 17 years for youth increased from 18.8 percent to 30.1 percent per 100,000 in comparison to non-Aboriginal youth which decreased from 4.1 percent to 2.6 percent for this period. Underlying causes for youth suicide included mental health, substance abuse and sexual abuse trauma. However, what failed to be highlighted was the acute poverty and lack of basic human rights of Aboriginal people in many of the troubled communities of today. Georgatos (2013) in his research undertook a comparative analysis globally of suicide data and confirm "the prevalence of spates of suicides among Australian Aboriginal youth are the world's worst statistics and these spates are becoming more prevalent and tragically setting higher medians year in and year out" Georgatos (2013, p. 3). The Australian Bureau of Statistics reported for the period 2000-2010 (refer to Appendix 1 figure 1.3 and 1.4) that there were 996 (1:24) suicides across the country for Aboriginal and Torres Strait Islander people (Georgatos, 2013). However, Georgatos (2015) identified that this figure is much higher (1:12) for Aboriginal and Torres Strait

Islander populations for example, estimates of unreported and unclassified suicides, were approximately 207-208 unaccounted for.

According to the Australian Bureau of Statistics, Western Australia, between 2006 and 2010, recorded an increase in the rate of suicide but this outlier spike in suicides disguises the fact that little has improved. The State Government may argue that they have lowered suicides rates, but this is against the outlier spike, but when you remove the outlier, the long-term high rates of suicides have not decreased (Georgatos, 2015, p. 1). During this period the State of Western Australia endured an increase 11.8 suicides per 100,000 to 13.2 per 100,000. Most of the suicides taking place in Aboriginal and Torres Strait Islander populations occur before 35 years. The Australian Institute of Health and Welfare indicate Aboriginal and Torres Strait Islander males between the ages of 25 to 29 years equate to 91 suicides per 100,000 populations when disaggregating to Aboriginal and Torres Strait Islanders (Georgatos, 2015). Consequently, for Aboriginal males 15-19 years rates of suicide equate to 44 per 100,000; 20-24 years 75 per 100,000; 25-29 years equate to 91 per 100,000 and 30-24 years equate to 60 per 100,000 (Georgatos, 2015). This is evident by example in the Aboriginal community of Mowanjum where suicide was 100 times the national average.

Aboriginal youth suicide in Australia is higher than every country across the world with the exception of Greenland where the suicides are much higher. The epidemic and vulnerability of Aboriginal youth to suicide is reflected in the demographics for instance the median for Aboriginal people is 21 years in comparison to non-Aboriginal people at 37 years (Brown, 2014). Over the last 10 years, Psychiatrist Dr Paul Brown in the field of suicide subsequent to working with Aboriginal and non-Aboriginal communities in Western Australia, Victoria, Queensland and Northern Territory hypothesizes that Aboriginal suicides relate to violence and secularization believing that individuals are

either driven or abandoned to suicide which he refers to as nemesis (ref to Glossary). In Aboriginal culture Dr Brown further states that secularization is equal to Westernization and nemesism-secularisation is informed by cultural studies of the environments in first and second World Wars of Jews and Nazi Germany. In his local analysis of suicides Dr Brown refers to First and Second Nation Australians as the historical-past and contemporary-present and refers to risk factors for suicides historically as they relate to loss of land and culture, trans-generational trauma, grief and loss, racism and social exclusion (Brown, 2014).

While in contemporary times risk factors relate to psychiatric disorders, stressful life events and substance abuse are entrenched in high levels of social disadvantage for unemployment, homelessness, incarceration and family issues (Brown, 2014). In relation to historical accounts of violence towards Aboriginal people Dr Brown states it is reliant upon the view of the author from their academic perspective and ethnicity. In colonial times violence is directly related to dispossession and oppression in the form of armed assault upon all Aboriginal populations across the country. This is evident in the analysis of bones conducted by Palaeopathologist, Professor Stephen Webb who dating back 50,000 years discovered limb spearing and disproportionate rates of injuries to female skulls. Terror was instilled from the earliest childhood unabated through life seeking perhaps to ‘inoculate’ the subject against the vengeful and the sorcerer. Violence ranged from domestic, misogynist violence and child abuse to crowd and clan violence and outright tribal warfare, the feud was endemic. Not infrequently communities protected offenders (Brown, 2014).

Violence in contemporary times includes: domestic violence, bullying in schools and workplace, interpersonal, gang, crowd and communal violence, violent persecution of minority groups, institutional and structural violence and civil war. Violence is perpetrated

by criminals and the mentally ill (Brown, 2014). The different types of bullying in contemporary times in Aboriginal societies include: bullying people for having lighter skin or darker skin tone and for not looking Aboriginal; attacking new people coming into the community; name calling; making obscene gestures; racially-motivated teasing, taunting, froshing and threats; spreading rumours or gossip about a subjects cultural identity; and isolating someone from his or her friends or peer group; and family differences, mutual resentments and grudges (Brown, 2014). The different types of cyber-bullying through the use on internet messaging and social media include: Intimidating people, put-down, spread rumors, make fun of, threaten or exclude someone because of their actual or perceived cultural identity (Brown, 2014). In understanding the relationship of secularization and suicide an understanding of traditional Aboriginal life must be achieved. Traditionally, Aboriginal life was central to the ancestral land and the Dreamtime. Aboriginal people were hunter gathers, married, had children and lived in tribal groups encompassing huge families. They spoke in their traditional language (tongue) and had rich cultural heritage, they never lived in a house, had money or drank alcohol. Aboriginal people did everything in a natural way rather than a Western way – narcissistic way. Aboriginal people encountered the Western way at a time when society was shifting from communalism to individualism. White Australians over the last two hundred years have been trying to shoe-horn Aboriginal Australians into narcissistic western culture. Conflicts have not only been between blacks and whites but intergenerational and intra-familial within Aboriginal culture resulting in culture clash. Intra-individual conflict was equally devastating (Brown, 2014). French sociologist Girard, reveals Aboriginal population's fell prey to western ways – same social ills by adopting narcissistic habits resulting in self- destruction in the form of suicide, alcoholism and crime (Brown, 2014). For that reason, regeneration or re-colonization of the land, art and culture within diverse communities across Australia with an emphasis on youth people

and families would bring to a halt the progress of increasing suicides, crime and substance misuse. Brown (2014), argues that community justice programs are far too downstream, public housing results in suffering consequent upon displacement and kinship networks, relationships and social and cultural needs are overlooked (p. 2). Suicide prevention programs from this perspective are constitutive to the Western culture suggesting that suicide is a medical condition mostly due to depression and can only be solved by putting pressure on youth and communities to either prevent or treat clinical mood disorders. Brown (2014) argues that these programs do not work as they only centre on the perpetrator by restoring patriarchal power to protect rather than destroys vulnerable youth.

Within the Australian population in 2011, Aboriginal and Torres Strait Islander peoples consisted of 669,900 people, a total of 3.0 per cent of the population, these numbers are increasing because of the importance of identifying in many statistics, social outlooks over time are changing for the better, and in the political arena there are advances and improvements in recognition and funding. To achieve a greater understanding of the wider Australian population it is important to be aware of the different localities of where Australian people live. Approximately 90 per cent of non-Indigenous people reside in cities and regional areas, whereas Aboriginal and Torres Strait Islander people reside across many different areas ranging from cities to regional areas to rural, remote and very remote areas across Australia. Aboriginal and Torres Strait Islander residency across different states and territories have 31.1 per cent living in New South Wales compared to 28.2 per cent living in Queensland. Although 10.3 per cent of Australia's Aboriginal and Torres Strait Islander population live in the Northern Territory they only equate to 29.8 per cent of Northern Territories total population. In regards to population health data this means that the Northern Territory has the highest amount of Aboriginal

and Torres Strait Islander people in comparison to other states and territories. When reviewing Australia's population pyramids young Indigenous people are over-represented with an average age of 21.8 years compared to Non-Indigenous young people at 37.6 years with only a small number of Aboriginal and Torres Strait people living beyond 65 years. This in turn reflects the high rates of fertility, morbidity and mortality rates for Australia's Aboriginal and Torres Strait Islander people.

Overall, there is a high burden of disease, chronic conditions, psychological distress and social and emotional wellbeing problems being experienced predisposing Aboriginal and Torres Strait Islander people to multiply and complex factors. This requires service delivery to have a comprehensive, interdisciplinary approach that takes into account the holistic view of health held by many Aboriginal and Torres Strait Islander people. Health professionals across the board must have a good understanding of historical pasts particularly relation to health services while continuing to provide culturally sensitive and competent healthcare to Aboriginal and Torres Strait Islander people.

Services, particularly mental health, are not being accessed by Aboriginal people at a level which equates to their need. Many have higher levels of physical illnesses, death rates, and psychological distress, predisposing them to a larger number of mental health problems and physical illnesses (Kanowski, Jorm & Hart, 2009). The majority have a number of mental health needs and issues, such as suicides and hospitalizations from injuries. Limited access to education and how to deal with crises while managing their mental health problems compounds the problem. Mental health strategies need to be developed by Aboriginal people to better provide communities and people with programs of how to recognize, respond, and prevent, mental health problems and suicidal behaviours (Swan & Raphael, 1995). The National Mental Health Plan 2003-2008, and the Social and Emotional Wellbeing Framework 2004-2008 recognized the need to

increase levels of literacy and awareness regarding mental health within the wider community (Kanowski et al., 2009). It is important to understand the cultural differences in how Indigenous people view mental health, suicide and suicidal behaviours. Indigenous people have a holistic understanding of health and wellbeing and that it not only affects the individual, but the community as a whole. Wellbeing includes all aspects of health, including mental, physical, social, cultural and spiritual health (Australian Health Ministers' Advisory Council, 2005; Australian Government, 2013; NACCHO, 2017).

CHAPTER 7 - ABORIGINAL & TORRES STRAIT ISLANDER YOUTH SUICIDE

Introduction

This chapter provides the reader with background information about Aboriginal & Torres Strait Islander Youth Suicide commencing with the most current statistics which illustrate a distressing picture of the high rates occurring among young Indigenous people in Australia but more disturbingly across the world. Within Queensland there are two organizations that have the responsibility for protecting and promoting the rights, interests and wellbeing of young people these include Commission for Children and Young People and Child Guardian (CCYPCG), whereas, the Secretariat of National Aboriginal and Islander Child Care (SNAICC), have a specific focus of advocating on behalf of Aboriginal and Torres Strait Islander children, young people and families. Additional areas of focus particularly in relation to Aboriginal suicides are psychological distress, sport in youth suicide and the collection of Indigenous suicide data in Australia.

Suicide amongst Aboriginal and Torres Strait Islander young people between the ages of 15 and 34 contributes to the death of 1 in 3 young people. Suicide rate for Indigenous male's 15-19-year-old is 37.8 per 100,000 persons and females 16.1 per 100,000 four times more than non-Indigenous young people. Indigenous males (64.2 per 100,000) between 20 – 24 years are more than three times more likely than non-Indigenous males and Indigenous females (20.1 per 100,000) are four times more likely than non-Indigenous females to suicide (ATSISPEP, 2015).

The World Health Organization (WHO) (1999), report every year approximately one million people die from suicide and 10–20 million attempt suicides around the world. The global mortality rate from suicide is 16 per 100,000, which equates to about one death every 40 seconds (WHO, 2010). Historically, suicide rates have not been as prominent as today.

In the 1950s, the mortality rate attributable to suicide was around 10 per 100,000. This rate has increased by more than 60% in the last 45 years (WHO, 2010), and likely has not yet reached its plateau. Once predominant among the elderly, suicide is fast becoming a youth phenomenon localized among those between the ages of 15 and 24. Young people all over the world are committing suicide at unprecedented rates, replacing unintentional injuries as the number one cause of death among this age group (WHO, 2010). This so-called epidemic of youth suicide is most prominent among Indigenous peoples, who are overrepresented in every suicide statistic (WHO, 2009). The aetiology of these trends is still poorly understood and few theories have attempted to elucidate it but one of the most promising is the cultural continuity theory, hypothesizing that lack of cultural connectedness may explain why Indigenous youth commit suicide at such alarming rates (Chandler and Lalonde, 1998). This theory proposes that a tight-knit and productive cultural community may buffer against Indigenous Youth Suicide. However, little research has examined cultural continuity theory in the social context in which Indigenous populations are embedded.

7.1 Commission for Children and Young People and Child Guardian (CCYPCG)

The Commission for Children and Young People and Child Guardian (2013) is an independent statutory body with the responsibility for protecting and promoting the rights, interests and wellbeing of young people under the age of 18 years within the state of Queensland. It produces annual reports on child deaths in Queensland for maintaining the register of all deaths, reviews the causes and patterns relating to deaths, conducts broad research into child deaths, provides recommendations to enhance laws, policies, procedures and practices in reducing possibility of child deaths and lastly provides annual reports to the Parliament and public. The Commission for Children and Young People and Child Guardian (2013) report Aboriginal and Torres Strait Islander youth have a much

higher suicide rate for the state of Queensland - five times that of any other youth in the state (refer to Appendix 1 figure 1.6). The suicide rate for Aboriginal and Torres Strait Islander youth between 10–17 years equates to 19.7 deaths per 100,000 in comparison to 3.6 per 100,000 for non-Indigenous youth. According to the evidence the most frequently cited risk factors for Aboriginal and Torres Strait Islander youth is “alcohol and substance use, behavioral and disciplinary problems and previous suicidal thoughts and behaviors which are further complicated by ongoing experience of social and economic disadvantages and loss of cultural connection” (Commission for Children and Young People and Child Guardian, 2013, p. 68).

It is acknowledged that an individual from a socially disadvantaged background classified as low socioeconomic status in which many Aboriginal and Torres Strait Islander families are originate, are predisposed to higher risks of suicidal behaviour than those who come from a privileged background. In support of this claim, The Commission for Children and Young People and Child Guardian (2013) found youth aged 10 – 17 years who suicided did originate from the initial background. Similarly,, within the child protection system a high representation of many Aboriginal and Torres Strait Islander families also exist. Youth suicides are multiplicative and frequently occur at the end of adverse life sequences with a combination of risk factors “resulting in feeling of hopelessness and a desire to make it all go away” (Commission for Children and Young People and Child Guardian, 2013, p. 68).

The Commission for Children and Young People and Child Guardian (2014) report a total of 446 deaths for young people were reported and 69 of those deaths were Aboriginal and Torres Strait Islander youth. For Aboriginal and Torres Strait Islander youth a death rate of 81.5 deaths per 100,000 was recorded - 2.2 times the rate of non-Indigenous youth deaths. The greatest amount of deaths occurred under the age of 1 – 63.8 per

100,000 subsequent to 5 – 9-year old's, resulting from transport incidents followed by suicide.

7.2 Queensland Family and Child Commission (QFCC)

Since 2004, the deaths of 5843 children and young people are registered in the Queensland Child Death Register as legislated and mandated by the Queensland Family and Child Commission (QFCC). The Commission has a responsibility to register analyses and report on the collection of youth suicide data (rates and patterns) through the establishment of the Queensland Child Death Register. This information is particularly important for academics, researchers and policy makers as a way to inform suicide prevention policies and programs and to be able to progress research into emerging risks factors that are often associated with youth suicides. The Queensland Family and Child Commission (2015-2016) report annually a suicide rate of 1.8 deaths per 100,000 which equates to 20 young people who were suspected or confirmed to have died by suicide. Further analysis of the data also highlights that since 2004 suicide was the leading cause of deaths for 10-14 years, and followed by 15-17 years as the second leading cause of deaths for young people in Queensland, with exceptions for the years 2007-2009. For the first time in the years 2009-10, youth suicides surpass transport fatalities as the leading cause of death for 15-17 years; nonetheless this continues to be evident in 2010-2016. The Queensland Family and Child Commission previously known as the Commission for Children and Young People and Child Guardian (CCYPCG, 2014) establish (Reducing Youth Suicide in Queensland project (RYSQ) (2011), differences between Indigenous and non-Indigenous youth suicides as follows: Indigenous young people are more likely to suicide at a younger age (average age of 13.9 years compared to 15.5 years for non-Indigenous young people who suicided between 2004-07), are less likely to have made a previous suicide attempt, and were more likely to threaten suicide

in an ‘off the cuff’ fashion, with threats of suicide often their first response to a stressful situation. As a result, this requires approaches to suicide prevention to not only be evidence-based but to also be designed and implemented by Aboriginal and Torres Strait Islander people and align with the needs and strengths of their communities. Fundamentally the report sought to support current and future efforts to prevent suicide deaths and related injury to children and young people. The purpose of the report was to provide context to the child death data by presenting risk factor information and complementary injury surveillance data and highlight key messages and opportunities for future action to help prevent youth suicide in Queensland.

7.3 Secretariat of National Aboriginal and Islander Child Care (SNAICC)

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) is a non-profit organization established in 1981 as a peak body. Their main role was advocating on behalf of Aboriginal and Torres Strait Islander children and families across Australia. From a family and community perspective suicides encompass risk factors that relate to human development and issues from trauma and continue to affect families and communities across Australia. A disconnect from culture and identity for Aboriginal and Torres Strait Islander children and youth is contributed to colonization and the effects of stolen generations which further contributes to children and young people intentionally harming themselves. The implementation of past government child removal policies continues to impart negative effects for mental health which in turn has led to the effects of ‘emotional distress, violence, self-harm, substance abuse and anti-social behaviour’ (SNAICC, 2014). The Bringing Them Home Report (1997) highlights that subsequent generations continue to suffer the effects of parents and grandparents having been forcibly removed, institutionalized, denied contact with their Aboriginality and in some cases traumatized and abused (HEREOC,1997). Literature from an International and

Australian perspective identifies that for Indigenous youth to maintain a positive self-identity strengthening connections to community and culture are imperative. For instance, Maori people of New Zealand maintain that the impact from colonization is a risk factor for self-harm and suicide among their youth and that building and strengthening young peoples' resilience will bring about strong cultural identity. Therefore, in response to suicides it is recognized in the Maori Youth Suicide Prevention Strategy that Maori have ownership in rebuilding, reclaiming, healing and restoring traditional cultural structures of the whanau (family), hapu and iwi (sub-tribe and tribe) in New Zealand. Some Canadian studies verify what the Maori have found in their communities by identifying that a decrease in suicides is the result of positive cultural connections at a community level which in turn creates positive self-identity. The strength and resilience of Aboriginal and Torres Strait Islander people, communities and cultures is evident and recognized in enhancing protective factors and providing supportive environments for youth. Some of these protective factors include maintaining connection to kin and community where many people within care support Aboriginal youth, having a strong connection to kin and networks within a community supports parenting rather than doing it in isolation, lastly, building and supporting young people to be autonomous, socially interactive and engaging, produces independent, confident youth with self-protective behaviours. The process of colonization through the implementation of assimilation policies and removal policies have resulted in the exclusion of traditional language being spoken and generations to be stolen causing further disconnection from Indigenous self and culture and generations of Aboriginal and Torres Strait Islander people. Disconnection continues to be worsened by the high levels of intervention from child protection. Collective impact, from past policies, forced removals and high rates of youth in out of home care result in quality care and support for Aboriginal and Torres Strait Islander young being less optimal. Each individual has a role to play in society and

this is particularly so for young people as they transition through the different developmental stages, and as they determine their rightful role and place in society. Identity is strongly connected to individuality and for Aboriginal and Torres Strait Islander people identity is evident in their cultural identity and their strong connection to country, land, language, traditional ways, ceremonies, family, friends and society. Furthermore, identity is culturally part of the transfer of knowledge, handing down knowledge about the history from one generation to the next. This cultural process and understanding is missing for young people as they walk between two cultures as an Aboriginal and/or Torres Strait Islander person and a member of the wider society in which their cultural identity is seen as unimportant and discriminated against. For that reason, intergenerational conversations between young people and elders is imperative in strengthening positive cultural identity and connection while restoring recognition and respect for Indigenous culture in the wider community. Suicide in Aboriginal and Torres Strait Islander communities is sometimes seen as an indicator of distress and has a cumulative effect on many people where a high level of loss, grief and mourning are occurring. Generally, after a suicide Aboriginal and Torres Strait Islander people and families come together at times of grief and loss and mourning in support of each other; because a sense of unity and belonging is felt in times sorry business whereby culturally obligations are fulfilled. The Northern Territory report ‘Gone Too Soon’ (2012) identified imitation and contagion (a process whereby exposure to suicidal behaviour influences others to suicide) with suicides is more common among young people (Legislative Assembly of the Northern Territory, 2012) than adults and more in Aboriginal communities. Hanssan (2008) identified that suicide and suicide attempts in Aboriginal communities are recidivist (recidivism - completed suicide preceded by attempted suicide) and contagious, in effect imitative (imitation - victim who copies the suicide of a previous suicide victim) producing clusters or outbreaks. Gould (1989) defines a cluster

as “excessive number of suicides which occur in close temporal and geographic proximity” and Joiner (1999) defines clusters as the ‘factual occurrence of two of more completed or attempted suicides that are ‘non-random bunched’ in space or time’ (Hanssan, 2008, p. 29).

Hanssan (2008) observed an emerging phenomenon called ‘echo clusters’ described as subsequent, yet distinct and taking place after the initial cluster. These were observed to be present in Indigenous communities in the same geographical location that were nearby and identified as a close-knit community. Tatz (1999) and Hunter (1999) in their research referred to clusters of suicides, Hunter refers to ‘waves of suicides’ where he identified five (5) suicides within one family over a two-year period in the Aboriginal community of Yarrabah. Coleman (1987) also speaks of cluster suicides, identified in a Native American reservation in 1985 a cluster of nine (9) suicides over a six-week period, imitation contributing to these. Wissow et al., (2001) identified regional trends and clustering were the main contributors for suicides and attempts in a Southwestern American Indian Tribe – had seven (7) victims in 40 days. In the Tiwi Islands (located in the Northern Territory) what has been observed to be different is each suicide cluster appears to stimulate another cluster, and another, which has produced the observed suicide ‘echo cluster’ phenomenon (Hanssan, 2008, p.29). Consequently, forty (40) suicides of Tiwi Islanders over a ten-year period in a population of 2,300 occurred resulting in x10 (260 per 100,000) suicides in one year alone. It is concerning that clusters, imitation and contagion appear to be the dominant factors contributing to suicides in children and young people of the Northern Territory. What is even more troubling is the relationship to social media use in supporting the contagion effect in Aboriginal and Torres Strait Islander communities. The use of social media in Aboriginal and Torres Strait Islander communities in particular deaths from suicides facilitates the

‘reach of news’ and allows members of the community to become aware of, and enhance the impact of, a recent suicide. An assumption is made from local knowledge of Indigenous communities that this information travels quickly from family to family within the community, and then from community to community within regions (Hanssan, 2008, p. 30). Clustering of suicides also places a high burden on Aboriginal and Torres Strait Islander communities in a number of ways, grief and loss (funerals, sorry business) contributing to the stress that already exists in many communities, the effects of family feuds, including payback responses which can occur after a death, destabilizing the unity of families and communities (Hanssan, 2008). Research conducted in Aboriginal communities in Canada identified two types of clusters, a mass cluster – influenced by media reports of celebrity suicides that cluster in time irrespective of geography and point clusters – occurring within institutional settings (hospitals, prisons, schools etc) close in time and/or space and identified as a major problem (Legislative Assembly of the Northern Territory, 2012). The Secretariat of National Aboriginal and Islander Child Care (SNAICC) identify culture as a protective factor against self-harm and suicide and in order to address the cultural trauma associated with Aboriginal and Torres Strait Islander history, culture must be regenerated, recovered and rejuvenated. This can be achieved through maintaining and/or establishing cultural connections through family, elders, language and country; otherwise our Aboriginal and Torres Strait Islander youth will miss out on the cultural education that will affect their connection to country. Efforts to support and maintain connections are especially vital to ongoing well-being and safety. The Elders Report, (2014) highlight in order to address self-harm and suicide in Aboriginal and Torres Strait Islander communities, access to land, culture and language are seen as preventative measures (protective factors) in supporting the learning and reaffirmation of culture and identity. The report says that young people don’t suicide in the homelands, they are proud there and they know who they are. The intergenerational importance of

elders in the community and the translation of cultural knowledge are paramount. The elders are the most critical part of the program for healing especially the elders who hold Lore because the greatest healing aspect is culture. In spite of the effects of colonization and assimilation policies, the loss of many traditions, customs and languages, Aboriginal and Torres Strait Islander elders have displayed a great deal of strength and resilience from within because of their strong foundations in culture and identity.

> "Cultural identity defines who we are as people, culture from an Aboriginal perspective means who you are; your identity; your color; your connections; your family; your heritage; your traditional owners; your traditional practices and ways. It also means being recognized and acknowledged by non-Aboriginal people; embracing cultural practices within today's society and showing respect" (Ward, 2010, p. 71).

Self-harming is more common in Aboriginal and Torres Strait Islander peoples, as is completed suicide, and those dying are more likely to be younger and to have substance-misuse problems. Impulsivity, then, is a major issue and ensuring safety is, accordingly, critical (also common with self-harm and interpersonal violence is 'jealousy' and intense arousal associated with being either subject or object). For children and teenagers, disengagement (from school, family and peers) and exposure to others' self-harming behaviours are associated with elevated risk and need to be asked about. Finally, problems in children and the elderly tend to be hidden. The behavioural problems of Aboriginal and Torres Strait Islander children are often associated with neurodevelopment delay compounded by education system failure, particularly in remote settings. Rates of referral from schools may be low because teachers in remote settings are often quite junior and overwhelmed (Hunter, 2014). Epidemiologists who have identified outbreaks of contagious communicable disease have undertaken much of the

cluster research. Suicide clusters have been identified but without the same public health response that, for example, an outbreak of measles demands. A proposed model of response to a serious suicide attempt or a completed suicide is a comprehensive 'contact tracing' of the victim's family, friends and cluster group members. It is suggested that after a serious suicide attempt or completed suicide is identified within a defined population, a comprehensive follow- up of those at risk of imitation is undertaken within the social network but in a culturally appropriate way. The high suicide rate among Indigenous young people is attributed to a range of complex and interrelated historical, political, economic, structural, and social factors that continue to impact on the younger generations of Indigenous people. Many Indigenous young people are disproportionately exposed to grief, trauma, loss and discrimination which greatly affect their social and emotional wellbeing. Many also experience a range of negative impacts associated with chronic economic disadvantage, lack of access to appropriate support services, ongoing discrimination by the criminal justice, limited educational and employment opportunities, loss of Elders and other adult family members and mentors due to early deaths or imprisonment. Indigenous youth are also directly impacted by very high rates of psychological distress and exposure to life stressors. In the Australian Aboriginal and Torres Strait Islander Health Survey (2012-13), Indigenous young people aged 15 – 24 years report the most frequent stressors experienced are family member or friend dying (31%); unemployment – not being able to gain work (24%); sever health problems (19%); pregnancy (16%); mentally unwell (12%) and trouble with the police (12%). Many face psychological insecurity, depression, anxiety, loss of kinship networks and parents, conflict with others, and the perceptual and cognitive disturbances associated with alcohol or substance use. Some Indigenous young people can experience extremely strong responses of guilt, shame, rejection, psychological distress and despair. Many of these risk factors and negative circumstances result in Indigenous children and young

people with diminished connections to identity-forming structures and support systems critical to their healthy transition from childhood to adolescence into adulthood. This may also lead to a severely diminished or absent positive future orientation associated with a loss of hope or will to live. A family stressor is something that can be experienced or happens as the result of a particular thing in someone's life in which an individual identifies as an issue or crisis. Seventy-three per cent of Aboriginal and Torres Strait Islander young people over 15 years report experiences one or more stressors among their family and friends in the previous year. In the 2008 National Aboriginal and Torres Strait Islander Social Survey, about two-thirds (65%) of Aboriginal and Torres Strait Islander children (aged 4–14 years) were reported to have experienced at least one stressor in the previous 12 months. The most common types of stressors reported were death of close family member/friend (22%), problems keeping up with school-work (20%) and being scared/upset by an argument or someone's behavior (19%) (ABS, 2014).

7.4 Psychological distress

Suicide among Aboriginal and Torres Strait Islander people must be considered in the context of racism, colonization, dispossession and policies of exclusion and economic disadvantage. This is evident from the high representation of young people in the criminal justice system resulting from chronic social and economic disadvantage. Consequently, social and economic inequalities are strongly linked to psychological distress. Psychological distress is more prevalent among Indigenous people and is evident among both males and females. Life stressors also contribute to psychological distress such as losing a family member to death, crime and racism; these affect everyone in a community whereas children are confronted with observing violence and experiencing poverty and overcrowding in the homes. In turn these experiences create a lower sense of cultural self-worth, self-identity, and self- esteem over their environment (ATSISPEP, 2015).

Mental health is a term used by non-Indigenous people to describe the ability for individuals to cope and function with the stressors of normal daily life, to work efficiently and productively, to realize one's own potential, to contribute and be involved within the community, and to establish and participate in positive and valuable relationships (World Health Organization, 2001; 2014). Determinants of mental health comprise of environmental and psychological factors: income, employment, poverty, housing, education, access to community resources, physical health, gender, age and ethnicity (DoHA, 2000 cited in Kelly et al, 2009). Determinates of social and emotional wellbeing would certainly encompass all of the above including grief, loss, racism, trauma and abuse, domestic violence, substance misuse, family breakdown, discrimination, adversity and forcible removal of children (Kelly, 2009, p. 6). Protective factors unique to Aboriginal cultures of relevant to strength and resilience are connection to land, culture, spirituality, ancestry and family and community. Serious psychological distress refers to scores of 12 or higher or 'high' or 'very high' as referred in the Australian Institute of Health and Welfare publication. Similarly, in other countries serious psychological distress is reported as a K6 score of 13 or higher (Aldworth et al, 2005). Measuring psychological distress as a domain of social and emotional wellbeing among Aboriginal and Torres Strait Islander Australian populations is promising. Facilitating Indigenous-led research on cultural validity of non-specific psychological distress is necessary. The Kessler Psychological Distress Scale was selected and modified from a 10-item (K10) to a 6-item (K6) scale to measure psychological distress in the National Aboriginal Torres Strait Islander Health Survey (2004-05). The Kessler High Distress Measure or K6 scale was used relating to one item to the feeling 'worthless' being removed for cultural reasons. The K6 has been implemented in Native American communities and found to be a concise and accurate measure of psychological distress. The evidence from the Kessler Scale in determining psychological distress is if left untreated or unaddressed for

a length of extended time; there is the potential of developing anxiety and depression. Positively this can serve as an outcome in measuring social and emotional determinants of health and wellbeing that have the potential of influencing these aspects. Wilkinson and Marmot (2003) support the concept of psychological distress as a contributing factor for health, illness and death, for instance life conditions and events such as anxiety, low self-esteem, isolation - socially and economically, work and family commitments contribute to ill-effects at an individual, family and community level. Those people associated with high to very high levels of psychological distress over an amount of time are at risk of developing poor health, mental health and early mortality. Regardless of the period of time, more importantly it is how people are feeling, for example how often do they feel anxious and how long has this been happening because this often results in poorer health conditions contributing to higher morbidity. Therefore, psychological distress should not be seen in the same context as 'mental illness' requiring clinical treatment instead it should be seen as 'worry, restlessness and sadness' in stressful or difficult circumstances (Wilkinson and Marmot, 2003; DoHA, 2000 as cited in Kelly et al, 2009).

Therefore, if psychological distress does impact on a person's ability to function normally then clinical intervention is required. Generally, Indigenous people report low to moderate levels of psychological distress which is alleviated by showing compassion and social support from family and friends as well as providing social and emotional wellbeing support. Literature from International and Australian research indicate serious psychological distress is identified more often as a risk factor across a number of physical health problems, for example chronic stress has the potential to cause mental health problems, contribute to risky behaviour in the development of long term health related problems. Furthermore, Kelly and colleagues (2009) report similar health outcomes of

increased morbidity (heart disease and diabetes) as a result of chronic stress. Achieving an understanding of these contributing factors and how they influence health and wellbeing of Indigenous populations will be significant (ABS, 2012. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4715.0/). Paradies (2006) in his study examining the relationships between racism and psycho-social stress and chronic disease among Indigenous populations found that African Americans report high levels of generalized stress which independently contributed to chronic disease and associated with general health, diabetes, high blood sugars, heart disease, suicide and drug misuse among Indigenous people (Kelly et al. 2009, p.9). Researchers in a South Australian study examine suicide ideation through the use of the K10 scale of psychological distress establishing that serious psychological distress does influence suicide ideation which further supports the idea that these people were more likely to report suicidal thoughts than those less distressed. However, people in the 'high' and 'very high' category more likely reported suicide ideation than those with no distress. Therefore, people experiencing high levels of serious psychological distress found in Indigenous populations are linked to high rates of suicide (Kelly et al, 2009).

The National Aboriginal and Torres Strait Islander Social Survey (NATSIS) undertaken by Australian Bureau of Statistics (ABS) (2009) report poorer health and educational outcomes, lower rates of unemployment, poorer living conditions – standards as a result of poverty. Furthermore, mental health, criminal activities, behavioural and attention problems for young people developed due to high rates of psychological distress (Hassan, 1998; ABS, 2009). Nearly one-third of Aboriginal and Torres Strait Islander young people aged 16-24 years reported high to very high levels of psychological distress, more than twice the rate of non-Indigenous youth (Australian Institute for Health and Welfare, 2011).

Findings from a Western Australia survey (2005) reveal children were at a high risk of developing clinically significant emotional and behavioural difficulties. This compares with 15% of children in the non-Aboriginal population; Growing up in areas of extreme isolation, where adherence to traditional culture and ways of life is strongest, may be protective against emotional and behavioural difficulties in Aboriginal children; Living in households with high occupancy may also be protective against emotional and behavioural difficulties, as compared to low occupancy households; Males were twice as likely as females to be at high risk of clinically significant emotional or behavioural difficulties; Children were more likely to be at high risk of clinically significant emotional or behavioural difficulties in families that had experienced more stressful life events; Associations exist between the social and emotional wellbeing of Aboriginal carers and their children and the past policies and practices of forced separation of Aboriginal people from their natural families; and just over one quarter of young Aboriginal people (27%) drink alcohol, while 30% of young people have used marijuana at some time in their lives (Zubrick et al, 2005 cited in Mindframe, 2014).

For many Aboriginal and Torres Strait Islander people, poverty is a normal part of life; they sit at the lower end of the socio-economic scale and the lowest income quintile, and because of this are not in a position to be financially independent – rather dependent upon various assistance programs. As a result, Aboriginal and Torres Strait Islander people resort to living with extended family and relatives which further add to the complexity of health and mental health related conditions. Aboriginal and Torres Strait Islander people suffering from psychological distress appear to be more at risk of being subjected to disciplinary actions than supportive interventions similar to incarceration and removal of children. These as a result have hindered new opportunities for recovery or

building on strengths but have caused more distress in developing serious psychological distress (Zubrick et al, 2005 as cited in Mindframe, 2014).

7.5 Sport as a deterrent for youth suicide

Tatz (2011) in his paper 'Aborigines, Sport and Suicide' presented to Pathways to Reconciliation Summit, Amman, Jordan in 2009, highlights the relationship between sport and suicide and the particular importance in deterring and repelling criminal behavior and suicide among youth. In contemporary times sport is a major part of Aboriginal people and communities it provides a sense of meaning, purpose and belonging, it is inclusive and embraces diversity when Aboriginal youth feel alienated, disempowered, rejected or excluded in society (Tatz, 2011, p. 1). Sport has been identified by some authors as a protective factor against suicide, but the momentum for exploring sport in relation to Aboriginal youth suicide appears to be lacking in Australia. Sabo et al (2005) found a significant reduction in both sexes of participants considering suicide and more so for females in planning to attempt suicide. In considering Durkheim's (1897; 1968) work Sabo and colleagues proposed that when participants were enmeshed in a social network a greater sense of social integration was achieved with less anomie. Chioqueta and Stiles (2007) work with military recruits (males) found participants displayed less hopelessness when they were actively engaged in sports. Babiss and Gangwisch (2009) exploring sports as a protective factor against depression and suicide ideation found participation in sports not only increased self-esteem but improved body image, social support and had an effect on substance abuse. Brown and Blanton (2002) in their research looking at effectiveness of physical activity and involvement in sports on suicidal behaviour found involvement in sports demonstrated a protective factor against suicidal behaviour – non-sporting men were more likely to report whereas non- sporting women

were more likely to do so. Whatever type of organized competitive sports available they are integral to Aboriginal life (Tatz, 2011).

Historically, suicide rates have not been as prominent as today and becoming a youth phenomenon localized among those between the ages of 15 and 24. Young people all over the world are committing suicide at unprecedented rates. This so-called epidemic of youth suicide is most prominent among Indigenous peoples, who are overrepresented in every suicide statistic. Colleagues in Canada believe that encouraging and facilitating a connection and sense of belonging back to culture and identity including the traditional ways of doing things has the potential to impact and lessen the high rates of young people attempting and committing suicide. Furthermore, a tight-knit and productive cultural community may buffer against Indigenous Youth Suicide. Youth suicides are multiplicative and frequently occur at the end of adverse life sequences with a combination of risk factors. Identity is strongly connected to individuality and for Aboriginal and Torres Strait Islander people identity is evident in their cultural identity and their strong connection to country, land, language, traditional ways, ceremonies, family, friends and society. Identity is culturally part of the transfer of knowledge, handing down knowledge about the history from one generation to the next.

CHAPTER 8 - RESEARCH METHODOLOGY

Introduction

This chapter provides background information and discussion on the following areas: qualitative research methodology, planning of the research activities: information sessions, consent, recruitment, interviews and focus groups, risk and benefits and limitations of the research. Processes undertaken in the data analysis phase through the use of thematic analysis will be outlined. Furthermore, a description of the research methods used in relation to ethics, participants, and processes for gaining informed consent. Data collection was obtained in the form of digitally recorded interviews and focus groups with all participants across each of the communities in preparation for transcriptions and analysis.

8.1 Philosophy of Social, Emotional and Wellbeing Framework

Historical evidence acknowledges that Aboriginal and Torres Strait Islander people are recognized as the original custodians of Australia for more than 60,000 years. Aboriginal and Torres Strait Islander people were athletic in appearance and illnesses were not evident (Flood, 2006, p. 121); this was supported by a nourishing diet of protein and vegetables that had little to no salt, sugar or fat and enabled them to maintain an active and physical lifestyle. Traditionally in Aboriginal culture mental health was seen in a collective sense of the Aboriginal self, being closely connected to everything in life – family, community, culture, spirituality and country. In essence Aboriginal culture was about sharing everything from rules, kinship and relationships, which defined much of the social roles within families and communities. Generally Aboriginal people are intelligent and wise for the knowledge they possess about the cycle of life and death, their cultural understanding of belonging from their connection to country regardless of the distress, death and illness encountered. Traditional teachings within Aboriginal culture among

tribal elders were highly respected and had a number of defined rules and consequences within social groups. Communication processes within traditional language groups were rich in ceremonial events, both men and women fulfilled specific economic and cultural roles and the protection of children was provided through the extensive kinship system (Parker, 2010b, Dudgeon & Walker, 2010; Parker, 2012). Aboriginal and Torres Strait Islander people have a different concept of health and wellbeing to western understandings and see health in holistic way that includes physical, social, emotional, cultural, spiritual wellbeing of the whole person and community (National Aboriginal Health Strategy, 1989; Dudgeon, Gee & Glaskin, 2009; Ward & Gorman, 2010). Traditionally and culturally Aboriginal and Torres Strait Islanders views and beliefs always centred on a solid sense of belonging and connection to the country in which people originate (Australian Health Ministers, 2003). Social and emotional wellbeing is viewed differently too western understandings of 'mental health' as this concept arises from an illness and clinical view with an emphasis on the individual. Whereas, from an Indigenous view a sense of belonging and connecting to everything around the individual extending to the land, culture, spirit, ancestors, family and community (SHRG, 2004). It must be recognized that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment (AIPA, 2009). "Aboriginal and Torres Strait Islander family and kinship ties must be recognized as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and caring" (AIPA, 2009, p. 17). The national peak body for Indigenous health confirms that Indigenous mental health is situated in the broader context of health and wellbeing and as a result needs to be incorporated within a holistic framework (NACCHO, 2009) which is fundamentally connected to Indigenous concept of 'whole of life', steeped in the harmonized inter-relations (spiritual, environmental, ideological, political, social, economic, mental and

physical), that establish cultural well-being (Swan & Raphael, 1995; New South Wales Mental Health Commission, 2013). Positioning mental health within a holistic framework supports Indigenous social and emotional wellbeing and western mental health diagnoses whereby historical and social issues have greatly impacted Indigenous mental health (New South Wales Mental Health Commission, 2013; Mindframe, 2015). The complexity of cultural, social, economic, historical, individual and environmental influences persistently affecting Indigenous mental health and social and emotional wellbeing do not support a one size fits all approach rather an inclusive service design and delivery that is culturally appropriate, competent and specific to individual Aboriginal communities (New South Wales Mental Health Commission, 2013).

8.2 The colonial experience

Colonization in 1788 brought with it major impacts for the physical and mental health of Indigenous people in Australia. Some of the fundamentals of devastation were the consequences of introduced new diseases; removal from ancestral land - producing psychological distress; spiritual despair; placing large groups of Aboriginal people onto reserves, settlements, missions; destroying the Aboriginal way of life leading to marginalization and poverty (Anderson, 1997). “Dispossession and war upon Aboriginal people continued to take its toll on the health and wellbeing of populations, traditional foods, Country and practices affecting their ability to carry out vital societal, legal and religious obligations” (Sherwood & Geia, 2015 p. 11).

Colonial policies and historical practices continue to have unrelenting effects on the health and wellbeing of Indigenous people that is evident in today’s inequity in health care, economy, social, political and educational outcomes (Sherwood & Geia, 2015). Effects from the Protection Policy impacted greatly on many generations of Aboriginal people, regarded now as stolen from 1930’s to 1960’s, by instigating a level of destruction

on family life and emotional despair. Protection Policy with the effect that it had on generations of Aboriginal people regarded as stolen from 1930's to 1960's has caused the destruction of family life and emotional desolation for vast numbers of Aboriginal people across Australia. In spite of current policies aimed at addressing health inequalities for Indigenous people, not much has changed as the dominant culture continues to create welfare dependency, the reliance on the provision of public sector resources and the means of delivery opposed to Aboriginal control (Anderson, 1997; Ward & Gorman, 2010; Ward, 2015). Many aspects of traditional Aboriginal societies were supported to establish strong mental health, for example, the meaning of connection and belonging for individual identity is important to the whole of life understanding and connection to dreamtime and spirituality that offers guidance and comfort for Aboriginal people (Parker, 2010b). Aboriginal people are not materialistic in the sense of the word however; their physical needs were often fulfilled through established roles and responsibilities and social roles were influenced by kinship ties. Traditional lore on the other hand, is supported by the Elders who interpret traditional knowledge and culture and were highly regarded within and across Aboriginal groups (Parker, 2010b; 2012). Australia has approximately more than 200 traditional language groups that occupy all parts of the continent including the Torres Strait Islands located between Northern Queensland and Papua Guinea. Both Aboriginal and Torres Strait Islanders are rich in culture, tradition, knowledge and ceremony which lay the foundations of transitions from birth to initiation to death. The economic and cultural roles of men and women in particular children became the role of Aunties and older siblings in raising children and taking up caretaking roles (Parker, 2010b; 2012). Overtime these traditional societies and roles have undergone a rapid social change in which mental health problems and social and emotional wellbeing has suffered the consequences in different settings (Hunter, 2003; Parker, 2010; 2012).

Social and emotional wellbeing was intrinsically woven and tied to social and family systems and relationships were overseen by cultural Lore, ceremony and spiritual practices within Aboriginal culture supported by a strong sense of belonging to Country to which the family was connected as a whole (Hellsten, 2014). Social and emotional wellbeing from an Aboriginal and Torres Strait Islander point of view must be seen differently to western 'mental health', as it originates from an illness and clinical viewpoint with emphasis on the individual and level of functioning in their environment compared to the relevance and importance of connection and belonging to land, culture, spirituality, ancestry, family and community, and how these affect the individual and wider community (SHRG, 2004:9). The Australian Indigenous Psychologists Association (AIPA) (2009, p. 3), suggest that Aboriginal and Torres Strait Islander health is holistic and encompass elements of mental health, physical, social, cultural and spiritual health that supports social and emotional wellbeing which are central to wellbeing through cultural connection to land, family and spirituality. Family and kinship are dominant features in Aboriginal understandings and ways of doing, the broader concepts of family, and connections with shared roles of discipline, love, compassion and commitment. Aboriginal and Torres Strait Islander people lobbied federal governments in Australia to address the inequality of health standards in comparison to non-Indigenous people and one of the key aspects in doing this was to establish Aboriginal and Torres Strait Islander specific health services that enabled people and communities to determine themselves how best to address their health situations. Establish health services based on cultural understandings is imperative to how health services are designed and delivered with cultural safety assessments and management of healthcare required to address health and mental health problems (SHRG, 2004, p.10). Factors that predispose Aboriginal and Torres Strait Islander's poor social and emotional wellbeing is a consequence of, historical traumas associated with segregation, dislocation and dispossession including

substance misuse, family breakdown, racism and discrimination, and social disadvantage (SHRG, 2004, p.9). Land is central to community connections and the spiritual and emotional wellbeing of people and communities (AIPA, 2009). Protective factors relate to many influences such as “connection to land, culture, spirituality, ancestry and family and community. These influences assist Aboriginal and Torres Strait Islander people with resilience and recovery to lessen the impact of stressful situations upon social and emotional wellbeing through their strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment” (AIPA, 2009, p. 2-3).

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2004-2009 and the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (2004-2009) report health is multidimensional, the strengths and resilience of Aboriginal and Torres Strait Islander community’s cultural rights, practices, values and expectations need to be considered when delivering services. “Improving social, emotional, spiritual wellbeing encompasses a holistic view of health and life, it also seeks to recognize the unique experiences of grief and trauma through colonization, separation from families, and loss of land and culture” (CCRMHQ, 2013, p. 6). The period of colonization and government designed assimilation policies have had devastating impacts on Australia’s Aboriginal people of whom have undergone centuries of segregation, dislocation, dispossession, racist and derogatory Acts of administration that have created violent and unforgettable events. The forced removal of communities from their land, the systematic denial of culture and language, the suppression of political and human rights, and the forced removal of children, have all contributed to an environment of poor mental health compounded by ongoing social and economic disadvantage. Aboriginal people and communities extensively are in a

constant state of grief and loss mourning for the loss of loved ones who have died. It is very commonplace for many Aboriginal families to experience a high number of trauma and funerals in many communities everywhere and often people will travel long distances out of respect (Ugle, Glaskin, Dudgeon & Hillman, 2009) in support of families. Grief and loss has widening effects in Aboriginal communities and when these effects are heighten in highly connected communities incidences of suicide clusters increase when mourning is taking place (Ibid; AIPA, 2009). The many traumas and physical illnesses suffered by Indigenous people have caused and continue to cause significant emotional stress, loss and grief for individuals, families and communities (Kanowski, Kitchner, & Jorm, 2008). Suicide in Indigenous communities did not appear to exist before the 1960s (Cantor, 1998) however, in present times suicide has emerged as a major public health concern. Suicide in some remote communities, are significantly higher particularly, among young males (Cantor, 1998). While the collection of reliable suicide data remains challenging (Welfare, 2007) the suicide rates, characteristics and behaviours of Indigenous and non-Indigenous people vary in different ways. The social risk factors for suicide and the connections to mental health for Indigenous people are tenuous (Elliot-Farrelly, 2004) and for that reason, the causation of suicide needs to be analyzed further in discussions with Indigenous people and their communities. Discussions based on a framework that encompass a broad and holistic view of the history, social and lifestyle issues confronting Indigenous people and their respective communities. Intent is not always obvious. In the context of Aboriginal people, suicides are often impulsive and in association with a combination of drugs or alcohol (Elliot-Farrelly, 2004; Hunter, Reser, Baird & Reser, 2001; Tatz, 1999).

Clusters of suicides have been identified in many Aboriginal communities where they occur at particular times and frequented across the population as a result of a number of

suicides in close proximity (Hunter, Reser, Baird & Reser, 2001) highlighting the need for suicide prevention strategies that address risk at a community level, rather than the individual (Hunter, 2007; Australia, 2008) which incorporate the ideas, values and beliefs of Aboriginal people and their communities into viable strategies (Elliot-Farrelly, 2004). For example, working collaboratively with local Aboriginal people in developing strategies that continue to address social risk factors in consideration with the lifestyle of Aboriginal populations is more appropriate than aligning them with mainstream factors and programs. This enables local communities, community resources and facilities to easily identify people at risk or in crisis so as to target and implement preventative strategies (Proctor, 2005) with the aim of reducing risky behaviors' and increasing a sense of connection and belonging to culture and identity.

Social and Emotional Wellbeing supports individuals in being able to identify needs and express feelings, to love and show compassion, being able to cope with difficult situations and relate to others in similar circumstances, be creative and assertive in decision-making and being able to be resourceful when in need. Suicide among Aboriginal and Torres Strait Islander people must be considered in the context of racism, colonization, dispossession and policies of exclusion and economic disadvantage. This is evident from the high representation of young people in the criminal justice system resulting from chronic social and economic disadvantage. Consequently, social and economic inequalities are strongly linked to psychological distress. Psychological distress is prevalent higher among Indigenous people and was evident among both males and females. Life stressors also contribute to psychological distress such as losing a family member to death, crime and racism; these affect everyone in a community whereas children are confronted with observing violence and experiencing poverty and

overcrowding in the homes. In turn, these experiences create a lower sense of cultural self-worth, self-identity, and self-esteem over their environment (ATSISPEP, 2015).

Knowledge of the colonial experience is important to the methodology for this research because it allows the researcher to have a strong relationship built on trust and rapport and understanding research participants, but more importantly, as an Aboriginal woman also from south west Queensland. Recruitment to the research had to follow not only university requirements for the conduct of research but enabling the researcher to operate in relational terms with potential participants, exercising the traditions of kinship systems, using yarning techniques as a way of speaking with and within Aboriginal communities. This is important because the participants were able to observe the researcher in close proximity through demonstrating appropriate cultural behaviours. Exercising these behaviours appropriately and being affirmed by the community strengthened the researchers standing within the community and led to culturally appropriate interviews and focus groups. There were protocols to be observed and followed in the research relationship and when the researcher is observed to follow these protocols there is a greater tendency for the participants to be forthcoming in their discussions in interviews and/or focus groups. An understanding of the colonial experience, also experienced by the researcher's family and participant communities ensured sensitivity to these effects when analyzing the interview data from an Aboriginal lens. This has the effect of adding to the literature about Aboriginal suicide and mental health because it has an overarching Aboriginal lens to the research.

8.3 Planning stages of the research

In the planning stages of this research the aim from the outset was to consult and engage with key people across the four communities with the intention of building new relationships and enhancing existing ones. Once key people within communities had

been identified, the beginning stages of consultations via phone and/or email by the researcher to inform people and organizations within communities of the research being proposed. This required sending out of information about the research in the form of background and overview of research and potential dates and times for the researcher to visit each of the communities. This whole process was done in collaboration with one key person within each of the Aboriginal Medical Services who had knowledge of the community and for linking others into the research. Initially contact with key people identified were associated with an Aboriginal Medical Service within each of the communities and this exchange was constructed strategically to evolve around these major Aboriginal organizations that had an impact on services and people within communities. On confirmation of dates and times to undertake field trips within communities' a number of flyers, participant information sheets, consent forms and other additional information were prepared and disseminated out among the community and key people via flyers, email and/or mail for review and distribution across the communities to participants. On a regular basis and leading up to the actual community visit the researcher would touch base with the key people about the research regarding any questions or issues, level of interest from participants, issues or concerns from participants interested in being involved, booking of venues, catering and in consideration to any sorry business taking place in any of the identified communities that would impact on the community visits and the research taking place. The researcher arranged a fleet car, accommodation, catering and venues in line with University of Southern Queensland's (USQ) policy and procedures for postgraduate students' research requirements and for the purpose of the research. The researcher had also planned a leave of absence from current work duties at USQ for two (2) weeks allowing the researcher ample time for travel to and from rural and remote communities across South West Queensland. The roll-out of information sessions, interviews and focus groups with

participants were either arranged prior to the community visit or followed up over the week of the actual visit. The other two (2) communities classified as semi-urban and urban were accessible locally by the researcher and they did not require high level of planning or leave of absence due to the researcher residing in the urban area. Across the four communities there was a total of 55 participants recruited taking take part in the research. Prior to participants' involvement in an interview or focus group each person was provided with a participant information sheet at the pre-planned information session to read, take away, share with family and approach the researcher if participants had any questions or concerns. Any questions or concerns raised by participants were addressed immediately by the researcher and prior to starting. Upon indication of participant's interest in being involved each person was provided with a consent form to also read, ask questions and sign if happy to proceed and return this form back to the researcher for collection and noting at the time of the scheduled interview or focus group session.

8.4 Method

Qualitative research approaches were incorporated into this research through the use of culturally appropriate data collection methods as outlined in the beginning of the thesis (Chapter 1). Culturally appropriate protocols applied to the research with Indigenous communities were comprised of information sessions; qualitative interviewing and focus groups were utilized because they were considered appropriate and sensitive to the cultural and language differences that exist in Aboriginal communities. The purpose of the research study explored Aboriginal understandings of suicide through cultural, behavioural, and social aspects in rural, remote, semi-urban and urban communities of Cunnamulla, Charleville, Oakey and Toowoomba across the Darling Downs and South West Queensland. This research study focused on achieving a better understanding of Aboriginal suicides from a social and emotional wellbeing framework. Furthermore, it was

important to achieve an understanding of both historical and contemporary perspectives towards suicide, views and/or opinions of Aboriginal people, the level of impact from suicides on people and communities, service provision and accessibility, and additional factors contributing to suicides.

8.5 Information sessions in Aboriginal community

Qualitative research approaches were incorporated into this research through the use of culturally appropriate data collection methods and as outlined in the beginning of this thesis (see Chapter 1) approaches to research with Indigenous communities require following of protocols. A series of information sessions were convened and implemented across the four identified communities which were planned in advanced to engage as many Aboriginal participants as possible. Potential participants were identified and invited in collaboration with each of the AMS's to attend an information session lasting 1-2 hours allowing time for meet and greet, presentation and questions and to informally yarn over a morning or afternoon tea. Community flyers were designed by the researcher for distribution and publicized in each of the communities prior to the researcher visiting. The information contained within these flyers for information sessions providing details of where the session/s would be held, time and dates, and that catering, and transport was available if required. Within the facilitation of the information sessions a summary of the research goal, aims and objectives, background to the research, risks and benefits of being involved, research activities (interviews and focus groups), and details of who to contact such as USQ’s human ethics committee and the researcher were communicated to participants. Participants, leading up to the day of their chosen activity (interview or focus group) were provided with a 'Participant Information Sheet' and 'Consent Form' ensuring all documentation was understood, signed and collected. Participants were also advised that if they chose to participate that they must have read the participant

information sheet and understand what was outlined, then proceed to sign the consent form and return this to the researcher. Interviews and focus groups lasted from 1-3 hours which was not an unusual amount of time considering this is a culturally appropriate yarning style approach for this selected group of Aboriginal participants. Participants in the beginning were informed that conversations would be digitally recorded using a Dictaphone ensuring the context of the conversations were captured as well as the accuracy of these for the purpose of analysing the data and cross checking of recordings against transcripts. Recordings were downloaded onto the researcher's computer onto a USB initially for storage whilst conducting field trips and for transcription purposes. An external agency was engaged to review the recordings made available and transcribed, these were then provided back to the researcher in the form of a word document for data analysis. In the beginning a thematic analysis manually of the data proceeded. A series of feedback workshops were convened and facilitated in each of the communities towards the end of the research project. Participants within communities were invited to attend; in which a presentation of the findings was communicated back to participants in plain language.

8.6 Processes for informed consent

Informed consent was obtained in writing from each participant; participants were required and informed about signing a consent form prior to being involved in the research and returning this to the researcher. The ‘Participant Information Sheet’ described the background to the research, risks and benefits, who to approach and where to go for further information, confidentiality and refusal or withdrawal to participate were important issues to think through ensuring that participants fully understood what was required. A copy of the consent form was provided to participants and maintained by the researcher for the purpose of the whole research and filed in a locked filing cabinet in the

researchers locked office on campus in line with USQ research policies. The researcher is an Aboriginal woman and has the ability to engage and consult effectively with Aboriginal people sensitively and respectfully, she has extensive connections both personally and professionally with many people and service providers across the Darling Downs and South West Queensland. The researcher has the experience, knowledge and the skills to work and facilitate research with Aboriginal people and communities as demonstrated in a number of research projects across the region and within USQ. Collaborating with local AMS's provided access to participants and communities of interest while following and adhering to Aboriginal community protocol. All relevant data was stored for the required five (5) years in accordance with USQ policy and ethics guidelines. No personal or identifying data will be published in any form of publication in the future without the permission of the participants. All recordings containing personal and sensitive conversations from interviews and focus groups were downloaded (onto USB, then computer program for secure storage), collated, transcribed and analysed for the sole purpose of the research.

8.7 Recruitment processes in community

Participants in the beginning were identified and recruited in collaboration with the researcher and each of the Aboriginal Medical Services, mental health professionals and community services through key people in the community through word of mouth, distribution of community flyers and regional advertisements through an Aboriginal radio station. Support letters were obtained from the Chief Executive Officers (CEO's) from each of the AMS's before commencing the research and for the purpose of the ethics process. Aboriginal elders, women, men, youth 18 years and over who currently resided in each of the identified communities at the time of the research were engaged and recruited for this purpose of this research. Across the communities both interviews and

focus groups were convened with participants in the following locations: Cunnamulla (12); Charleville (11); Oakey (6) and Toowoomba (26).

8.8 Data collection, analysis and storage requirements

In regards to the interview process a number of factors were considered by the researcher prior to undertaking the research in context of community's locality, physical aspects of the environment, family circumstances and composition of groups. For example, one of the key aspects considered was where interviews and focus groups were located within communities including individual and family circumstances relevant to participation. For example, catering for transport, younger children and other family commitments were issues identified in consultation with potential participants and assistance provided accordingly.

Interviews and focus groups were available to all participants and facilitated in each of the communities and comprised of participants who were already involved in suicide and knew what was happening on the ground within and across the communities. Interviews were conducted face to face and included the researcher and the participant. Focus group consisted of 5-10 participants, lasting up to 1-3 hours. A total of 55 participants were recruited across the four (4) communities participating in either in an interview or focus group session. This research involved the contribution and commitment of local, regional Aboriginal Medical Services with whom the researcher had established long-term relationships from working collaboratively on previous projects. The Aboriginal Medical Services across the communities included Goolburri Aboriginal Health Advancement; Charleville and Western Areas Aboriginal and Torres Strait Islanders Corporation for Health (CWAATSICH) and Cunnamulla Aboriginal Corporation for Health.

Through the process of traditional yarning that was centered around culturally appropriate methodically approaches to research with Indigenous people and communities enabling conversations to occur naturally while eliciting information from participants that were not coerced rather supported through the whole process. Traditional yarning is similar to focus groups and is chosen for this research because of the cultural application and sense of relaxed atmosphere in which they are conducted. Which allowed the researcher to elicit information, experiences and feedback that is relevant to this topic (Grbich, C. 1999 p. 108-114). Therefore, focus groups are established for "collecting background information or identifying issues that will form the basis of hypotheses, more structured questions, evaluations or needs assessments; investigating responses to policy changes; pre-testing advertising and marketing strategies; and investigating sensitive issues that are difficult to broach on a one-to-one basis" (Grbich, C. 1999 p. 108-114).

For the purposes of this study this method has generated discussion and aided in the collection of information. Refer back to Chapter 1 – Keeping Research on Track and Ethics processes on page 21. All relevant data pertaining to the project was stored and maintained at the researchers locked office on a computer password computer at USQ; this data will be stored for the required five (5) years in accordance with USQ policy. No personal data will be published in any type of publication/s.

8.9 Thematic analysis of the data

Thematic analysis was selectively chosen because of its appropriateness in qualitative research by searching through the data to identify recurrent themes through what Morse and Field (1995) describe 'as the building of a set of themes to describe the phenomenon of interest by putting 'like with like'. For instance, through this research recorded discussions obtained through interviews and focus groups in the form of transcripts were

achieved through thematic analyses (Aronson, 1994). The process for identifying themes or patterns can be identified from a bottom up (inductive) or top down (theoretical or deductive) approach (Frith & Gleeson, 2004; (Boyatzis, 1998; Hayes, 1997).

8.10 Process of analysis

A description of the analytical process will be provided in a series of steps in which there is movement back and forth and between these steps: 1. preparing the data for analysis involved a number of tasks: after the collection of the data via digital recordings were complete they were prepared for an independent transcribers external to the university; digital recordings were uploaded onto a computer program in which the exchange of data was shared between an independent company and the researcher through the use of secure passwords. On the completion of the recordings being transcribed they were uploaded onto a computer program in Word format for access by the researcher and all transcripts were reviewed and cross- checked against initial recordings for translation purposes and accuracy. 2. Reading the text and noting items of interest involved a number of tasks: 1st stage of reading text – print off Word documents - this process was repeated 2-3 times in order for understanding the information and jotting down of initial ideas; 2nd stage of reading text – this involved re-reading the text, generating further ideas around themes –making notes, repeating this process 1-2 times; 3rd stage of reading text – ideas were generated from the previous step to facilitate micro analysis of the data. 3. Preparation of the data for structuring themes involved a number of tasks: listing broad themes and potential sub-themes into headings with additional information in point form - keeping themes simple for flexibility and generate these into a Word document with edited versions – allowing for categories to be modified and the development of new ones. 4. Examination of the themes and sub-themes in previous step; re-examination of the themes and sub-themes from the previous step, including

original data for each theme separately and assigning descriptions for themes and sub-themes. 5. Beginning construction of each theme involved developing a name/theme, meaning and supporting evidence for each theme. 6. Preparation to report themes and sub-themes involved completing each theme and sub-theme/s in line with the data and providing descriptions and excerpts to communicate meanings of the data. This research carried out a bottom up approach to analysis also known as an inductive approach because it demonstrated strong links between the identified themes and conversations that evolved with participants. The researcher was able to code the data relevant to the themes that prevented manipulation of the data and any preconceptions held by the researcher were separated to avoid any influence (Patton, 1990). Inductive analysis also has synergized with the need for Aboriginal research participants to give a voice to their issues and have strong senses of belonging in the research. This is very much an approach that is supported in research with Aboriginal and Torres Strait Islander communities (AIATSIS, 2012).

8.11 Risks and benefits

'Time imposition' was potentially identified as a risk by way of inconvenience for participants in being able to attend an interview or focus group and for the required time of 1-3 hours. Research activities take time and participants must be fully aware of what the process involves, particularly for them. 'Psychological Risks' is a potential discomfort causing participants to become distressed and emotional regarding the nature of conversations. However local AMS's and mental health professionals within communities were identified and engaged as resources for the researcher to access in relation to referral pathways. Although the researcher is a qualified Registered Nurse, who has specific training and knowledge in mental health, for the purpose of this research and facilitating effective referrals the researcher has the capacity to identify people at risk who

may require early intervention and prevention measures. There is always a level of risk associated with any kind of research being proposed with potential (human) participants. ‘High Risk’ was chosen for this research due to potential participants being identified as Aboriginal and the nature of inquiry into suicide. The researcher asked people to reflect on their own experiences, knowledge and thought processes personally and from the perspective of their community. Undertaking this reflection may have caused participants to become distressed, emotional or anxious at times and throughout conversations as participants begin to re-tell or re-live their experiences. In focus group deliberations participants may become distressed and emotional. The researcher ensured that local mental health professionals were present or on standby at focus groups, this was pivotal to the risk management strategy. Participants were informed of these processes from the very beginning. Should such an incident occur in any of the communities the researcher would have shut down the focus group taking place to attend to issues? This research will contribute to a new body of knowledge and research into understanding suicides across Darling Downs and South West Queensland communities. Emphasis on this research and what it means to Aboriginal people is important for this region. There is a wealth of literature focusing on suicide in the broader population incorporating mainstream approaches to suicide prevention however, literature dealing with suicide prevention within Aboriginal communities is limited (Suicide Prevention Australia, 2008) across these communities. Suicide Prevention Australia (2008) affirm that suicides in Indigenous communities is significantly higher than that of non-Indigenous population, nevertheless understandings and definitions of suicide and self-harming behaviors from Indigenous perspectives requires further research. This study provides information on the historical and contemporary factors that impact on suicides in Aboriginal communities and their level of understanding about suicides in the context of social, emotional and wellbeing. Potential risks were managed by the researcher in line with ethical standards

when conducting research with Aboriginal people and their respective communities. Benefits of the research may include an increase in knowledge and understanding of suicide and the significance of suicide to Aboriginal people and their communities extending to the wider community.

8.12 Limitations of the research

The first limitation of this research is that it was limited to the communities involved. This means that the findings cannot be generalized to other Aboriginal or Torres Strait Islander communities. However future research in this area using this approach could potentially provide new and additional insights from existing and other Indigenous groups in Australia and internationally and will be highly relevant if this study was replicated and used more widely among many Indigenous groups. There were a number of other limitations for this research however they did not impact on the research being implemented and were identified as merely challenges and/or barriers confronted during the process of the PhD journey. These challenges and barriers identified will be referred to in future research projects in which the researcher will encompass and improve on when conducting research with Aboriginal people and their communities. The second limitation was the recruitment of Aboriginal participants across the four communities. In the planning stages of the research the researcher had intended recruiting a number of participants across different age groups and sex but in actual fact there were less numbers recruited across all of the age groups and sexes. In hindsight it would have been ideal to capture more data from more Aboriginal participants however what was captured was sufficient in gaining insight into suicide within regional and remote communities thus value adds to the existing knowledge. Further investigation can be developed from this research with particular attention to diverse age groups, larger number of participants and more localities. The third limitation was the availability of

historical and contemporary information pertaining to each of the traditional owner groups across the four communities in preparation for the write up of the literature review. It became evident that for some of the traditional owner groups there was plenty of literature however for others this was limited. This could potentially be due to the restriction of traditional knowledge being readily accessible.

Research has historically not benefited Aboriginal Peoples. In this study the methodology applied has sought to rectify this situation. In particular, methods have been selected which align to Aboriginal ways of being thus, the selection of individual face to face interviews, focus groups and feedback workshops to center Aboriginal people and their knowledge and understanding of suicide. This inductive approach counters research which has not been able to elicit deep engagements with Aboriginal communities. Of particular benefit in this research has been that the key researcher is both Aboriginal, names herself from a remote community, has proven professional experience in the field and is known within Aboriginal health community contexts. It is recognized that the study value adds to the research work that has been conducted to date however, richer research can eventuate with broader consultation, recruitment of varied age groups and more localities.

CHAPTER 9 COMMUNITY PROFILES

Introduction

This chapter provides a profile of each community incorporating both traditional and contemporary information relevant to specific Aboriginal populations across the 'Darling Downs and South West Queensland. Additionally, a historical overview of Indigenous health in Queensland will be provided. Furthermore, historical and contemporary accounts will be the focus from a traditional owner's perspective pertaining to each community. This information was obtained through archival accounts that were available at the time of this review. Each community was also described in relation to their Aboriginal Medical Service providing insight into what services were provided.

9.1 Darling Downs and South West Queensland communities

For the purpose of this research four (4) Aboriginal communities (Toowoomba, Oakey, Charleville and Cunnamulla) situated throughout Toowoomba Darling Downs and South West Queensland were chosen with the aim of exploring Aboriginal suicides in the context of Aboriginal people within each individual community. Within these communities there are currently four (4) Aboriginal and Torres Strait lslander Community Controlled Health Organization's (ATSICCHO's) with whom the researcher has worked on a number of projects. It was the intention of the researcher to maintain and enhance existing relationships with the possibility of forming new partnerships while undertaking this research. This in turn provided the researcher access to communities and potential participants. Across each of the communities a series of interviews and focus groups was convened in collaboration with each of the Aboriginal Medical Services providing specific services for Aboriginal people including other mainstream stakeholders.

9.2 South West Queensland

The above image represents traditional owner groups located throughout South West Queensland and illustrates each of the traditional owner groups within their identified boundary. For this section of the chapter there are two regions that form the basis of this research these are the Darling Downs and South West. An overview for each region will be presented providing a context for the Aboriginal communities. The South West Queensland (refer to Appendix 2 figure 2.3) region is so large that it encompasses an area of 399,502km2 and touches all three surrounding states – New South Wales, South Australia and Northern Territory. The population for South West Queensland in 2012 was 27,009 – 0.6 percent of the total population for Queensland. In 2011 Aboriginal and Torres Strait Islander people made up 10.7 percent of Queensland's total population. In the same year seven percent of the population was born overseas and 2.9 percent spoke another language other than English. People living in very remote areas represented more than 48 percent whereas those in outer regional areas represented 30 percent and those in remote locations represented 21.6 percent. In relation to economy, industry and development the main three employment industries are agriculture, forestry and fishing, health care, social assistance and construction. Small business continues to be the backbone of many industries in rural and remote communities situated across South West Queensland, however the unemployment rate continues to increase (AIHW, 2013).

9.3 Toowoomba and the Darling Downs

The Darling Downs is the home of the largest inland city in Queensland – the city of Toowoomba also known as the 'Garden City'. It is also the second largest inland city aside from Canberra. The Darling Downs region (refer to Appendix 2 figure 2.2) encompass 110,753km2 and known for the diverse agricultural assets as well having an abundance of coal, natural gas and other resource deposits. Population for the Darling

Downs was 251,893 in 2012 – 5.5 percent of Queensland's total population and the population for Toowoomba is approximately 113,687. The Darling Downs aging population represents 16.1 percent over 65 years. In 2011, Aboriginal and Torres Strait Islander peoples represent 3.7 per cent of the total population of the Darling Downs, approximately 5.8 percent of Queensland's total population. Darling Downs's population born overseas represents 9.7 percent and 4.0 percent spoke another language beside English. Darling Downs's population is becoming more educated representing 48.9 percent of people holding non-school qualifications and there were fewer people owing their own home outright – 33.8 percent in 2011. In relation to economy, industry and development the main three employment industries are health care and social assistance; retail; agriculture, forestry and fishing. Small business opportunities declined, and unemployment rate increased (AIHW, 2013).

9.4 National Aboriginal Community Controlled Health Organisation (NACCHO)

The National Aboriginal Community Controlled Health Organization (NACCHO) is the peak group advocating on behalf of Aboriginal Community Controlled Health Services (ACCHSs) across the country on Aboriginal health and wellbeing issues. This organization represents approximately 150 individual Aboriginal Medical Services in urban, regional and remote communities supporting and aspiring Indigenous communities in their fight for self-determination since 1974. The National Aboriginal Community Controlled Health Organization received funding from the Federal Government to establish a Secretariat subsequently increasing Aboriginal Peoples involvement in developing national health policies within Aboriginal Community Controlled Health Services. Aboriginal Community Controlled Health Services are autonomous and independent large multi-functional services employing a wide variety of health and medical practitioners delivering a wide range of health related services and

programs with a preventive, health education focus. The main purpose of these services is to deliver holistic, comprehensive, and culturally appropriate health care to Indigenous community members. Aboriginal Community Controlled Health Services are community and community driven through a locally elected Board of Management tasked to address unequal health status of Indigenous people. Aboriginal Community Controlled Health Services work within a primary health care model, which aligns with the philosophy community control and holistic view of health that allows Indigenous people to determine their own affairs, protocols and procedures. National representation facilitates the goal of having greater access to effective health care for culturally respectful and needs based approaches to improve health and wellbeing outcomes (NACCHO, 2018).

9.5 Queensland Aboriginal and Islander Health Council (QAIHC)

Originally established as QAIHF (Queensland Aboriginal and Islander Health Forum), the organization provided a voice for the community controlled health sector in Queensland. This organization was self-funded until 1996, when the Commonwealth Department of Health started to provide funding support. QAIHC has experienced considerable growth in membership and the services provided to those members since its establishment. In 2004, the organization was reconstituted under the Australian Investment and Securities Commission (ASIC) and assumed its current form as QAIHC. Currently QAIHC represents 26 Aboriginal Community Controlled Health Services and has a number of associated members who share a passion and commitment to addressing the unique health care needs of their communities. This is achieved through specialized comprehensive and culturally-appropriate primary health care. QAIHC was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the community controlled health sector (Queensland Aboriginal and Islander Health Council, 2016).

9.6 Historical overview of Queensland Aboriginal communities

In 1859 the state of Queensland was established as a separate colony to New South Wales. The white population at the time was 28,000 people and 6,000 resided in Brisbane. In the new colony sheep - 350,000 and cattle – 500,000 industries flourished and settlement centred on the Darling Downs, Moreton Bay, Burnett region, and the coastal and near-coastal areas from the New South Wales border to just beyond Rockhampton, which is located inland in the northern part of Queensland. More than 70 percent of Queensland's revenue was directed through the pastoral industry which in historical times was a huge industry. The Government at the time saw this contribution as valuable with the chance of emerging this opportunity for the future direction of Queensland. One of the new initiatives prompted by the Government quite quickly in developing and attracting more people to move and reside in Queensland was the introduction of the 1860 Land Acts. People particularly from the South were encouraged to move and take up land in Queensland. The aim of the Land Acts set down the policy in respect to settlement and alienation of Crown Land, impartially as a way of securing real settlement than assuming pastoral land (Smith, 2003 cited in Bush Heritage Australia, 2018). James Tyson is a large figure in Queensland history and stories about him abound. He became Queensland's first millionaire, the richest Australian-born pastoralist and had a persistent reputation for meanness and yet some people attributed him with generosity. He acquired property from Heyfield in Gippsland to Cunnamulla in Western Queensland. In 1872, he bought Felton on the Darling Downs and this was to be his home until his death in 1899. By 1887 he was the largest owner of freehold land in Queensland (Smith, 2003 cited in Bush Heritage Australia, 2018).

Within the state of Queensland Aboriginal and Torres Strait Islander Peoples are represented two specific and different Indigenous groups. Archaeologists recorded that

occupation within this country by Aboriginal people dates back to 36 to 55 thousand years before present whereas, occupation by Torres Strait Islanders is dated in the last 3000 years before present (Briscoe, 2003; 2010 cited in Queensland Historical Atlas, 2010). It is alleged that in 1606 a Dutchman by the name of William Janzoon explored Cape York approximately 50 years prior to Englishman William Dampier indicating that Europeans entered the east and west of the continent as early as 1522. This historical account is different to the account of Captain Cook's landing in 1788 at Botany Bay in Sydney. Aboriginal and Torres Strait Islander people however believe that in pre- contact times these two groups maintained a fit and healthy lifestyle through nomadic transitions of cultural exercise and rest within country and practiced traditional hunting and gathering of food (Briscoe, 2010). These accounts are supported by Captain Cook and Captain Phillip reporting "Aborigines in good physical health". The health, fitness and wellbeing of Indigenous people started to slowly decline however declined rapidly as the British invasion increased and their colonising expanded across the state and country, resulting in Indigenous health status decreasing and incidences of medical conditions increased due to poverty (Briscoe, 2003; 2010 cited in Queensland Historical Atlas, 2010). Subsequent to colonization the state of Queensland enacted the 'Protective' legislation of law and policy designed to control every single aspect of Aboriginal people's lives up until the 1970s. This legislation authorized the removal of just about every Aboriginal person to missions, reserves, settlements managed by white missionaries and for those that weren't removed they were required or sentenced to work for white employers in which an employment agreement was in place. Some people were exempt from the Act in this period. Following the Protection policy was the Assimilation policy where very little acknowledgement was offered to Aboriginal people, their culture and knowledge, hindering the process of 'civilization'. Consequently, Aboriginal people's right's as citizens of Australia were being recognized in yet another policy - 'Self-determination'

(Copeland, 2010). The Federal government then proceeded to dismantle paraphernalia from ‘self-determination’ in support of mainstream. Mainstream initiatives over time have been overhauled with another direction. At this particular time in history, the phrase that would best describe the current approach by all levels of government would be 'closing the gap' between Aboriginal and Torres Strait lslander people and the wider Australian population. During periods of our shared history there has at times been a very deliberate intention to take Aboriginal lives, break apart families and suppress or eradicate Aboriginal knowledge and culture (Copeland, 2010).

The relocation of Aboriginal and Torres Strait Islander people and introduction of colonists continued to affect the idyllic landscape including the water and food sources that supported cultural and traditional ceremonies performed by traditional custodians. Having to now share the land with new colonies the health and wellbeing of Aboriginal and Torres Strait Islander people began to suffer forcing people off their land into areas reliant upon food and medical sources. As colonies invaded and dispersed across the land confronted with a great fight by the traditional custodians, the recruitment of native police contributing to the massacres of Aboriginal and Torres Strait Islander people and causing the desecration of populations by allowing the number of colonists to take up ownership. Replacing the native police were the protection legislation policies with avid supporters like Archibald Meston and Dr Walter Roth. The Federation period (1901) saw much of Queensland’s legislation controlled by the Commonwealth in directing hospitals (health and medical services) focus and priorities about race relations, segregation and seclusion (Briscoe, 2003; 2010 cited in Queensland Historical Atlas, 2010). Priorities for Government imposed policies on Aboriginal people were labor and managing the types of health and illnesses at the time. Aboriginal people worked under very poor work conditions often resulting in their wages, withheld by the Government through Protectors.

Many Aboriginal people were plagued with infectious diseases that resulted in death or grave sickness and cared for by missionaries on Government established reserves or ration depots, whereby researchers would undertake studies into Aboriginal health (Briscoe, 2003; 2010 cited in Queensland Historical Atlas, 2010). Some large numbers of Aboriginal people were relocated to penal colonies for the treatment of tuberculosis and leprosy. Fringe camps contributed to the increasing health problems relating to limited visits from Government services and the deprived living conditions, making it very difficult to transport people to hospitals and provide follow-up treatment due to wide-spread illnesses (Briscoe, 2003; 2010 cited in Queensland Historical Atlas, 2010). Key obstacles confronted by Aboriginal people over time and impeding change was the difference in separate legislation such as the Aboriginals Protection and Restriction of Sale of Opium Act, 1897 and the broader inequality in health, education, housing and employment statuses and lifestyles of Australia (Briscoe, 2003; 2010 cited in Queensland Historical Atlas, 2010).

In spite of this, in the year 2010, there was considerable evidence suggesting that Aboriginal people have survived, and some community members continued to practice a connection to kin and country that has existed for tens of thousands of years. Indigenous people continue to be exposed to wide-spread policies separate to mainstream populations resulting in dissimilar social risk factors experienced by both groups (Ward, 2010). Garvey (2000) and Vicary (2002) in their work argue that despite the prevalent and severe types of mental health problems affecting many Aboriginal people and the delivery of mental health services, less in rural and remote settings compared to urban settings are specifically not meeting the wants or needs of Aboriginal people (Westerman, 2004) because of issues with access, knowledge and awareness. Severe mental health problems, physical illnesses, mortality rates, and psychological distress

are all predisposing Aboriginal people to a larger number of mental health problems and physical illnesses (Kanowski, Jorm & Hart, 2009). Many Aboriginal people continue to have a number of mental health problems that are either diagnosed or undiagnosed and often related to suicides and hospitalizations from injuries. Some of the most common issues for Aboriginal people are around access to services, education, and having limited awareness of what is available contributes to people's inability to deal effectively with different crises in particularly mental health. National frameworks (National Mental Health Plan 2003-2008; Social and Emotional Wellbeing Framework 2004-2008) recognize that for Aboriginal people to deal effectively in crisis situations a strong focus on building the literacy and mental health awareness across the whole community is key (Kanowski, et al., 2009). One of the key strategies at first is to understand the cultural differences of Indigenous especially between those who are Aboriginal and Torres Strait Islanders as their views about mental health will vary and so too will their view regarding suicide. Collectively, Indigenous people have a holistic view regarding health and wellbeing and include physical, social, emotional, cultural, spiritual aspects of the individual, and the whole community (Kanowski, et al., 2009). Therefore, Aboriginal people need to be supported and mentored in identifying and developing specific strategies that allow people to recognize, respond and prevent the escalation of mental health problems and suicide (Swan & Raphael, 1995).

9.7 Queensland Aboriginal community profiles

In the following section, it is imperative for this study to establish a profile of each of the participant communities situated across the Darling Downs and South West Queensland both historically and contemporarily in which the position of this research has taken place. Each community will be described based on historical and contemporary information

gathered from a number of primary and secondary sources which will assist in establishing a context for these communities across the region.

9.8 Cunnamulla Profile

Cunnamulla (refer to Appendix 2 figure 2.8 and 2.9) is a small country town on the Warrego River in far west Queensland. The word Cunnamulla means "big waterhole" or "long stretch of water" in the Kunja Aboriginal language. The traditional owners for Cunnamulla are the Kunja people, with additional 4 language groups: Kooma (Nebine River); Kullilli (Barcoo River South); Budjiti (Mid Warrego River); Mardigan (Barcoo River North). The 'long stretch of water' refers to the nearby Warrego River, in the Paroo Shire which also includes the towns of Wyandra, Eulo and Yowah. The town was established in the 1860s servicing the massive sheep and cattle industries of the area. Today, Cunnamulla still supports these industries and is the gateway for travellers heading west to opal fields. Cunnamulla is situated centrally on the crossroads of the Balonne Highway (Adventure Way), connecting St George and Thargomindah the Matilda Highway, connecting Charleville and Bourke. Cunnamulla's economy is dominated by agricultural production; the main products are beef and harvesting of wildlife and wool. Opal mining continues in the area, with tourism becoming increasingly important to the local economy. Cunnamulla is known for its famous character the Cunnamulla Fella, brought to life by Stan Coster’s lyrics and later immortalized in song by the late Slim Dusty (Simpson et al., 2009).

When Queensland became a separate colony from New South Wales in December 1859 the white population consisted of 28 000 people of whom only 6 000 lived in Brisbane. There were some 3 500 000 sheep and 500 000 cattle in the new colony. In the 1880s, Australia at the time had one of the largest pastoral properties located in south west Queensland hosting one of the biggest shearing sheds in the world. The property of

Tinnenburra was owned by the legendary James Tyson an Australian self-made millionaire who further owned a number of other properties across Australia. Tyson never married, drank or smoked and was a very shy man who later became immortalized for his fame as a pastoral tycoon, in the Banjo Patterson Poem called T.Y.S.O.N. (Powell, 2010 cited in Queensland Historical Atlas, 2010).

9.9 The 'Kunja' People

The 'Kunja' people originate from south west Queensland largely occupying the township of Cunnamulla and surrounding areas as Traditional Owners. The area was roughly the same size as Tinnenburra whereby Aboriginal people would compete with pastoralists for resources eventually interrupting the traditional owner's economy style of gathering and hunting for resources that supported economic growth and social migration. This would further result in Aboriginal people not being able to move freely between tribal boundaries for the purpose of conducting traditional ceremonies and practices. Over time, Tinnenburra became a place where Aboriginal groups would settle and interact with Kunya people. It is reported that Tyson was accommodating to the Kunja People through the provision of land for their purposes of maintaining their cultural life and heritage. This arrangement also served its purpose of providing a source of labour for Tinnenburra station (McKellar, 1984; Queensland government, 2016). Tinnenburra station supported the close association of colonists and Aboriginal people living side by side in an effort to culturally hybridize the colonists and Aboriginal people residing at Tinnenburra. Dinnenbooroo was a significant place located on the Cuttaburra where Aboriginal people to gather and undertake ceremonial practices in which the main home was also established. The Bootha Waterhole was only for women and the Binya Waterhole was significant for rainmaking ceremonies in which only older men could perform and upon collecting particular stones, symbolising land and water. Older men upheld a number of

roles in traditional Aboriginal society such as stockmen, holders of power, clever men – performing magic, initiation ceremonies and holder of knowledge. Shortly after the Great Depression (1930) Aboriginal people were forcibly removed vacating to fringe camps on the outskirts of Cunnamulla known as the Yumba - top camp and bottom camp. One of my oldest surviving relatives from this period was Granny Mackellar – my great great Grandmother spoke in her native dialect 'Matya ngaya bindala Dinnenbooroo' translated as 'I used to live at Tinnenburra a long time ago', when she passed away (1971) she was one of the last native speakers of the Kunja language living to 101 years of age. Over time the original camps where Aboriginal people resided on Tinnenburra were less obvious with only some marked graves, minimal remains of discarded items and humpies. More recently, the remaining Kunja people was successful in having the remaining graves documented as an Aboriginal ‘Sacred Site’ and eventually being listed on the Registered of the National Estate and the Heritage Commission with the erection of plagues in memory of the last Aboriginal people buried (McKellar, 1984; Queensland government, 2016).

Cunnamulla is located 1000 km west of Brisbane, 200 km south of Charleville and has a population of approximately 1,955 for the region. According to the Australian Bureau of Statistics (ABS) (2006), lndigenous population comprises of 27.6% of the Paroo Shire, higher than the State average of 3.6%. Among this group almost everyone identified as Aboriginal, with seven people identifying as both Aboriginal and Torres Strait lslander and one person identifying as Torres Strait lslander. Furthermore, high percentages of the population were relatively young people, for instance 14 years and under at 38.6% compared with non-lndigenous representing 5.3%. Regarding education levels particularly among lndigenous youth successfully completing high school was an issue with 163% aged 15 years and over completing in comparison to 33.5% for non-

Indigenous people for the same age group. Regarding Socio-Economic status in the Paroo Shire there is a significant trend growing towards further socioeconomic disadvantage for the period 2001 to 2006. Yet the most important statistics for the Paroo Shire reported by 2006 census data was that a total of 111, Indigenous youth were aged between 10 to 9 years, whereas in 2009, 13 of the 11, young people were subject to youth justice orders from Cunnamulla. Of concern is the 11.7% of young people being represented in the juvenile justice system which proportionally demonstrates a significant over-representation in the court system in comparison to other communities across Queensland (Simpson et al 2009).

9.10 Cunnamulla Aboriginal Corporation for Health

Cunnamulla Aboriginal Corporation for Health - CACH, is one of an increasing number across Australia of self-governing, independent, community-controlled Indigenous organizations providing primary health care services to Indigenous people. CACH has grown up out of the desire of local Indigenous people to take control of their own health and of how primary health care services are delivered to and within Indigenous communities in South West area of Queensland. In line with the principle and practice of self-determination, the general membership of CACH has the mandate to determine the broad policies and procedures governing the operations of CACH. To this end, community gatherings of CACH members are held at least approximately 12 months to ensure that all members have the opportunity to participate in the review and updating of CACH governing policies and procedures. The local Indigenous community with the mandate to manage CACH on their behalf entrusts a Governing Committee. At each year's annual general meeting of members, a minimum of two new members are elected to the seven-member CACH Governing Committee. The new Governing Committee is thereafter delegated with the authority to undertake the executive management of CACH

over the following two years. In the course of executing its executive management responsibilities, the Members of the Governing Committee are guided by the general policies and procedures and constitution of CACH. The Members of the Governing Committee make executive management decisions through the process of interpreting how the general CACH policies and procedures apply in particular situations under consideration by the Governing Committee. In line with the CACH Constitution, while the general control of CACH is the responsibility of the CACH membership as a whole, the executive control of CACH is the responsibility of the elected Members of the Governing Committee. This means that specific executive management decisions taken by the Governing Committee should not ordinarily be subject to review by the CACH membership at a general meeting. In other words, it is the general policies and procedures relating to a specific Governing Committee executive decision that are subject to review at any general meeting of members rather than specific executive decisions as such.

9.11 Charleville Profile

Charleville is situated in South West Queensland, about 600 km west of Toowoomba, the population for Charleville is approximately 4580 (refer to Appendix 2 figure 2.6 and 2.7). Charleville is known as the heart of Queensland's 'Mulga Country'. Charleville is the largest town in the south west outback region, boasting a rich history and incredible flora and fauna. The area around Charleville was first explored by Edmund Kennedy during his 1847 journey through the area. At the time he was trying to solve the riddle of the rivers. His expedition succeeded in establishing that the waterways in Central Queensland, particularly the Barcoo, which Thomas Mitchell had called the 'Victoria', flowed south into the Channel country rather than north into the Gulf of Carpentaria. Charleville played a significant part in Australia's aviation history. Amy Johnson was the

first woman to land there in 1920. The aviation tradition continues with Charleville being an important base of the Flying Doctor Service. Charleville is the base for the School of Distance Education, which teaches children living on isolated properties. The Bidjara people are the traditional owners of the Charleville country and surrounding areas including Augathella, Morven and south to Wyandra (Queensland government, 2014)

9.12 The 'Bidjara' People

The Bidjara people are the traditional owners of Carnarvon Station Reserve, with a historical connection to the land stretching back at least 18,000 years before European settlement. The reserve holds many sites of cultural importance to the Bidjara, including rock art, burial places, scar trees and quarry sites. Carnarvon Station seems to have been grazed from the early days of European settlement, with records dating back to 1884. Libby Smith has researched and documented the history of the property since European settlement, which is a fascinating reflection on the changing attitudes of Australia through the years. It includes stages in which the wholesale destruction of native wildlife was officially approved by a 'Marsupial Destruction Act' for the purpose of trade in exotic furs and countless thousands of koalas, possums and dingos were slaughtered. It's also been the home of notorious bush rangers, survived infestation with prickly pear and seen many owners come and go as it weathered severe droughts and floods. It is thought that the Bidjara and the Karingbal had strong social ties during the period prior to colonization and that both were using the Gorge, although not on a permanent basis. Some early researchers believed that the Gorge was not permanently occupied due to defensive concerns and a lack of resources, however Australian Nature Guides have developed other theories that also fit the facts given the Gorge's local spiritual significance. Prior to colonization, law was administered through a religious framework, so it is worthwhile taking spiritual beliefs into account when examining social

patterns. Local material culture was quite sophisticated, and much knowledge of it can be gleaned simply by observing what has been stencilled at the art sites. Bush medicines were readily available, as is mentioned in the section on Carnarvon Gorge's flora (Queensland government, 2016). Carnarvon Station Reserve is a rich and significant cultural site located in the Southern Brigalow Belt in Central Queensland northwest of Brisbane and sits within the Traditional Lands of the Bidjara people. The significance of the cultural landscape holds a rich and continual sense of belonging and connection for the Bidjara people and their country. Throughout the landscape widespread rock shelters displaying historical evidence of rock art, engravings, stone tools and flakes scattering the slopes and ridges of terraces and banks and scarred trees. Local Aboriginal park rangers and the Bidjara people work collaboratively to preserve and manage these cultural sites through the identification and documentation of evidence. For example over the last decade a cultural heritage assessment was undertaken by the Bidjara people and local rangers documenting significant like the ochre pits, for the use of painting in ceremonies. All of these sites, whether it be one scar tree or a grinding stone, are all important, as it's evidence of our people's presence, my relatives being here and that I am walking in their footsteps. This means a lot to me and I have a responsibility to look after these places,' said Keelen Mailman, Bidjara community member (Queensland government, 2016; Bush Heritage Australia, 2018).

Conducting cultural workshops and visiting the area to identify and document places of significance for the Bidjara people is an ongoing project in collaboration with government organizations of cultural heritage. Cultural knowledge gained through this process will inform the development of a cultural heritage management plan that highlights and integrates the cultural and environmental values of the landscape of the Bidjara people and facilitates a partnership of working together to uphold and manage by protecting the

rights and values (Bush Heritage Australia, 2018) of the Bidjara people. 'We're happy that Bush Heritage is doing this, looking after our country and sites. Other than our [Bidjara] people owning and managing Carnarvon, we couldn't ask for a better mob. You mob have been respectful, providing access and consulting traditional owners and community members in management of our sites,' said Floyd Robinson, Bidjara Cultural Heritage Officer (Queensland government, 2016; Bush Heritage Australia, 2018). An outcome of this work is the creation of employment opportunities in the form of a trainee (Bidjara descendant) funded through the Rick Farley Memorial Scholarship for the purpose of building capacity in conservation and land management skills and training. Indigenous Ranger Fred Conway was recognized as one of the Queensland Greats for his tireless efforts and advocacy in protecting Indigenous cultural sites, particularly the rock art sites in Carnarvon National Park in central west Queensland. A ranger with the Queensland Parks and Wildlife Service, Fred has spent the majority of his life helping people understand Aboriginal history and culture, and in particular to respect and protect the rock art sites, which draw thousands of visitors each year. Fred has also been instrumental in developing and ensuring the success of a unique program for Queensland—the Seasonal Indigenous Ranger program. This program trains young Indigenous people and allows them to return to country, gain employment and have a meaningful involvement in the management of their traditional lands. Due to the program's success, damage to rock art has declined as visitors understand and respect the national park's cultural history (Queensland government, 2016; Bush Heritage Australia, 2018).

9.13 Charleville and Western Areas Aboriginal Torres Strait Islander Community Health (CWAATSICH)

Charleville and Western Areas Aboriginal Torres Strait Islander Community Health was founded in 1993 and incorporated in April 1994 and the objects for which the Company

was established include all or any of the following, which is in relation to the Aboriginal and Torres Strait Islander health in the Charleville and Western Areas. The primary objective for which the Company is established is for the public charitable purpose of the relief of sickness, poverty and disadvantage amongst the Aboriginal and Torres Strait Islander population of the Charleville and Western Area.

9.14 Toowoomba Profile

Some of the oldest evidence of human activity on the Darling Downs comes from a place called 'Talgai' situated near the town of Warwick. 'Talgai Skull' contributing to this evidence proving that humans existing in the area for 12000 - 15000 years earlier also indicating Aboriginal life existed 40,000 years ago or more (Broome, 1982, French, 2010). In recent years traditional owner groups of the Jarowair and Giabal people have been recognized as the custodians, restoring a ceremonial site at Gummingurru on the outskirts of Toowoomba (refer to Appendix 2 figure 2.10 and 2.11) providing cultural awareness sessions to school groups and the wider community. Toowoomba Darling Downs is one of Queensland's productive agricultural and pastoral areas producing high quality products across the region and internationally. The landscape of the 19th period was rolling in rich black soil and grass producing large wealthy stations, evident in much of the art and literature of historical times (Broome, 1982). Across the Darling Downs a pattern of violence was being portrayed by the Leslie brothers, in one account of George Leslie's writing in 1841 "we never allow them to come about the stations or hold any communication with them except it be with a gun or sword. Two blacks were shot the other day by a new arrival on the Downs for attempting to spear some sheep he had lost in the bush" (Letters of the Leslie Brothers in Australia, 1834-1860, letter 195). Toowoomba Darling Downs hosted many Aboriginal people - descendants of the Keinjan, Giabal, Jarowair and Barunggam groups. The Jarowair people were the custodians of

the Bunya Mountains, facilitating large gatherings of Aboriginal groups at the Bunya festival. The triennial festival supported safe dialogue and traditional practices between traditional groups on cultural ceremonies, disputes and exchange of ideas regarding the new colonists arriving onto their land (French, 2010).The Bunya Nut Festival was established to create a place of healing and gathering of many Indigenous groups to participate in cultural and traditional dances and ceremonies of initiation while dealing with disputes, knowledge sharing and celebrating the cooking and eating of bunya nuts. The festival would see many groups congregating on the Bunya Mountains travelling from many different locations from south west and central Queensland, Brisbane, south coast and the Darling Downs (French, 2010).

After explorer Allan Cunningham colonized the Darling Downs area in 1816, George and Patrick Leslie established Tooburra Station approximately 56 miles from Toowoomba. Other settlers quickly followed, and tradesmen and businessmen settled in an area of Toowoomba now called Drayton. Towards the end of the 1840s, Drayton had grown to the point where it had its own newspaper, general store and trading post. The Royal Bull's Head lnn, which was built by William Horton, still stands today. Local historians believe Horton is the founder of Toowoomba. lt appears that the Leslie brothers set a pattern of violence at the frontier on the Darling Downs employing measures deemed necessary to protect white servants, stock and property (Copeland, 2010). Another prominent family were the Dalrymple brothers related to the Leslie family were key figures to the European expansion believing that settlers "must make the Blacks fear them". Although the deaths of white settlers were recorded and publicized the same could not be said for the deaths of Aboriginal people. Only a small number of inquests were conducted into the deaths of Aboriginal people, these are the only known records of these inquests in a New South Wales register. Arthur Hodgson conducted the inquests and is

reported as maintaining a ‘conspiracy of silence’ (Meston, 1920). Between 1840 and 1843, across the Darling Downs and Moreton Bay was a particularly violent period with the use of state-sanctioned violence against Aboriginal people in Queensland, such as the chasing a group of Aboriginal people into the Rosewood Scrub following the 'Battle of One Tree Hill' in the Lockyer Valley. Upon William Stamer's visit in 1850's, he describes the number of Aboriginal deaths on the Darling Downs it was enough to make one’s blood run cold to listen to the stories that were told of the diabolical manner in which wholes of tribes had been 'rubbed out' by unscrupulous squatters. No device by which the race could be exterminated had been left untried. They had hunted and shot down like wild beasts – murdered whilst sleeping within the paddock rails and poisoned wholesale by having arsenic or some other substance mixed with the flour (Stammer, 1866, P.11).

The Aboriginal population in a number of towns had decreased rapidly due to the intensive settlement of white Australians. According to official reports in 1861 there were 150 Aboriginal people living at Drayton however by 1900 there were just four blankets distributed to Aboriginal people. ln 1904 a survey on 'half-caste' populations was conducted for the provision of the Chief Protector of Aborigines authorizing police to remand half-caste children until a removal order was obtained. Regardless of the forced removals and decline in numbers, connection to country was still important. Between 1971 and 2007 local lndigenous population had grown from 230 to 3500 in Toowoomba. ln 1967 – the year of the referendum, 9% of the Toowoomba population voted YES in support for the Federal Government to take responsibility for lndigenous Affairs (Toowoomba Chronicle, 1967 cited in Copeland, 2007, p. 9). The City of Toowoomba is well known for its parks, gardens and scenic views. The city is set 700 metres above sea level, on the edge of the Great Dividing Range. lt is located at the junction of major

highways from Brisbane, Sydney, Melbourne and Darwin and is about 90 minutes' drive from Brisbane.

9.15 Carbal Medical Centre

Prior to the development of Carbal an Aboriginal Medical Service known as Goondir Health Service was the original service established in 1994 providing Primary Health Care services to the Indigenous community of Toowoomba up until 2005. That same year, Carbal originated from the efforts of local Aboriginal people to establish their own Aboriginal Medical Service. Carbal designed culturally safe and secure health services to comprehensively address the health needs of Indigenous people locally and regionally. Carbal Medical Centre is also known as an Aboriginal and Torres Strait Islander Community Controlled Health Care Organization (ATSICCHO) and is a member of the Queensland Aboriginal Islander Health Council (QAIHC) in Brisbane. Carbal translates to the tribal totem (carpet snake) for the Traditional Owners the ‘Jarrowair’ and ‘Giabal’ people of the land on which Darling Downs resides. Carbal continuously redesigns policies and processes ensuring that the client’s health journey needs are addressed through a wide range of health, medical, specialist and community related services. Carbal works in collaboration with multidisciplinary team of individuals who continue to work towards closing the gap by improving and enhancing the health outcomes for Aboriginal and Torres Strait Islander populations. Overall, Carbal strives in providing excellence in Aboriginal and Torres Strait Islander Primary Health Care in a Caring and Confidential Environment (Carbal, 2016).

9.16 Oakey Profile

Aboriginal people have existed for more than 50,000 years in the Oakey area. Prior to European contact, there were at least forty traditional owner groups in the region and similar to other communities. As many as 20,000 Aboriginal people lived across the

Darling Downs and South West Queensland region (Healy, 2009). Credible archival evidence suggests during the mid-century a large-scale conflict between white settlers and Aboriginal people across the region had occurred. An explorer by the name of Charles Pemberton Hodgson recalls "the earliest inroads of settlers were marked with blood, the forests were ruthless, and the native tenants hunted down like their native dogs" (Copeland, 2010, p. 10). There is ample evidence that Aboriginal people have survived and like community members living in Oakey continue to practice a connection to kin and country that has existed for tens of thousands of years (Copeland, 2010).

9.17 The 'Jagera, Giabal and Jarowair' People

Aboriginal descendants of the Jagera, Giabal and Jarowair people occupied the land for over 50,000 years with a population ranging between 1500-2500 people. These traditional groups took up residency of different parts of the landscape ranging from the foothills of the dividing ranges to the escarpment and extending beyond to the Bunya Mountains. Indigenous people at the time of this area had innovative ways in hunting animals for food through traditional burning methods so as to attract animals to an area when regrowth occurred. They were known as "Gooneburra – those who hunt with fire. Allan Cunningham was the first European explorer on the Darling Downs (1827) with the first wave of settlement being led by Patrick Leslie. As identified in the literature settlement on the Downs had significant and serious impacts upon the Aboriginal populations particularly in the form of sickness and diseases that were not heard of and introduced by the Europeans. This resulted in huge numbers of Aboriginal people being disintegrated and dying in addition to social upheaval, relocation, and mass murders and childhood removals from communities (Toowoomba Regional Council, 2012). At the time of the Bunya festival as Europeans settled in the area they felt threatened by the large numbers of Indigenous people congregating and therefore, instigated a brutal tactic

against the Indigenous group as a way of intimating and dispersing people. This annual celebration occurred at the same time as the blanket distribution in honour of the Queen's Birthday (Queensland government, 2014). The harsh treatment of Indigenous people in the area continued however most relationships with Europeans were non-existent. These poor relationships were the result of misunderstandings and a deep appreciation of the cultural significance of the land with sacred sites and what it means to Indigenous people. Tension and conflict escalated to the famous Battle of One-Tree Hill being led by King Moppy – better known these days as Multuggera (Copeland, 2007; Toowoomba Regional Council, 2012). Aboriginal survivors from this battle would eventually come under the control of the Queensland Government (1897-1957) as Europeans knew what was best for Indigenous people's lives. This resulted in the development of the Queensland 1897 Aborigines Protection and Restriction on the Sale of Opium Act allowing the Government to legally control the whereabouts of Indigenous people in Queensland (Copeland, 2007; Toowoomba Regional Council, 2012). There was also a process of separating Indigenous people from Europeans and relocating them onto Government established and controlled missions and reserves far from their original connection to country. These removals broke apart families, traditional ways of life, connection to country and values and beliefs as a race. Europeans believed they had an obligation to save Indigenous people and the way to do this was to civilize them into colonial ways (Copeland, 2007; Toowoomba Regional Council, 2012).

9.18 Goondir Health Service

Goondir Health Services is one of 27 established Aboriginal Community Controlled Health Services located in Queensland delivering Indigenous specific health and medical specialist services from their home base of Dalby. Services and programs encompass communities of Dalby, Oakey, St George and smaller communities in between such as

Jandowae, Surat, Dirranbandi, Thallon, Chinchilla and Tara servicing more than 5000 clients. Services and programs encompass culturally appropriate holistic primary health care that aims to enhance the health and wellbeing of all Aboriginal and Torres Strait Islander people within the region

CHAPTER 10 RESEARCH FINDINGS

Introduction

For the purpose of this Chapter an overview of the findings from the research will be provided. Participants' comments highlighted from individual transcripts in the form of an excerpt are provided within each theme. In describing the layout of this Chapter individual excerpts are written as a quote in inverted commas with an identification record number as follows (i.e. Participant Interview/Focus group DS95) for the purpose of maintaining confidentiality, accuracy and anonymity. Each identification number is unique and does not allow for participants to be identified or known within the conversations. For this research the following themes and (sub-themes) were identified

1. Suicide (overarching theme),
2. Community – underlying issues and substance misuse,
3. Young people – relationships and help-seeking,
4. Mental health – services and awareness,
5. Culture – cultural perspectives, social, lifestyle and leadership

(refer to Appendix 2 figure 2.16)

'Story-telling from the people'

10.1 Theme 1 - Suicide

Suicide was identified as the overall theme and was evident across all of the communities and in conversations with participants. It is pivotal to this research in achieving an understanding of what suicide means to Aboriginal people. Suicides were linked with all the communities. Consequently, in dialogue with participant's regarding suicide one participant attempts to describe what happens in one of the communities "Suicides that happen here has an impact on the community, but it doesn't seem to be enough to bring

some of them that are in a rut out of their rut – doesn't change their ways" (Participant interview – DS49). There appears to be a sense of normality in communities about suicides. Another participant attempts to describe suicide as "somebody taking their own life for whatever reason, it could be seen as a joke and it's really gone too far and now it's too late to stop or in a serious way where people can't cope with their life for whatever reason, people who are desperate and they just can't cope" (Participant interview – DS55) resulting in suicide. In the past suicides were associated with white people "you'd hear stories growing up about people committing suicide over the years and it was always whitefellas and never heard of any blackfellas, the first one I heard about was my sister (2007) but now it's been all these young fellas attempting suicide". These attempts occur because "there's nothing out here for them, there's no support, it's like no-one cares, they feel worthless, they've got depression, and they turn to drugs and alcohol". They "try to hang themselves and self-harm by cutting and/or burning themselves with cigarettes" (Participant interview – DS59). Suicides are normalized and seem as a solution to many of the stressors experienced by young people with depression. However, the effect is not just individual but impacts on the community as well.

10.2 Theme 2 - Community

'Community' is one of four (4) themes identified through the data analysis process and relates to and includes the holistic concept of encompassing the individual, family and wider community. For the purpose of this research 'community' refers to all of the four communities individually and collectively participating in this research. Additionally, within this theme are two (2) sub-themes recognized as underlying issues and substance misuse. Each of the sub-themes will be outlined and described in detail in relation to participant conversations regarding these themes. In the past each of the communities were known for their closeness or being tight knit however over time there has been

division among the wider community due to various key and influential organizations where the community largely felt that their voices were being heard have since devolved or shut down due to lack of funding, political change, re-focus of funding, policy and corruption “community feel their voices haven’t been heard and that has caused division in the community” (Participant interview – DS59).

Nowadays community express their lack of support and safety in being able to voice their opinions and feelings about particular local and regional community, health and wellbeing issues pertinent to their community. There is a general apathy in the community by letting other people make decisions on behalf of the wider community and the people voice this by saying, “I haven’t been heard” or “I’m – We’re not being heard or listened to – our treatment isn’t equal with the services being provided or available” (Participant interview – DS59). This reaction isn’t evident for all Aboriginal people and their communities but unless it involves them personally – then people don’t become vocal. The consequence of mainstream management and delivery of services is keenly felt by Aboriginal community who well understand that their needs are not being met, their voice is not being heard and as a result services are not taken up.

Psychiatrist Dr Paul Brown (2014) hypothesized that Aboriginal suicides relate to violence and secularization believing that individuals are either driven or abandoned to suicide which he refers to as nemesis. Brown (2014) refers to First and Second Nation Australians as the historical-past and contemporary-present referring to a number of historical risk factors contributing to suicides such as dispossession of land and disconnection from culture, impacts from trauma, grief and loss commonly referred to as trans-generational effects, racism and social exclusion. While in contemporary times risk factors relate to psychiatric disorders, stressful life events and substance abuse entrenched in high levels of social disadvantage through unemployment, homelessness,

and incarceration and family issues. In understanding the relationship of secularization and suicide an understanding of traditional Aboriginal life must be achieved. Traditionally, Aboriginal life was central to the ancestral land and the Dreamtime they were hunter gathers, married, had children and lived in tribal groups encompassing huge numbers of families often congregating in the same place at different times. They spoke in their traditional language (tongue) and had rich cultural heritage they never lived in a house, had money nor drank alcohol. Aboriginal people did everything in a natural way rather than a Western way – and were highly individualized in their approach. Aboriginal people encountered the Western way at a time when society was shifting from communalism to individualism. White Australians over the last two hundred years have been trying to shoe-horn Aboriginal Australians into narcissistic western culture. Conflicts have not only been between blacks and whites but intergenerational and intra-familial within Aboriginal culture resulting in culture clash. Intra-individual conflict was equally devastating. French sociologist Girard says Aboriginal population's fell prey to western ways – same social ills by adopting narcissistic habits resulting in self-destruction in the form of suicide, alcoholism and crime (Brown, 2014).

The long-lasting effects of colonization, at its core individualism, hierarchies of power, capitalism built from the dispossession of Aboriginal lands and the blunt force of industrialization impacted adversely on Aboriginal community lifestyles. What has been most evident across time is that Aboriginal peoples have had little opportunity to recover and hopes for wellbeing are undermined by the narcissistic tendencies of white ways which work to dismantle community, shared power and responsibilities and connections to country and traditions.

Evidence indicates there are general socioeconomic and demographic trends or risk factors in rural and remote areas that contribute to an increased suicide rate when

compared to urban areas. These risk factors include such things as social and economic marginalization, social isolation, economic hardship/ unemployment, easier access to means that lead to death and reduced access to support services and education facilities. It is evident from research that suicides do increase because of rurality (Kõlves et al, 2012) - meaning the more remote you are the more at risk you are of suicide.

Statistically suicides are believed to be underestimated in rural communities similarly in many other population groups, and actual figures are significantly higher than what is reported and registered. Suicide rates are higher in rural communities for both males and females (Kõlves et al, 2009) and some of the challenges around this are being able to determine the proper intent of deaths as accidental or unspecified (Lifeline Australia, 2011). Living in a rural or remote community itself may not be a risk factor but, in combination with other risk factors, may lead to a higher vulnerability to suicide among its inhabitants (Commonwealth of Australia, 2007).

10.3 Subtheme - Underlying issues

Underlying issues are explained as problems, concerns and disputes that exist among Aboriginal people and families within their respective community. Underlying issues can be associated with historical backgrounds as well as contemporary backgrounds for each community and often relating back to intergenerational periods of time. Underlying issues are obvious across participant communities and recognized by Aboriginal participants as either problems or weaknesses but pertinent to each individual family and community. For instance, participants across the different types of conversations recognize that Aboriginal people within communities effect “do not have the ability to understand and/or sort out problems without making use of violence of some form…..leading to an eruption of violent behavior” (Focus group – DS51) all the while experiencing a combination of alcohol and drugs. This type of violent behavior is seen as a regular occurrence within

communities where it has been happening over time for months or more. The high concentration of alcohol abuse is also apparent as similar people within communities continue to drink alcohol at extreme levels “where they get out, get drunk and try to push problems a side by masking these with alcohol” (Focus group – DS51).

Some participants have indicated that when people drink they are covering up their individual problems, concerns by masking it with alcohol and drugs that protects the underlying issues resulting in “people not being able to recognize their own issues” (Focus group – DS51). However, what’s happening is the “issue/s is still there when they wake up, so they haven’t recognized their need for intervention” for instance “presenting themselves to their doctor or talking to someone, a friend……to find out what’s going on within themselves” (Focus group – DS51).

Page and colleagues (2002) report some male suicides have been related to socio-economic status and location of residency such as residing in a rural and remote community (Commonwealth of Australia, 2007). For example for men in rural communities some of the relatable risk factors identified are masculinity, stoic attitudes, connection to land and ‘broad shouldered’ behaviours – men masking mental health issues and/or playing down of their issues or problems and seen as not important. Additional contributors to suicide that hinder accessing services are depression and social stigma when seeking help – concerns of confidentiality, drought-related trauma, finances, substance misuse, isolation, violence and access to education on mental health (Page et al., 2002). Participants also stated that community people were “not willing to admit that they’ve made a mistake, and just sort it out…..instead they continue to use violence (fighting) as a means to an end….that seems to be the easiest issue to sort out….seen as an easy option, way out” (Participant interview – DS51).

Men have a tendency to shoulder the blame for any failed accomplishments by taking it out on themselves resulting in indications of suicidal thoughts and actions. On the other hand, this sense of failure may be directed towards others close to them in violent ways (Alston, 2010; Alston & Kent, 2008 cited in Commonwealth of Australia, 2007). Consequently, it is evident that a lack of or inability to recognize the need for help or assistance and is an identified weakness within communities "lack of respect and accountability to accept and recognize abilities and inabilities within people (themselves)" (Participant interview – DS51) and communities are also identified by participants who reside in these places. In addition participants believe that many people may speculate what they know about an individual or family "some are assuming they know details of people and events and continue to tell others (which aren't true) which adds fuel to the fire…..adds more to the pile of things that people have to deal with already" (Participant interview – DS51) making it difficult for people to manage.

This in turn creates additional problems such as a "lack of understanding or appreciation of each other's situations and being respectful of people and their actions, otherwise not being involved in each other's systems (life, personal situations)" (Participant interview – DS51). Participants believe these actions can have either a negative or a positive outcome for instance…."they say that it takes a whole village to raise a kid whereas on the other side you can't do that in today's society…… if you did chastise or get involved in families and children's welfare the parents would come looking for you" (Participant interview – DS51). Consequences or repercussions for being involved in someone's affairs often carries negative impacts on those (people) who feel obligated to help (others). For instance, Aboriginal people within communities who feel the need to watch someone's back, cover for them or just even support them in difficult times find it is not a positive experience or outcome as expected. Participants state that in communities if you

(as an adult or child) “report incidents to police or retaliate in defence” of individuals or families “you get the repercussions from that….you get called dogs or other names for telling the police….kids break into your yard, house” and make it difficult for you and your family (Participant interview – DS51). “Once you interfere you wouldn’t know what they’ll do in return” (Participant interview – DS51).

Some of the older participants stated “it was never like that when I was growing up….if you did something wrong you’d usually get a kick up the ass or they’d flog you and then tell your parents – you were punished straight away – you didn’t do it again” (Participant interview – DS51). The shifting dynamics within the community from practices of the old to contemporary contexts exposes vulnerabilities. It is in this space of not knowing that substance misuse fills the void.

10.4 Subtheme - Substance Misuse

Substance misuse involves elements of alcohol and drugs (illicit drugs) or a combination of both alcohol and drugs creating a dreadful concoction. The consumption of alcohol and drugs is viewed as habitual in some communities among Aboriginal adults and young people, participants across the communities support these views by indicating that drug use is on the rise and appears to be worsening. Historically alcohol was prevalent among Aboriginal adults mainly, whereas drugs was not and certainly not to the extent that both of these substances are used, misused in contemporary times. Alcohol in these communities is readily available and while the distribution of drugs is illegal they are also readily available and often a source of income for many living in these communities, particularly those situated in rural and remote areas where employment opportunities are scarce.

Substance misuse has a connection to the sub-themes of domestic violence, youth and mental health. These will be outlined in the subsequent sections. “Substance misuse is

creating mental health problems for our families and communities, the mental health problems that don't get addressed in our communities generally have high occurrences of substance misuse" (Participant interview – DS60).

Retrospectively, not only is a heightened risk of suicide for males living in rural and remote communities linked to socio-economic status but high rates of alcohol consumption are also evident. Regardless of the location of communities, suicides are multi-faceted (Alston, 2010; Macintyre et al, 2002), often linked to relationship failures, legal issues, physical and mental health problems. Suicides in rural communities are often associated with farmers due to the effects of drought forcing many into financial hardship and/or selling their properties in desperate times (Thacore & Varma, 2000 cited in Commonwealth of Australia, 2007).

The first notable issue for young people was that of drugs and alcohol which was recognized across all of the communities in conversations with participants as a major problem, concern and is ever-increasing. One of the common drugs is "Marijuana (Cannabis) which is readily available" throughout many communities among other types of more serious drugs "are going out to younger people. You're not going to stamp it out; you're not going to stop people using drugs, it's more about making sure that they've got somebody with them if they're going to be using drugs and stamping out the non-consensual drug taking such as when people slip mickeys in your drink" (Participant interview – DS55). "There is a big drug problem in these communities, it's not going to get any better as everyone just about has a vehicle these days and it's nothing now to go away for a weekend and bring back stuff (drugs)" (Participant interview – DS55) into the community. There's "a lot of pressure on people in these communities today with buying a house, a car, which adds to the burden of lifestyle and if people don't cope this

creates more social problems because of people's situations" (Participant interview – DS55).

One participant describes how it is in communities saying, "parents can't see that their kids need them today and kids are growing up thinking no-one cares about me, so what the hell I may as well waste away doing drugs, alcohol or suicide" (Participant interview – DS52). Therefore, the question is what problems are going to exist in these communities in "ten years' time, it's like a chain reaction, and for instance it might be gambling now for the parent however down the track it's going to end up being mental health in relation to the children" (Participant interview – S52). Some of these early problems are evident in communities today with "children being born to addicts and experiencing withdrawals from drugs, parents continue to play the poker machines without considering the home and children such as buying food for the house, school" (Participant interview – DS52).

There is not much to do in this community if you don't work, study or attend school, "the only thing to do is drink and use cannabis", participants go on to say, "there are eight out of ten young people" (Aboriginal and non-Aboriginal) "who use cannabis in this community. Young people identify that older Murri men use heavier drugs (gear) such as speed, ICE and ekkies, whereas young people choose and often to use cannabis" (Focus group – DS58). The 'Weed it Out' project (implemented by regional police in rural communities, originally adapted from North Queensland communities) "it's never going to happen….."They need to take the speed to weed out the weed", should be the speed out program…..slow it down program….. Cannabis keeps people's feelings down (relaxant)…when certain people get out that's when they go shooting up….go stompin….terrorising other people" (Focus group – DS58).

Participants believe that enforcements “need to leave the weed because it keeps communities calm” (Focus group – DS58). “Teenagers are doing drugs…younger kids are coming and hanging around with them, then they’re doing drugs….kids as young as seven are sniffing glue. Parents say they can’t do anything about it….it comes back to a generational thing, it’s like a chain reaction, it’s up to the parents” (Participant interview – DS62) to change so if there doing the same thing what hope do the children have. Children are “starting to experiment at a younger age compared to what they did in the past” (Participant interview – DS62). Mental health problems are evident in older people based on their past use of drugs – which you now “see drug induced psychosis; this is not evident among the young people” (Focus group – DS62). “Substance misuse (drugs and alcohol) affecting young people as young as fourteen years on speed, heroin, sniffing….a lot of the kids are being removed from families due to parents being drug addicts” (Participant interview - DS59).

From another participant’s perspective and experience in the community it’s the combination of both alcohol and drugs and that these are only going to get worse as we move into the future, for instance, my experience with a young man “who was seeking employment through a job network centre locally had to meet certain requirements in order of keeping his payments, I accompanied the man to Centrelink so he could be assessed, I had to help the man out of the car, into the car, helped him put his seatbelt on, this man was 14 years younger than me” (Participant interview – DS60).

If this does not scare anyone it surely scared me by physically seeing what I experienced. This is what’s happening to our people from substance misuse. This “young man had been experiencing depression from an early age about things from his past and he resorted to turning to alcohol and drugs” (Participant interview – DS60). The community feels that substance misuse is a huge problem and creates mental health problems not

only for the individual but families (domestic violence to women, children being scarred from being in the same environment) and the wider community. For instance, “Mental health problems that don’t get addressed there’s also a high incident of substance misuse”. One participant describes her personal experience of substance misuse “I can remember being a child and my uncle drinking methylated spirits and coming home and self-harming and now I see my nephews self-harming” (Participant interview – DS60) but in a different way.

10.5 Theme 3 - Young people

The main theme for this section is ‘young people’ (<18 years) comprising of sub- themes: relationships and help-seeking. ‘Young people’ identified as a key theme in this research was evident across all of the participant communities as one of the main population groups besides adults for this research. Evidently the terms ‘young people’ and ‘suicide’ are linked in the literature as well as in dialogue with the communities of interest as the most vulnerable populations who are at risk of suicide. Associated with this high risk are contributing factors such as those mentioned above for relationships and help-seeking? A wide range of issues exist in communities for young people and were identified as either problems or concerns that affected young people. According to participants these are recognized as the “most significant (drugs, alcohol, violence, crime, relationships - lack of family stability and cohesion, lack of responsibility and participating in further risky behavior)”, (Participant interview – DS59) affecting and impacting on young people’s lives across and within these communities currently. According to participants these are recognized as the most significant, affecting and impacting on young people’s lives in these communities currently.

According to the data a wide range of issues exist in communities for young people and were identified as problems or concerns that continue to affect young people. One

participant in a neighbouring community describes “young people close to her son, [including her son] as all having depression, they’re all frustrated because there are no opportunities for work, young people are not being given a fair go in their community and there having to compete for work with non-Aboriginal people” (Participant interview – DS59), who are often given the job/s over Aboriginal people. This group of young people (males) have all attempted suicide, the “usual pathway is to be admitted into hospital provide Valium, assessed by mental health team then discharged in few days with no support or follow-up. Young people think that there worthless and even when there playing the game of football that they love; sometimes they aren’t even given a go on the field either” (Participant interview – DS59).

What becomes evident is a lack of appreciation of young people in one of the communities for whom they are as young people and not for their sporting ability as such. Across all four of the communities “young people are over-represented in court every week in these communities due to legal issues not being dealt with locally (due to systems and processes), there’s no support like there was in the past” (Participant interview – DS59; Participant interview – DS53), and before they removed Aboriginal legal aid from these smaller communities “Aboriginal people had good legal representation” (Participant interview – DS59) and instantaneous. Whereas “nowadays representation and legal aid officers are non-Aboriginal workers who don’t come from the communities, who don’t know Aboriginal way of life or the people they are representing” (Participant interview – DS59).

Legal and mental health issues are multifaceted and coincide with each other which in turn causes further destruction of lives in particular for young people. Young people are vulnerable in their adolescence and young adult years and in these communities, are more susceptible to issues around mental health, legalities, education, employment and

health due to no opportunity, no support and inequality. Participant's (young people) identify some of the positive reasons about living in this community "it's peaceful and quiet and football season and the fact that everyone knows everyone" (Focus group – DS58), but this can also be a drawback as well. Additionally, some other negative reasons include "football in your late teens (18-20 years) as the season runs longer and becomes boring towards the end and travelling to and from these games is a challenge, as majority of Aboriginal people don't own their own car and fuel is expensive, and more so for young people" (Focus group – DS58). Therefore, not being able to participate at elite levels. "Crime such as break and enters, and stealing is common but not by those who reside in the community but those associated with neighbouring communities" (Focus group – DS58). The police are not well received by young people who indicate "police harass them, pull them up all the time, asking them questions and needing to know whereabouts" (Focus group – DS58) all the time. "This community is racist, you don't realize this until you get older, then you start to see it and feel it" (Participant interview – DS59; Focus group – DS58).

In relation to suicide there are a lot of people across the whole community who attempt suicide and self-harm by cutting themselves. Self-harm occurs among primary and secondary school aged children across both sexes but more prevalent in girls. Self-harm results out of fighting, jealousy, break-ups, stress and attention seeking. When young men get together to support each other they describe it as "it's not about sitting around, and you just don't sit there and say G'day what's going on, tell me your problem 'çause you know they're not going to talk. When you sit there it eventually comes out but not before you sit and talk shit to them for a while that they're going to let it out. If you keep bugging them and harping on about what it is they will get wilder and wilder and won't say anything and jam up" (Focus group – DS58).

Invisibility is a key issue for young people. There are few young role models in employment, succeeding in education. There is a definite lack in recognizing young Aboriginal peoples' capabilities. Each compounding to make young people feel undervalued and unworthy. In their spaces drugs are much more readily available and in the absence of a role in the community and direction from respected community adults, young people are open to drug experimentation.

10.6 Subtheme - Relationships

Relationships are built upon trust, good support networks and communication within communities and between individuals like friends, family or a support network that enables people to talk to each other without bottling things up inside. Support people are regarded as someone close that you can trust and vent in a safe environment whilst providing people with some relief. Relationship as a sub-theme in this research has been identified and relates to families as a whole and in particular the relationship between parents, guardians (families) and young people within communities. Relationships relate to other sub-themes of underlying issues and conflict resolution and are interrelated in many aspects. Within communities, participants indicate that problems exist within families due to the dysfunctional state of these families which automatically impacts young people generating a malicious cycle of disengagement and disempowerment. The breakdown within families is evident by the degree of violence, domestic violence and the effect of drugs and alcohol while carrying out these acts. The families that exist within communities are large single parent families who manage everyday situations including their children with very little support from fathers who may not be present. Parental responsibility – adult responsibility and negative behaviour impacts upon youth. Family breakdown is about trouble at home between individuals and family members. Relationships from the past and present are challenging as participants state that

“everybody knows everybody, they know your family, your history in the community and based on this information people won’t give you a chance if you’re looking for” (Participant interview – DS60) opportunities in work, study or anything to keep you busy. In “Aboriginal communities, everyone’s related to everyone so it’s harder for you to separate yourself from these” (Participant interview – DS60).

In community’s fathers appear to be missing from communities and is noted by participants in their reflections that “there’s no fathers for the children, they never take part in trying to raise their children, I suppose the fathers are there, but you don’t see them actively involved in their children’s life, they appear to come and go freely. Fathers that exist, they go to work however responsibility is entirely facilitated by the mothers” (Participant interview – DS49). “There have always been single mothers left behind to look after the children in communities. People just keep to themselves, they just don’t want to get involved with anybody else or any other families, they don’t talk about their own sickness or illness and they bottle it all up” (Participant interview – DS49). One participant stated that we “need to be more loving, caring and show them (young people) and let them know they are really wanted, don’t turn your back on ‘em because if you do they sort of wonder why, thinking no-one cares about them and that’s why they go on the wrong track” (Participant interview – DS49).

Conflict resolution is an aspect of relationships that was evident across all of the community conversations and relevant to this research. For instance, participants point out, that people, do not understand each other (by) not giving each other the ability or the time and consideration to sit down and talk about their problems instead of knuckling up (fighting). There is an underlying issue of conflict resolution among Aboriginal people in having the capacity to deal with difficult situations and relationships within families and communities where people reside. According to participants there is a lack of awareness

of self and others, insight into other people's situations as highlighted earlier as well as lack of respect, accountability for own actions and understanding the consequences of those.

Within communities there's a lack of understanding in that people don't know what they're going through, where to seek help and therefore indicating that there is no help, whereas some young people are aware and know how to access help when needed as indicated by their intention of going back to school and the importance of obtaining an education for future work opportunities and/or further study. These participants indicate that there should be an element of giving and taking both from Government and the community, there needs to be "real commitment from local and regional agencies like local government, Education Queensland, police and the wider community to break down barriers that exist" (Participant interview – DS59).

It appears that barriers are generational, meaning that some families have experienced similar barriers over time. Within communities there's a lot of blaming of others, fighting, arguing particularly bullying on social media (Facebook) which the majority of Aboriginal people in rural and remote communities are associated with, however, often messages are misconstrued resulting in further repercussions among individuals and families within communities.

10.7 Subtheme - Help-seeking

In relation to help-seeking there is limited knowledge, understanding and trust for young people to access culturally appropriate, prompt and effective services within their respective communities which provide effective responses and adequate follow- up care. Help-seeking is another sub-theme that specifically relates to young people and is evident across the four communities. Help-seeking is about being knowledgeable of what is available in the way of services, resources and programs in respective communities

as well as young people having the capacity to initiate and seek help when in crisis. Participants believe mental health issues, such as depression and anxiety exist in these communities .however, help-seeking is viewed differently “the community as a whole don’t recognize mental health problems, signs and symptoms, how to help people and where to go” (Participant interview – DS55). There is the perception of some community people that “if your depressed that your supposed to go on depression drugs that make you feel like a zombie……and we just live with it until it’s too late……for someone has suicided or withdraw within themselves thinking about their problem” (Participant interview – DS55).

This participant further stipulates that because there’s “not enough awareness, that’s why people don’t talk about it (suicide, mental health), then there’s some people who don’t want to talk about it, but they just want to feel better. Some young people have the ability to reach out, problem solve and deal with difficult situations and know where to go if they need help however there are some that don’t understand what they’re going through…. there’s no help for them” (Participant interview – DS55). The challenge here for young people is to sort through problems and identify coping strategies that work for that person. “Young people will reach out to their peers, friends – someone their own age but what skills has that young person got to help their friend in need in being able to recognize the signs and symptoms clearly, identify how urgent help is required and where to go immediately” (Participant interview – DS51).

On the other hand, an older participant believes that “people don’t look for help; it’s a one-off thing because their drunk and they don’t think they want help. If a person needed their help (from someone) they would start by talking to them, finding out what’s going on, they might listen to you. If someone wants your help they’ll accept but if they don’t

you can't do anything about it but to report it to the police or the hospital" (Participant interview – DS49).

Many Aboriginal and Torres Strait Islander people believe they do not receive adequate services from mainstream mental health service providers and there are limited services that provide social, emotional and mental health support (Dudgeon, Gee and Glaskin, 2009). According to one participant (in a neighbouring community) "there's no service that identifies people at risk who have been self-harming, or who have attempted suicide to try to intervene in some way. Young people will go to mental health at community health, but they will very rarely go on their own accord unless there under a court order….and it's not culturally appropriate either. They (non-Aboriginal workers) don't get our boys, they don't understand them, and they don't speak the same language" (Participant interview – DS59).

Mainstream mental health professionals are limited in their understanding and awareness of Aboriginal and Torres Strait Islander history, culture and societies when diagnosing and applying culturally appropriate treatment (Dudgeon, Gee & Glaskin, 2009). "Aboriginal people are different to non-Aboriginal people because we're Murri's, we are different to white fellows, we're more in touch with our spirit, we act differently, and we see things differently. Some people have grasped our spirituality, but they don't understand it or how it applies to our way of life. Aboriginal people we're not just physical, spiritual, emotional we're all of those together as one. We're more in touch with our spirituality and guided by our inner most being….it defines who we are…it's our identity" (Participant interview – DS51). Young people "rarely access mental health services off their own accord, they'll do it under a court order. Young people once there at a service there not really listening, they get bored, and both the language and services are not practical or culturally inappropriate". The health professionals "don't get our boys, they

don’t understand them, they’re not black and they don’t speak the same language” (Participant interview – DS59).

10.8 Theme 4 - Mental health

‘Mental health’ is the second last theme recognized for the purpose of this research. Mental health incorporates a number of domains (physical, social, spiritual, psychological and cultural) evident from within participant communities that potentially affect and/or impact on Aboriginal people overall health and wellbeing. Mental health from an Aboriginal perspective is not seen in isolation but holistically with all of the aspects interconnecting. For the purpose of this research mental health collectively encompasses service provision, knowledge and self-awareness. Within this theme there are two (2) sub-themes applicable: services and awareness, these will be outlined and described in detail in additional sections of this chapter. Mental health is not just about being unwell and experiencing a mental health crisis it’s also about awareness, education, treatment, diagnosis, service provision, training and health promotion, early intervention specific to workforce – health professionals as well as communities and the people (and carers) who are affected by mental health. Mental health across many health sectors within communities and the broader health care system are key to service delivery. From a community perspective mental health is “about yourself and the person wanting to take their own life because they’re at the end of their tether” (Participant interview – DS49).

One participant says she is “concerned about the level of support being provided to people for many health problems”. Building rapport and relationships with people based on trust is challenging but this must be achieved in order to help people acknowledge they have a problem and may need to see someone, “you have to walk a fine line because as soon as you say you’ve got mental health problems people say are you telling me I’m mad” (Participant interview – DS60).

10.9 Subtheme - Services

The sub-theme ‘services’ within mental health is about a number of aspects, such as mental health service provision, awareness and acknowledgement of mental health, recognizing signs and symptoms within themselves or a friend, being knowledgeable about what’s available in respective communities and how to reach out for these services in a crisis. Across the participant communities there were several barriers identified in relation to mental health services: access, availability, facilities, crisis intervention, young people’s mental health, no life skills or experience present which impacts on people’s capacity to seek help. People residing in rural and remote communities are less likely to seek help, receive treatment or support due to a lack of information to access available quality services (Queensland Mental Health Commission, 2015; peersupport.edu.au?). Across communities there is also high turnover of General Practitioners or doctors impacting on continuity of care. There appears to be a lack of awareness and education provided to community people with the aim of enhancing the capacity of communities to recognize mental health issues. As a result, involvement from local Aboriginal people and their communities in designing and evaluating services and programs is imperative otherwise participation is not likely to occur and nor will health outcomes (Ward & Gorman, 2010; Swan & Raphael, 1995).

There is the perception from participants “that people (professionals) who can fix the problem don’t want to fix the problem” (Focus group – DS52). In relation to mental health services visiting communities, for instance “you know mental health (services) come here….I know they come here because I see them in the community and what do they do?.....they come down here for a couple of hours….what can you achieve in a couple of hours” (Focus group – DS52). Dudgeon, Gee and Glaskin (2009) found little understanding on behalf of mental health professionals of the history, culture and society

of Aboriginal and Torres Strait Islander people when diagnosing and applying culturally appropriate treatment (Ward & Gorman, 2010), resulting in a lack of social, emotional and mental health support provided to Aboriginal and Torres Strait Islander people. It is evident that many Aboriginal and Torres Strait Islander people believe they do not receive adequate services from mainstream mental health service providers. In dialogue with participants one participant describes mental health from her perspective as “long way thinking, long way action, not having the capacity or ability to sort their own stuff, they need help – ability to act on those thoughts” (Participant interview – DS51). Some people have the ability to talk to individuals and families about tough issues affecting them but generally “Aboriginal people don’t tend to put it out there in the general community as in nobody knows what we’re going through – it’s our business” (Participant interview – DS59).

Historically Aboriginal people tend to keep things to themselves, there has been no encouragement for you to keep it to yourself - individualizing problems and so on……it’s like a protective barrier for us, shielding us from mainstream. “We tend to bottle things up even while self-harm is obvious to other people. I have family members who are taking drugs and alcohol and I am aware of others in the community whose family or close friend go home each night and threaten to hang stab or cut their throat, some people believe it is ok to keep this information to yourself and the family should not tell anyone else but enough is enough. I share my personal tragedies to others who listen or don’t listen, when there are problems, “when you need help, you’ve got to put it out there, and so you can get help” (Participant interview – DS59). There is a lack of support for people in crisis and they don’t know where to go and “it all gets repressed and doesn’t get dealt with and starts creating further problems” (Participant interview – DS59). This is where “organizations employ people who are not qualified for the job therefore they cannot deal

with people in crisis or know how to support an individual whole heartedly. “I don’t think that organizations do that enough where they employ a qualified person and support them whole heartedly” (Participant interview – DS59).

Historically Aboriginal community services enabled people to raise and address particular issues, but they didn’t address the underlying issues. It is necessary for more cross collaboration between services (Government) and the wider community (Mayers, 2002) to better support individuals who experience a number of risk factors based on the social determinants framework. I don’t believe that organizations provide and support individuals enough in meeting all their needs – from a social and emotional wellbeing perspective they are consumed in addressing the physical presenting problem in the first instance and based on consult times and requirements around these everything is so busy. Individual services need to be resourceful in their own capacity to be able to provide further support by referring people to other services beyond what people already know from their connections or networks. “Tapping into different people, accessing different service providers will provide people with the education, skills or tools to make themselves self-sufficient and so they can take control of their own lives” (Participant interview – DS59). To be able to reach total satisfaction on mental health and wellbeing people must recognize their capabilities in being able to identify and establish goals and aspirations for future prospects while adapting to changing environments (CCRMHQ, 2013, p. 6).

Getting people to identify what their needs or issues may be and how services can assist them or what help do they need to address their concerns is important. Unequal power relationships between Governments and Aboriginal Community Controlled Health sectors relate to a lack of understanding and respect for Aboriginal people, their history, culture, society, intelligence, human rights and sovereignty. This further diminishes,

devalues, and contradicts the expertise of Aboriginal people – these are inherently embedded since colonial oppression (Mayers, 2002).

10.10 Subtheme - Awareness

'Awareness' as a sub-theme within mental health relates to the individual, community, health professionals, service provisions, how to access services, signs and symptoms. Awareness is also about enhancing the knowledge and understanding of mental health in the form of health education, promotion, intervention and prevention. Participants believe that "there is not enough information being shared about whose doing what program or service…there's not enough to build awareness" (Participant interview – DS59). One participant in a neighbouring community describes "Young people close to her son, including her son as all having depression" (Participant interview – DS59). This group of young people (males) have all attempted suicide, the "Usual pathway is to be admitted into hospital provide Valium, assessed by mental health team there discharged in few days with no support or follow-up" (Participant interview – DS59). Across all four of the communities "young people are over-represented in court every week in these communities due to legal issues not being dealt with locally (due to systems and processes), there's no support like there was in the past" (Participant interview – DS59; Participant interview – DS53), and before they removed Aboriginal legal aid from these smaller communities "Aboriginal people had good legal representation" (Participant interview – DS59) and instantaneous. Whereas "nowadays representation and legal aid officers are non-Aboriginal workers who don't come from the communities, who don't know Aboriginal way of life or the people they are representing" (Participant interview – DS59).

Legal and mental health issues are multifaceted and coincide with each other which in turn cause further destruction of lives in particular for young people. Young people are

vulnerable between fifteen to twenty years of age and in these communities more so are susceptible to issues around mental health, legal, education, employment and health due to no opportunity, no support and inequality. There is interconnectedness in young people's lives with the discussion in all of the factors discussed so far. This results in young people being at a loss to know how to resolve issues within their lives, thus marking their vulnerabilities as being hyper-sensitive. Answers are not easily found within their families, community, and their own peer groups.

Relationship break-ups among teenagers are common and young people go through this as a part of their rites of passage through adolescence into young adult life). People who don't have the skills or knowledge are more inclined to be judgmental if someone presents with mental health problems; issues need more awareness of mental health specific to communities plus incorporating more learning beliefs of different culture. One participants experience with mental health crisis (attempted suicide) follows a "young man had voiced his thoughts about committing suicide to his parents when they called the police to assist they responded with taking him into custody initially to the hospital for assessment to which they couldn't hold him due to not having the correct facilities or resources thereby holding him in a cell or the watch house of the police station was the only option" (Participant interview - DS51) available at the time.

10.11 Theme 5 - Culture

'Culture' as another theme relating back to the overall theme of 'Suicide' and in the context of this broader study for instance, culture from a community's perspective is about being Aboriginal - people's identity, what group (mob) there from, history of their ancestors - traditional teachings, rituals, stories (passing down of stories, culture, knowledge), learning, beliefs, values and customs shared from one generation to another. In contemporary times culture emanates from a different perspective in that

some of the young people don't identify or know anything of the above which has created turmoil among the youth with a loss of connection, belonging and identity crises associated with culture and tradition. Culturally parents and guardians have failed to provide their children, dependents - younger generations with the history about their culture through passing down knowledge which has resulted in a lack of respect for culture and people. What's also evident is the effect of intergenerational trauma impacting on younger generations in their capacity to seek help and/or recognize and develop coping strategies in crises. The sub-theme of culture is: cultural perspectives - intergenerational trauma and historical and contemporary cultural perspectives.

10.12 Subtheme - Cultural perspectives

Cultural perspectives are views and opinions that participants have in relation to culture broadly, their own culture, knowledge, beliefs, values, traditions and practices. There is the belief that "if stories are not being told or knowledge isn't being passed down from one generation to another the story and knowledge ends with that person" (Participant interview – DS52) and is lost forever. Therefore, in order of "keeping our culture alive we must continue to tell our stories" (Participant interview – DS52).

Intergenerational trauma from the perspective of participants is something that people have inherited from their families, similarly problems, behaviors, attitudes towards life and this impacts upon individuals and families to the point where people become very bitter and don't want to change or address their issues. For instance, the health and mental health problems seem to be carried over from generation to generation that have not been dealt with because there's a cycle of ongoing sick, death, dying and not enough time to grieve and talk openly about how people cope. What is evident across these communities is the mixed reaction around the topic of suicide coupled with attitudes,

perceptions and pre-conceived ideas about those who attempted suicide and those who completed suicides.

In relation to the name ‘suicide’ “in the past participants believe that they did hear of suicides but it meant something different back then….for instance one participant reflects by saying that the old people would say they (who suicided) were silly and weak minded for what they had done and they took the easy way out” (Participant interview – DS52). “Some people were told not to talk to people like that” (who had mental health) (Participant interview – DS52). On the other hand, another participant says differently that “we sort of never knew anything about suicide or mental health in the past” (Participant interview – DS52). This participant and the previous participant are of different ages and different eras, regardless, there appears to be limited understanding of the type of mental health services being offered and available within one community and whether this relates to age and era. “Don’t talk to him, he’s mad”, because he had a mental problem. Personally (participant) my opinion is that I don’t agree that because someone has suicided that we should not talk about them and forget them because they are dead otherwise you are losing favourite and fond memories of them. Once you have started to openly talk about the person you will be surprised just how many other people have experienced the same thing but have not been game enough to do this or say it. Culturally, there is the belief that the person who passed away should not be mentioned or talked about (by their first name) out of a sign for respect. “The loss of respect often results in a loss of culture” (Participant interview – DS52).

For instance, one participant explains that “because we were not explained anything about our culture we weren’t knowledgeable enough to know who and who we could not speak with……as a direct result our culture has been lost…..therefore mental health

problems started to occur" (Participant interview – DS59). This is yet another cause and effect from colonization.

10.13 Subtheme - Social and Lifestyle

From a social perspective residing in these communities is challenging for Aboriginal people because of the location (approximately 9 hours one way from Toowoomba) distance, and lifestyle (very expensive to purchase fresh fruit and vegetables, fuel, electricity, mortgage, car loan) in these small rural and remote communities in particular (as well as urban communities). In these communities it appears that people feel they are caught in a cycle of disempowerment, disengagement and poverty where children are the forgotten ones through parental neglect which only adds to further social problem and concerns.

Social issues as a sub-theme is also evident across the identified communities in relation to individuals (youth) and families as well as the lifestyle people embrace. The distance, location and associated costs (fuel) for identified communities are dynamic forces that inherently go hand in hand with rural and remote communities which largely impacts on the lifestyle of people. Additionally, cycles of disempowerment, poverty and disengagement are too obvious among individuals and families within these communities. The lifestyle choices (drugs, alcohol, gambling) being made by parents clearly impacts on dependents (children, youth, and siblings) to the point where children are going without, young people are caught within the cycles of disempowerment, poverty and being disengaged from families, services and potentially communities. Socially, problems that exist in these communities will "lead into larger problems in the near future. Parents currently can't see that their kids need them, so they grow up believing that no-one cares about them so they think what the hell I will waste it away….life on drugs, alcohol….suicide. Affordability of living in these communities is also a contributing factor

to people's lifestyle choices, for instance access to fresh fruit and vegetables, meat and so on is challenging because of the dynamic forces above. Food generally is expensive and does not last long; the costs of living are also very high" (Participant interview – DS52) considering the number of large families and the socioeconomic status of Aboriginal people who are situated at the lower end and are the most disadvantaged in these communities.

10.14 Subtheme - Leadership

Historically opportunities were available to local people because there were Aboriginal people in positions of influence and who used to work with the 'grass roots people' whereas these days' opportunities are provided more to white people in local communities. These don't exist due to the closing down or removal or funding to major Aboriginal organizations. "Aboriginal organizations today don't do enough for the community like they did in the past; there is plenty of opportunity to employ young Aboriginal people yet white people are preferred" (Participant interview – DS59).

Communities' sense of power, ownership or control has been removed since devolution of key organizations in the past leaving communities without the capacity to deal with their own issues locally in relation to legal, health, education and employment. For instance, legal issues historically were fully operational by Aboriginal people and issues were dealt with by Aboriginal people whereas nowadays this has been replaced with non-Indigenous people "it's still blackfella legal but it's not like that….it's not like our legal service anymore" (Participant interview – DS59).

Legal issues today are compounding other issues and causing further destruction in the form of crime. In relation to education some Aboriginal youth particularly the boys were identified as being too violent, aggressive and getting into trouble and were suspended from school or kicked out, there was no room for flexibility in helping these young men to

conform outside of their normal learning environments with offering school-based traineeships.

Leadership was explored across the communities with a participant saying, “I don’t think we have strong leaders anymore, they get a lot of support, they’re pampered more than in the past, they could have more input into the community by giving the young people more support” (Participant interview – DS60). Elders who we identify as leaders in communities “could support young people going to court, chastising them and getting involved in their lives” (Participant interview – DS59). The living arrangements of Aboriginal people and most families with “young people don’t get disciplined in any way….the children stand over and run their lives and either end up in juvenile detention or walking the streets, smoking drugs or drinking alcohol and that’s a big thing which leads to suicide” (Participant interview – DS52).

CHAPTER 11 – DISCUSSION OF SUICIDE IN ABORIGINAL COMMUNITIES

Introduction

'Discussion of Suicide in Aboriginal communities' this chapter provides the reader with contextual information pertaining to rural, remote communities including semi- urban and urban communities relevant to this research. As well the researcher has captured from the findings and understandings of Aboriginal participants an overview of Aboriginal suicides from a social and emotional wellbeing framework, for instance each element of the framework was aligned to what communities said about suicides in their region. Towards the end of this chapter a historical review of the literature on suicide from as far back as possible - the 18th Century highlights a number of theorists from this period. A historical review of suicide literature was performed to identify the very beginning of research conducted in this area. It is important to achieve an understanding of historical developments to establish a breadth of knowledge but to also appreciate the past because without our past we have no future. One of the objectives for this study was to scope the literature both historical and contemporary and analyses over time what was important, identify where the gaps were and deficits in knowledge and understanding of suicides.

11.1 Rural, Remote Communities

The purpose of this section is to provide an overview and explanation for the interpretation of the results from the analysis in the previous chapter in which a number of themes and sub-themes were identified. Additionally, a comparative overview for each of the communities will be provided as part of this discussion, as well the researcher will aim to tell or paint a story from what the data is saying in relation to the research. For this section an overview of each of the communities in context to Aboriginal population data, accessibility of communities and service provision including an overall discussion of the

results data obtained from the previous chapter will be provided – 'telling the story of the data from the people'. This study was conducted in four Aboriginal communities two of these are situated in South West Queensland classified as rural and remote and the other two are situated on the Darling Downs, one classified as semi-urban and the other urban. Each of the communities is dynamically different in their historical and contemporary establishment of today as liveable communities. The two rural and remote communities will be described firstly, these communities are very similar yet have differences; there was a noticeable difference in the population sizes for instance for the community of Cunnamulla – Paroo Shire the total population size was 1857 with 571 (30.7%) people identifying as Aboriginal and Torres Strait Islander, though 87 did not identify at all. As for the community of Charleville - Murweh Shire the total population size was 4618 with 530 (11.5%) people identifying as Aboriginal and Torres Strait Islander, though 318 did not identify at all. In relation to the population size and structure for both of these communities Aboriginal and Torres Strait Islanders for the Paroo Shire had slightly more children and young people aged 0 – 14 years representing 40.3 percent; they had slightly less elders – older people present in the community at 4.0 percent; and also had less unemployed people for the age group 15 – 64 years at 16.3 percent. As for the Murweh Shire for the age group 0 – 14 years 39.6 percent of Aboriginal and Torres Strait Islanders were represented. The Murweh Shire had slightly more elders – older people in the community represented as 5.1 percent. The number of Aboriginal and Torres Strait Islander one parent families was evident in each of these communities and were very similar to each other – approximately 24.3 percent. When accessing both of these rural and remote communities they can be accessed via road (car, bus), rail and air and are located within similar distances, for instance travelling to Cunnamulla via road from Toowoomba will take anywhere from 7 – 8 hours approximately 680 kilometers one way. As for Charleville travelling via road (car, bus) from Toowoomba will take anywhere from

6 – 7 hours approximately 620 kilometers one way. Each of these communities has a hospital, police station (conduct their own court proceedings), Aboriginal Medical Service, Legal aid, Community Development Employment Program (CDEP), Fly – in Fly – out services and medical specialists (heart, diabetes, kidney, renal, nutritionist, mental health) conducting frequent visits within and across these communities. For the purpose of this research mental health services can be accessed in a number of ways via the Toowoomba Hospital and Health Service, as well as a number of other schemes – psychologists, etcetera and mental health services are dispatched through larger neighbouring communities such as Charleville and Roma to Cunnamulla. Consequently, there are obvious differences in population size and the make-up of these communities in which there are many advantages and disadvantages in particular access and availability of specialist health and mental health services (Simpson et al., 2009; Queensland government, 2014).

Some of the underlying issues prevalent in these communities are suicide, mental health, violence and drugs and alcohol resulting from a number of social issues such as unemployment, lack of discipline, crime, limited education, limited finances, racism, discrimination, poverty and poor health. There appears to be a sense of normality occurring in communities in relation to the act of suicide (Participant interview – DS55). Perceptions within communities about those who suicide or attempt “they were not in the right frame of mind at the time and/or have gone too far and or couldn’t stop before it was too late” (Participant interview – DS55). They lack the ability to manage and cope in their situation and their actions are seen as desperate measures in times of crisis (Focus group – DS51). Historically suicides were never heard of in the Aboriginal community, they were only heard of being present in the white community. However, in today’s communities there appears to be a high incidence of self-harming and attempted suicides

and suicides occurring among the youth with them believing there is nothing in their communities for them and that there is a lack of support, that no-one cares, they feel worthless, depressed and turn to drugs and alcohol or attempt suicide and self-harm. Communities have changed over time and they don't appear to be like they were in the past (Participant interview – DS59; Participant interview – DS53). For example, all of the participant communities historically were independent advocates and actively participated and facilitated a number of community activities and controlled a number of key Aboriginal services which no longer exist. Nowadays the communities don't appear to be close-knit, supportive or encouraging of all community members; there is division occurring within the communities as well as within individuals and families. People don't feel that their voices are being heard regarding issues within their communities. Communities express their lack of support and safety in being able to voice their opinions and feelings about particular local and regional community, health and wellbeing issues pertinent to their community (Participant interview – DS59). What is different now is if in the past there was a personal tragedy for a particular family, the community at large would pull together to try and support the family and work collectively, this appears to be absent nowadays. There is a general apathy in the community letting other people make decisions on behalf of the wider community. This reaction isn't evident for all Aboriginal people in their respective communities however unless it involves people personally then people will not get involved or become vocal nor become united. In this community there are only a couple of Aboriginal organizations with whom the community have access and the people who work at these organizations have little to no experience of being in trouble with the law and so the ability of these staff to understand and support local people from various backgrounds is still a challenge. Both of these organizations provide and cater for different population groups within the community, who have different needs or wants, and this isn't being replicated across each of the services; they are working in isolation

not in collaboration. This results in people feeling they're not getting equal treatment or being involved in decision-making processes locally or regionally. Aboriginal people lack the knowledge and understanding of situations of others around them or in the same community, it seems they have limited education in recognizing signs and symptoms of crisis when someone is stressed, difficult situations, mental health, violence, self-harm, suicide, depressed, anxious, understanding relationships and so on to help others. They lack the ability to problem-solve and to work things out without resorting to violence, drugs or alcohol and even contemplating suicide. Participants report violence is a common way of dealing with conflict and commonly occurs in communities often erupting into volatile outbursts (Focus group – DS51) in combination with drugs and alcohol resulting in further harm precipitated either into self-harm or potentially suicide. There is a high prevalence of extreme drinking of alcohol and illicit drug use in these communities. People are using drugs and alcohol to mask their problems; and as a result, people don't recognize or want to recognize they have a problem at all that requires intervention of some form. Some people do not recognize they need to seek help (Focus group – DS51). There is a lack of respect towards each other and being accountable for individual actions and reactions. People don't feel safe in helping others due to a backlash, retaliation and repercussion from being involved. Therefore, if people feel like this in response to helping someone how does someone recognize or support others around them who are in crisis or need help of some form if they don't feel safe in providing assistance (Focus group – DS51). This community is perceived as very weak; women are perceived to be the stronger ones than the men and people working in mainstream organizations are seen to be working from a white man's approach – they think like white people. Racism is prevalent, alive and well across all of the communities. Many Aboriginal people feel they are competing against white people in the communities for jobs as well as against their own people. Some people in the community from various professional backgrounds tend to judge and

place blame onto others for some of the issues for young people for example, “Well they’re young men now, they need to stand up and only they can make the change, but it’s more than just saying that and leaving them with that, it’s about looking at what’s really going on for that person or group, looking at the underlying issues and asking questions, why aren’t they doing this or doing that. What chances have young people got when their faced with comments like this from people who are meant to be there to help them. Well if only it was that easy to stand up” (Participant interview – DS59). Attitudes within community are obvious “if you can go and get drunk and have sexual relations, they don’t need their mother but when they come into a service they present with their mother” (Participant interview – DS59). The legal and mental health issues are multifaceted and coincide with each other which in turn causes further destruction of lives in particular for young people. Young people are vulnerable within these communities and are more susceptible to issues around mental health, legal, education, employment and health due to no opportunity, lack of support and overall inequality. Some programs and interventions have been imposed onto people irrespective of their need or requirement (Participant interview – DS59), rather than implementing appropriate services, - programs and education to prevent further incidences – otherwise setting them up to fail. It’s that crab syndrome (where a group of crabs in a bucket will pull back any crab that tries to climb out); they (other Aboriginal people) don’t want people to succeed. This can be seen in the lateral violence that occurs within Aboriginal communities to the point where they don’t want people to succeed or become better than anyone else – they don’t like to see success in any form.

Suicides continue to affect these communities and it was identified by all of the participants in this research, that when suicides occur they had an immediate impact on individuals, families and the wider community and even more widespread across to other

regions. Some participants believe that it is difficult to get out of situations as they appear to revert back to their old ways and can't see any way out, a sense of familiarity in some communities regarding suicides. Sometimes suicides are not viewed as serious and that they occur because people have gone too far or that it's too late to stop or that people can't cope with their situation or crisis effectively and appropriately (Participant interview – DS55). In the past suicides were heard of in the community but were always carried out by non-Aboriginal people; as for the Aboriginal community they didn't hear of suicides being carried out by their own people until early 2000 in one community hence they have become more noticeable. Attempts occur in communities because there is little or nothing to keep people engaged; there is a lack of support and concern that people don't care or about how people are feeling and often people feel worthless, depressed and eventually turn to drugs and alcohol to either cope or block out their feelings of distress " (Participant interview – DS59).. As a result, people then attempt to harm themselves by hanging, cutting or even burning with cigarettes (Participant interview – DS59).. Some of the underlying issues in these communities have been recognized by Aboriginal participants and are inherent as either problems, concerns or disputes that exist between individuals, families and communities and can often be described as intergenerational. There are underlying issues around conflict; a lack of conflict resolution is evident among Aboriginal people in having the capacity to deal with difficult situations, relationships within families and communities where people reside. What makes this worse for Aboriginal people and their communities is what results from not being able to address or deal with the conflict. It appears that for these communities there is an inability to understand or solve problems without making use of violence, which is exacerbated by the influence of alcohol and drugs. This type of violent behaviour is ever present in communities associated with extreme levels of drinking as a way of masking problems or as a coping mechanism. The inability to problem solve is compounded by the lack of accountability by Aboriginal

people in not being willing to admit they may have issues or to know where they have gone wrong or to even recognize they have made a mistake. Violence appears to be used as a means to an end; it's the easiest option or easy way out for people. Regardless issues continue to exist in these communities.

In some instances, however, when this offer of support is provided it has resulted in negative consequences for those involved so people are hesitant to offer assistance. Substance misuse, the combination of drugs and alcohol is viewed in communities as habitual, increasing and getting worse. Historically alcohol consumption was prevalent in Aboriginal communities particularly among adults but over time the combination of drugs – illicit drugs and alcohol are used more frequently in more recent times. Alcohol in communities is readily available and while the distribution of drugs is illegal they are also readily available and is a source of income for many people living in rural and remote communities where employment opportunities are scarce. With an increase in substance misuse, an increase in mental health problems will in turn evolve affecting more individuals, families and communities. There will be an increased need for mental health services in the near future given that the current position of mental health service provision is limited. A wide range of issues continue to exist in communities for young people and were identified as either problems or concerns that affected them. According to participants these are recognized as the most significant (drugs, alcohol, violence, crime, relationships - lack of family stability and cohesion, lack of responsibility and participating in further risky behaviour), affecting and impacting on young people's lives across and within these communities currently. What is evident in one of the communities is a lack of appreciation of young people for whom they are as young people, rather than for their sporting ability. Across all four of the communities "young people are over-represented in court every week due to legal issues not being dealt with locally (due to

systems and processes), there's no support like there was in the past (Participant interview – DS59; Participant interview – DS53). Legal and mental health issues are multifaceted and coincide with each other which in turn causes further destruction of lives, in particular for young people. Young people are depressed because there are no work opportunities, similar to white people they are not given a fair go in their community, no-body wants to give them a go, they hang around other young people who share the same journey - they're frustrated, they've attempted suicide there's no help so there put into hospital medicated then sent home with no support or follow-up. There is the perception that if you attempt suicide in work hours you're more likely to get support. They feel like their worthless – for instance when training for their sport their abilities shine through over white players, yet they can't get a proper run in game times or even to acknowledge them outside of their sport in the community. Within community's participants specify that problems exist within families due to the dysfunctional state of such families which repeatedly impacts on young people therefore, creating a malicious sequence of disengagement and disempowerment. The breakdown within families is evident by the degree of violence, and the effects of drug and alcohol while carrying out these acts. The families that exist within communities are large single parent families who manage everyday situations including their children with very little support from fathers who may not be present. Parental responsibility – adult responsibility and negative behaviour impacts upon youth. Lateral violence within Aboriginal communities exists. Due to the intricate kinship system of Aboriginal people and extension of extended family member's grief and loss are transferred rapidly across to many communities and people. Indigenous families and communities commonly experience three or more deaths over a short period of time, many of those are from suicides. There is little to no time between deaths and funerals and so the grieving process neither starts or ends, families and communities are crippled with a constant state of mourning, grief and bereavement (Ugle,

Glaskin, Dudgeon & Hillman, 2009). Where communities are highly connected or close-knit, grieving those who suicide has wide-spread effects extending beyond the original community, either resulting in increased risk for those most vulnerable and/or clusters of suicide (AIPA, 2009).

Participants describe social and emotional wellbeing as “emotionally if you’re not stable, socially if you don’t have a home and are sleeping on peoples’ floors, physically if you don’t earn a decent wage, mentally if you’re not aware of where to go for help or how to address your own issues; these things bottle up and allow you to become depressed, even suicidal” (Participant focus group DS60). These factors cannot be separated or dealt with in isolation without stability or emotional, social stability and addressing these issues you’re going to have these problems that create further problems for social and emotional wellbeing (mental health). There is a lack of available, accessible and affordable housing across these communities. The introduction of new industries moving into the region will create further social impacts for Aboriginal people and their communities. Impacts will be evident in people moving away or overcrowding of 2-3 families living together in one house which in its self creates additional issues for health and wellbeing for Aboriginal people and their communities. There is a need for an Aboriginal hostel or safe haven for both women and men, and the emergency housing relief funds is only available if you indicate that you are suicidal. There was an Aboriginal hostel which has since closed down. There are some good things about living in rural and remote communities it’s quiet and peaceful, easy to get around and everybody knows everyone this can be a good or bad thing. Playing football is good but it brings with it some negative aspects in relation to travel for games; for instance, many Aboriginal youth don’t have the same opportunity as others to obtain a driver’s license coupled with not having their own car and have to rely on others, impacting on their level of independence.

Another negative aspect for this community is a neighbouring community coming into the town and performing break and enters and stealing which makes it look bad for the local Aboriginal people that live there. “Crime such as break and enters, and stealing is common but not by those who reside in the community but those associated with neighbouring communities” (Focus group – DS58). Young people believe a lot of white people in Aboriginal communities judge them before they see or get to know them for who they actually are, this is racism. “This community is racist, you don’t realize this until you get older, then you start to see it and feel it” (Participant interview – DS59; Focus group – DS58).

11.2 Semi-urban, Urban Communities

The community of Oakey, similar to other smaller communities around the Darling Downs, was amalgamated some time ago and now exists under the Toowoomba Regional Council as part of one large region. For both of these communities (Oakey & Toowoomba) a separate discussion initially will be provided as demonstrated for the rural and remote communities with a description of population, location, demographics, services and accessibility in relation to the previous chapter of analysis. The community of Oakey is located in South East Queensland, a small country town situated towards the middle of the Darling Downs, approximately 160 kilometres west of Brisbane and 30 kilometres west of Toowoomba. The town is surrounded by agricultural farms processing livestock and grain, two abattoirs, stockfeed manufacturers, transport businesses, an open cut coal mine at Acland and the Oakey Army Aviation Centre including a museum of Australian Army Flying memorabilia from World War 1 to present. The community is accessed via road and bus services connecting Brisbane, Toowoomba and South West Queensland. The township hosts a number of organizations, services and small business enterprises. Oakey has a local hospital providing emergency services, in-patient care as

well as co-located nursing home facility. There are only two General Practitioner services privately owned operating in the community alongside an Aboriginal Medical Service. Goondir Health Service provides holistic, primary health care including medical and specialists services first and foremost to Aboriginal and Torres Strait Islander people within their community of region. With this established Aboriginal Medical Services are in a prime position to improve the overall health status through the effective delivery of culturally appropriate health related services (Queensland Government, 2016). According to the Census data the population for Oakey District in 2011 was 1,786 with 94 people over the age of 85. The largest age group was 15 to 19-year olds. Oakey also had a higher proportion of people in the younger age groups under 15 years (22 percent) as well as a higher proportion of people in the older age groups 65 years (16.3 percent) an older (Refer to Appendix 2 figure 2.12). There was also a lower proportion of couple families with children as well as a higher proportion of one-parent families (Queensland Government, 2016). For the Toowoomba region 5,242 persons representing 3.5% identified as Aboriginal and Torres Strait Islander peoples. There were approximately 2513 Indigenous males with a higher proportion of Indigenous females 2729. For the age group 0 – 14 years 42.2% were Aboriginal and Torres Strait Islander peoples and 2.9% were aged 65 years and over. As for households 28.9% were occupied by Aboriginal and Torres Strait Islander peoples one parent families (Queensland Government, 2016). Toowoomba, Queensland a rural city known as the largest inland settlement located towards the western side of Brisbane on the Great Dividing Range. Toowoomba sits in the centre of the Darling Downs and hosts a modern city lifestyle with old style Victorian buildings that offers a relaxed country feel combined with easy access to Queensland's larger capital city Brisbane and the beaches on both the Northern and Southern coasts AIHW, 2013).

For the semi-urban and urban communities, it is acknowledged that these communities offer more in the way of activities to keep you busy, more opportunities and better environment than what you would see in rural communities that are disadvantaged. On the other hand, it was evident that the urban communities were not as close-knit as in some of the rural communities and lacked some of the essential requirements. For instance, in rural communities, people felt there was more time and effort put in by people who worked in being able to get out and about in communities. While time and effort were obvious in rural communities in establishing trust and rapport through enhancing relationships and being more involved in community activities and events, at the end of the day, it's about being able to engage with local people across the communities which are not so evident in some urban communities. Some of the main issues particularly for young people are drugs, alcohol and crime which appear to be high on the agenda of some organizations in developing and implementing specific services and programs across these communities (Queensland Government, 2016; AIHW, 2013).

These issues appear to be factors contributing and are due to a lack of leadership within the communities for instance, in comparison to the past there are a lack of role models that people in the communities look up to. Many of the local elders whom were leaders in the past did not exist are either deceased or do not have the ability anymore "I don't think we have strong leaders anymore, they get a lot of support, they're pampered more than in the past, they could have more input into the community by giving the young people more support" (Participant interview – DS60). It is recognized that many of the young people don't appear to be disciplined in any way, as children stand over their parents and tend to run their own lives, potentially they may end up in juvenile detention or just walking the streets smoking drugs, drinking alcohol contributing to further social and behavioural issues which then leads to suicide "young people don't get disciplined

in any way….the children stand over and run their lives and either end up in juvenile detention or walking the streets, smoking drugs or drinking alcohol and that's a big thing which leads to suicide" (Participant interview – DS52). This further "leads into larger problems in the near future. Parents currently can't see that their kids need them, so they grow up believing that no-one cares about them so they think what the hell I will waste it away….life on drugs, alcohol….suicide (Participant interview – DS52). The responsibility of leadership can be taken up by anyone in the community – young or old, as long as they have the right morals, values and goals to lead anyone or community in the right direction. It appears that many teenagers in the communities are doing drugs and the younger kids are hanging around them, because they're bored, and then they're doing drugs. Older siblings are influencing the younger ones who are following, some as young as seven years of age are sniffing glue, disengaged, taking drugs, drinking and are involved in crime "Teenagers are doing drugs…younger kids are coming and hanging around with them, then they're doing drugs….kids as young as seven are sniffing glue. Parents say they can't do anything about it….it comes back to a generational thing, it's like a chain reaction, it's up to the parents" (Participant interview – DS62). It appears that many children are starting to experiment at a younger age compared to the previous generation and that's frightening "starting to experiment at a younger age compared to what they did in the past" (Participant interview – DS62). Parents indicate they feel they cannot do anything about some of their situations. There is the belief that what's happening in these communities is a generation thing, it's like a chain effect nonetheless it is up to the parents, guardians to intervene and provide discipline of some form. The majority of the young are the ones that are typically drinking and doing drugs either because their parents are doing the same thing, or that some parents and young people don't appear to care too much about what they're doing and what effect this will have on them in the future. One participant states there "needs to be more loving, caring and

show them (young people) and let them know they are really wanted, don't turn your back on 'em because if you do they sort of wonder why, thinking no-one cares about them and that's why they go on the wrong track" (Participant interview – DS49).

The types of mental health issues we see in this community are drug-induced psychosis, schizophrenia, paranoia, depression, anxiety, and stress in not being able to cope with everyday life challenges "see drug induced psychosis; this is not evident among the young people" (Focus group – DS62). "Substance misuse (drugs and alcohol) affecting young people as young as fourteen years on speed, heroin, sniffing….a lot of the kids are being removed from families due to parents being drug addicts" (Participant interview - DS59). Some people felt confident in being able to provide support to another person in difficult times and refer them however there were also some who did not feel confident in providing support, knowing what was available and where to refer and how to recognize signs and symptoms of mental health or crisis. Most people were able to pick up on cues for instance when someone starts talking negatively or has negative attitude towards everyone, body language, how they present themselves, they may break down and cry for no reason because they have bottled things up inside for so long. Some people were knowledgeable but largely there appears to be a lack of understanding and awareness of what's available in communities and how to access appropriate services and programs.

Racism, prejudice and discrimination are present historically and contemporarily in these communities and continue to cause problems for many Aboriginal and Torres Strait Islander people. There is an element of control present in some communities by gatekeepers who are prominent families trying to control what happens in a community, they either support or don't support what's being proposed. Aboriginal politics is also referred to in reference to this kind of behaviour and if you are responsible for providing

a service you cannot avoid being involved in the local politics – so if you're not from the community it can be challenging. The community will judge you regardless, and if you don't appear to be socializing among the Aboriginal community you may be seen as a coconut (black on the outside, white on the inside). In relation to suicide and mental health more involvement from young people in decision making processes is required simply because they can relate and communicate by mentoring other young people through difficult times like adolescence, relationships, sexuality, drugs and alcohol, crime and so on. Aboriginal people must be supported while navigating the mental health systems within the current health system through education and awareness programs. Health and mental health systems also need to incorporate alternative and culturally appropriate counseling services. Aboriginal people don't feel comfortable talking with a non-Indigenous professional; they feel more comfortable talking to an Aboriginal person in their own home.

11.3 Aboriginal suicides and social and emotional wellbeing framework

Poverty is the largest hurdle in many Aboriginal communities and is the greatest threat to their current health. Therefore, it is equally just for all people across the globe to be able to live in peace, be educated, access and achieve financial stability, establish social connections, access fresh food and water, access and sustain resources efficiently and be empowered as an individual while maintaining fairness, respect and equity for all (Sheehan, Martin, Krysinska & Kilroy, 2009).

Traditionally in the physical sense Aboriginal people from a cultural perspective were faithfully and spiritually devoted and connected to earth – 'Mother' earth and the concept of nature surrounding Aboriginal people was seen as family, so there is an obvious deep connection to country and land where Aboriginal people originate from and this is seen as a source of renewal energy - being regenerated. Mother earth and nature provide

Aboriginal people with the medicine, diet and activity to be able to live a long life and traditionally be resourceful and healthy specimens. Historically genocide occurred in a physical way from the beginning of colonization in 1788. This form of genocide had a devastating impact on Aboriginal people being dispossessed, displaced, removed and uprooted from their country and land of significance. This caused rapid environmental change – degradation of environments which impacted on changes in diet, hunting and gathering of traditional food. Incarceration, institutionalization and forced labour resulting in ill-health and exposure to disease (Milroy, 2006).

For Aboriginal people underlying mental health issues do exist and are inherent in some families and communities - intergenerational. Psychological suffering and psychological pain is strongly linked to a higher suicide risk (Black Dog Institute, 2015). A wide range of issues exist in communities for young people and were identified as either problems or concerns that affected young people. According to participants these are recognized as the “most significant (drugs, alcohol, violence, crime, relationships - lack of family stability and cohesion, lack of responsibility and participating in further risky behaviour)”, (Participant interview – DS59) affecting and impacting on young people’s lives across and within these communities currently. Young people are depressed because there are no work opportunities similar to white people they are not given a fair go in their community, no-body wants to give them a go, they hang around other young people who share the same journey - they’re frustrated, they’ve attempted suicide there’s no help so their put into hospital and medicated then their sent home with no support or follow-up. There’s a lack of appreciation and acknowledgment for young people and their proper role in community and they are only recognized for their sporting abilities. There is the perception that if you attempt suicide in work hours you’re more likely to get support. They feel like they are worthless – for instance when training for their sport their abilities

shine through over white players, yet they can't get a proper run in game times or even to acknowledge them (young people) outside of their sport in the community. "Indigenous societies have undergone rapid social change and it should be no surprise that there have been changing patterns of mental health problems including mental health disorders" (Hunter, 2003, p.16).

Historically within traditional Aboriginal society good mental health was underpinned by many factors within culture however in order of sustaining good mental health people had a strong sense about themselves and their identity which extended to their connection of whole of life view, community, spirituality, culture and country (Parker, 2010b). Physically Aboriginal people and their communities continue to experience rapid changes since colonization which has resulted in the development of mental health issues and ever-increasing suicides. Physically suicides are evident and appear to be a normal occurrence in communities and they have an impact on those left behind and across the wider community. Suicides have debilitating effects on the person responsible whereby they are unable to stop or just can't cope anymore with life. For the person who is suicidal there appears to be no support, follow-up care or empathy from others and they feel hopeless, worthless and they chose to hang or self-harm by cutting or burning themselves. Some people feel they don't have the resilience, strength or ability to deal with their own problems. The Black Dog Institute describes hopelessness as a negative state of mind strongly associated with suicide ideation and behaviour for those most vulnerable (2015, p. 3).

Socially Aboriginal people and communities in the past were close-knit, supportive and were collective in voicing and addressing many of the issues affecting people and communities across the region. Aboriginal communities felt like they were being looked after, they felt united in their needs and a sense of pride, influence and empowerment

was being achieved by those in control and power at the time. Over time this has changed where socially communities now feel there is division, clash of cultural groups and lack of unity when advocating or lobbying for funding, services and programs. Socially Aboriginal people feel there is not much available in keeping people engaged and they feel a sense of boredom. A high consumption of alcohol and drug use appears to be socially accepted in communities nowadays. Access and availability of drugs and illicit drugs appears to also be socially accepted in some people and communities. The levels of crime carried out in communities maybe seen as socially customary for young people who are bored and under the influence of alcohol and drugs – rites of passage for some young people as they transition into young adulthood. For the social aspects surely family disruption, stolen generations, forms of structural violence such as racism, poverty and whiteness have ensured that social wellbeing can only be obtained by dealing with these structural issues as per Ottawa and Jakarta Declaration. All of the above are social symptoms of these major structural problems that become individualized and personalized rather than dealt with as coming from social structures as such.

Spiritually the concept of life-death-life for Aboriginal people is inherent in their culture and practices historically and contemporarily. Spiritually Aboriginal people have survived and have overcome incalculable adversities since colonization through the implementation of derogatory government policies. From an Aboriginal perspective spiritualty is about being strong, managing everyday life challenges as well as enduring pain and suffering and knowing what is expected as a part of Aboriginal life. This sufferance will in turn strengthen and build a strong disposition for Aboriginal people. In traditional Aboriginal societies suicides did appear not to be present before the 1960s in the majority of the extensive literature search conducted by the researcher. Hunter in his research of suicides in North Queensland communities verified this. From a cultural

perspective it appears that among the young people there is a lack of identity in knowing who people are connected with from a traditional owner group. The passing down of cultural knowledge to future generations is not evident in some communities nowadays which is apparent when people don't know where there from, who their mob are. Across the communities some Aboriginal people recognized that they were not explained anything about their culture and lacked enough knowledge to know who they identified with, who they could speak with and as a direct result their culture had been lost from their perspective and some believed that's when the mental health problems started to occur. Disadvantage in Indigenous communities consists of disparities most notably in the inequalities of health and life-expectancy for Indigenous Australia. Life expectancy is much shorter for Aboriginal and Torres Strait Islander people between 10.8 years gap – Aboriginal and Torres Strait Islander men die at approximately 69.1 years compared to non-Indigenous men at approximately 79.9 years. They have much higher rates of death across all age groups and for all major deaths. The higher rates of mortality among infants, poorer health status, lesser levels of educational attainment and lower employment opportunities also affect Aboriginal and Torres Strait Islander people. Depending on the source of this information it will vary across communities, localities and regions. Disadvantage can be recognized as social, economic, cultural determinants and deeper underlying roots such as the high rates of violence influenced by immediate issues with alcohol, illicit drug use, mental health and youth exposure to violence (refer to Appendix 2 figure 2.17 and 2.18). The deeper underlying issues affecting Aboriginal and Torres Strait Islander people historically and contemporarily are the increasing effects from intergenerational trauma as a result of colonization, loss of land, language and culture. Additionally, the loss of cultural and spiritual identity, being forcibly removed from families and communities and continually confronting racism and discrimination on a daily basis consequently are also seen in contemporary times of today.

Aboriginal and Torres Strait Islander history in Australia has been plagued by disadvantage since the beginning. People were dispossessed and displaced and discriminated against yet the effects from history continue to be intergenerational resulting in many communities still living in poverty - third world conditions and striving to be autonomous in their own right, entangled within the socio-politics of race and power. Change to this situation is difficult to bring about particularly from the perspective of Aboriginal people who are frustrated and exhausted in the struggle. Aboriginal and Torres Strait Islander peoples often face prejudice when trying to rent a home, find employment, get service in shops and banks, and do the everyday things that most Australians take for granted. Disadvantage in one area increases the likelihood of disadvantage in other areas. For example, without study facilities at home, even with parental encouragement, learning for many will be hard. Similarly, children with hearing loss from middle ear troubles or undernourished children will find education difficult. Poor sanitation affects health, as does poor or inappropriate housing. Career progression to middle and senior levels often requires tertiary education. Being poor and unemployed lowers self-esteem and increases illness, death and the likelihood of arrest and imprisonment, just as poor health and limited educational achievement affect employability. Ultimately, all Australians benefit from a united effort to address Aboriginal and Torres Strait Islander disadvantage. As Indigenous disadvantage is overcome, the economy grows and the need for government expenditure is decreased. At the same time, Aboriginal and Torres Strait Islander peoples will be better placed to fulfil their cultural, social and economic aspirations. Addressing disadvantage places responsibilities on those providing support and assistance and on those receiving it. For those who provide support there is a duty to those being assisted? It means that service providers should: work in partnership with local Indigenous people and communities; recognize the cultures and histories of Australia's Aboriginal and Torres Strait Islander peoples and the consequences of past

policies and practices; and build the capacity of local Indigenous communities to help themselves. For those being assisted, there is the responsibility to help themselves as best as they can. This may involve seeking out information about available services, helping service providers to improve delivery outcomes, and recognizing and tackling personal barriers to improvement. Some Indigenous communities have identified that taking responsibility in education and employment is an essential part of the way forward.

Indigenous people's identity is strongly connected to individuality which supports connection to their cultural identity and their strong connection to country, land, language, traditional ways, ceremonies, family, friends and society. Additionally, identity is culturally part of the transfer of knowledge, handing down knowledge about the history from one generation to the next; this cultural process and understanding is missing for young people as they walk between two cultures as an Aboriginal and/or Torres Strait Islander person while a member of the wider society in which their cultural identity is seen as unimportant and often discriminated against. For that reason, intergenerational conversations between young people and elders is imperative in strengthening positive cultural identity and connection while restoring recognition and respect for Indigenous culture in the wider community (SNAICC, 2014). Why it is that suicide in traditional Aboriginal societies did not appear to exist yet over time they have become prominent and are at their greatest level? If suicides did exist historically it was never spoken about openly it was associated with sorcery or self-harm directed toward oneself if say their children were removed forcibly and the literature supports this claim. Suicides historically in the wider population and worldwide were recognized as something different than today's understanding. Suicides were more commonly practiced and punished accordingly, were mostly associated across many different cultures and religions and were seen as a criminal act. Therefore, there has been a dramatic shift in attitudes,

perceptions, treatment, and understandings historically from being a criminal act to now being a crisis in many Aboriginal communities in Australia. Aboriginal people were treated separately to non-Indigenous people because they were not accounted for and special laws imposed on Aboriginal people forcibly enabled them to become separate, segregated and incarcerated. Everything about Aboriginal people was separate and substandard in comparison to non-Indigenous in relation to housing, education, wages, employment, training, health, voting, and welfare and legal. So, in hindsight, given the context of Aboriginal and Torres Strait Islander disparities in contemporary data, Aboriginal and Torres Strait Islanders were always going to be behind the eight ball per se and consequently inequalities still exist and suicides increase. Historically Australian Indigenous suicides have evolve changed over time due to number of factors in identifying and reporting suicide, classifying or categorizing of suicides through coronial processes including research into suicide prevention for Indigenous populations. On the other hand, the rates of Indigenous suicide have also increased in accordance with the above but more importantly the underestimated or undetermined number of deaths that have not been accounted for as a suicide due to some of the criteria not being addressed would potentially explain some of these increases. From a family and community perspective, suicides encompass risk factors that relate to human development and issues for trauma and continue to affect families and communities across Australia. A disconnect from culture and identity for Aboriginal and Torres Strait Islander children and youth as a result of colonization and the effects of stolen generations further contributes to children and young people intentionally harming themselves. The implementation of past government child removal policies continues to impart negative effects for mental health which in turn leads to the effects of emotional distress, violence, self-harm, substance abuse and anti-social behaviour. Alcohol, substance misuse, behavioural and disciplinary problems and previous suicidal thoughts and behaviours are all compounded

by the ongoing experiences of social and economic disadvantages, loss of cultural connection, belonging to land and identity (SNAICC, 2014).

11.4 Historical literature review of suicides

Undertaking a review of the literature as far back as it would take was an interesting journey for me personally and professional and more so as an Aboriginal researcher as I was on a new journey of exploring new found knowledge from my perspective on the topic of suicide in Aboriginal communities. As a health professional I have always found studying mental health and suicide appealing and intriguing while wanting to fill the void and enhance my knowledge even more about suicide. It is evident from the literature that suicides have been present a lot more than I had even realized and after undertaking a historical review it all started to make sense and my newfound knowledge now paints a different picture from what I had originally in mind. In the beginning I did not intend to take a historical review of suicides however over time as I explored more about the notion that suicides did not exist historically in Aboriginal communities I became more inquisitive to the point that if I did not go down this path of reviewing historical information then I would not feel settled within myself and in knowing what I already knew, I had to find more information. The statement that appeared in just about all the literature I reviewed was ‘suicides did not exist in Aboriginal and Torres Strait Islander communities before the 1960s’ and this is where my journey begins.

A historical review of suicide literature was performed to identify the beginning of research conducted for the purpose of this study. It is imperative to achieve an understanding of historical developments to establish a breadth of knowledge. One of the objectives for this study was to scope the literature both historical and contemporary and analyses over time what was important, where there were gaps in the knowledge and understanding of suicides. This review has purposively selected Emile Durkheim and

his theory on suicide as one of the earlier researchers working in that space while positioning other historical key theorists developments in suicide research and more importantly, from an Australian perspective and in the context of this research. Suicide from a historical perspective was understood to be one of the lowest possible criminal acts in Britain by the 1600s, as illustrated in earlier literature the suicide (person) “is drawn by a horse to the place of the punishment and shame, where he is hanged on a gibbet, and none may take the body down but by the authority of the magistrate’ (www.deathreference.com/Sh-Sy/Suicide-Basics.html).. Burial was usually at the crossroads so that carriages would trample the dead, by now seen as a vampire; and if that were not enough, a stake was driven through the heart and a stone placed over the deceased’s face – to prevent any rising” (Tatz, 1999, p. 36). Suicides in this era were seen as criminal (felon de se) and dealt with accordingly. For the suicide their personal possessions were not passed onto next of kin or relatives but surrendered to the Crown due to the criminality of the act, this practice ceased towards the end of 1882. The law at the time (1870) was amended to incorporate inheritance and property rights of the deceased (suicide) to bestow personal possessions and be provided a religious burial (Tatz, 1999). Over time the situation of suicides across the world and within Australia continue to plague communities and cause havoc upon those left behind. A significant number of people from all ages have chosen to escape the realities of living by deliberately embracing death through the act of suicide. In Australia between the periods 1890 – 1990 there were over 98,000 deaths from suicide, in the order of 2,000 deaths annually. Suicide as a form of death evokes multiple reactions ranging from sadness (grief); fascination (attraction), repulsion (disgust) and even condemnation (blame) (Hassan, 1992). Suicides in the 18th century were looked upon as an ethical problem and socially perceptions were shaped by the influences of religion. Towards the 19th

century however attitudes towards suicides were changing and were looked upon as a social problem requiring further clarification (Hassan, 1992, p. 1).

11.5 Historical context of suicides

It is evident in the literature that suicides have been around a lot longer than initially realized and in the most primitive ancient of tribes throughout the world, mostly associated with evil spirits, revenge and unappeased anger and eventually finding their way into Christianity as taboos that continue through to today. In many cultures suicides were actually encouraged. Goths and Celts believed to die naturally was a shame, Vikings often died in battle or falling at the hand of their own swords. In Hindu culture suicide wasn't a choice this was a socially forced act, for example the untouchable's widows would suicide by undertaking the ultimate sacrifice on her husband's funeral, but this has since been banned in some rural countries (www.deathreference.com/Sh-Sy/Suicide-Basics.html). Among the Egyptians the first reference to suicide was about 4,000 years ago. Within this culture people did not feel shame or disgust with those who committed suicide. It was somewhat seen as a passage from this life into the next (the dead were coequal with the gods) and to evade excessive pain and dishonour (www.deathreference.com/Sh-Sy/Suicide- Basics.html). In Greece and Rome suicide was acceptable, even heroic under some circumstances. As Christianity developed over time suicide was seen as self-murder and an insult to god. The suicide term had slowly begun to change and replace self- murder while engaging the interests of emerging scientific disciplines in the 1700's (Minois, 2001). Greeks and Romans' acceptance and tolerance of suicide were varied; negative attitudes towards suicide were associated more with the lower class than the higher class (www.deathreference.com/Sh-Sy/Suicide-Basics.html). Greeks did not see suicide as wrong however it had to be justified in a number of ways "legally ordered by the State" (as in the case of Socrates);

for painful and incurable illness; and when one is compelled to it by the occurrence of some intolerable misfortune (www.deathreference.com/Sh-Sy/Suicide-Basics.html).. Democritus and Speusippus, Greek philosophers of the 18th century developed health problems as they became older which also contributed to their suicides; however Epicureans had felt that suicide was justified when life became intolerable and hard to manage and Stoics supported suicides if an illness or disease was incurable. Suicide among Roman citizens was not forbidden however it was forbidden for slaves and soldiers based on economic and patriotic reasons. Most Romans believed that life was not gifted from god but the support of suicide in relation to dishonour and old age was upheld. For the middle ages suicide was observed to be the result of despair or madness. History conveys to us the body of the person who suicided would result in savage punishments as in being dragged through the streets where the deceased had lived, and hanging it. The estates of these persons were confiscated, and Christian burial was forbidden. Sometimes, the corpse of a suicide was buried at a busy crossroads (in order to confuse the spirit), pinned down by a wooden stake through the chest - thus preventing, it was hoped, the spirit emerging to bother the living (www.deathreference.com/Sh-Sy/Suicide-Basics.html). Moving into the ninetieth Century, slowly but surely people's attitudes began to change. In Europe suicide was a crime however up until the 1960's and it was slowly being decriminalized which has been adopted in England and Wales (www.deathreference.com/Sh-Sy/Suicide-Basics.html).

11.6 Historical theories on suicide

In England and in many countries at the time and up until the mid-twentieth century, people were instructed 'you must not commit suicide on pain of being regarded as a criminal if you fail and a lunatic if you succeed.' For Aboriginal people up until the mid-

1960s Aboriginal administrators and many other agencies and organizations had been profiling Aboriginal people separate from non-Indigenous statistics simply because they were not accounted for like all other Australians in most states and territories. In fact, they were subject to special laws that forced Aboriginal people to be separated, segregated and incarcerated onto reserves, missions and settlements throughout Australia. Section 28 of the Australian constitution precluded the counting of 'full-blood' Aborigines in the national census. In 1967 a referendum removed the statement that excluded Aboriginal people from the census and in 1971 Aboriginal people were included in the census (Tatz, 1999). As a result of this it wasn't until the 1991 census where Aboriginal and Torres Strait Islander people's demography would be realized. Tatz (1999) identified that between 1991 and 1996 census data was so disproportionate that any prior data must be regarded as inaccurate. As of the 1960s and 1970s most of the states took sanctuary in knowing that keeping data separately was a form of apartheid nevertheless Aboriginal data became absorbed in the collection of mainstream data. The collation of Aboriginal and Torres Strait Islander and mainstream data resulted in a wide range of serious problems being missed as they could not quantify or accurately estimate based on these data. Therefore, based on this information Tatz (1999) believes that the only category that aligns to Aboriginal and Torres Strait Islander suicides from Durkheim's typology of suicide is that of anomic suicide. Despite Aboriginal society's being in crisis, and, following Durkheim's theory, being more integrated, suicide is increasing rather than decreasing. This occurred in parallel with Aboriginal society's disintegration policy rather than integration in response to crisis (Tatz, 1999, p.42).

11.7 Emile Durkheim's theory on suicide

Durkheim (1897) hypothesized that there were two basic social forces that existed and interacted in society, these being regulation and integration. Emile Durkheim (15th April

1858 – 15th November 1917), a French sociologist was one of the first to break through and discount popular non-sociological explanations of suicide pioneering systematic and scientific research by publishing in 1897 ‘Suicide: A study in Sociology’. Durkheim utilized a case study approach to investigate opposing rates of suicide among Protestants and Catholics and report a strong social control among Catholics and found that rates of suicide were lower than Protestants (Hassan, 1992; Crossman, 2015). Additionally, Durkheim (15th April 1858 – 15th November 1917), concluded suicide rates were highly prominent among single men who did not have any children, higher among soldiers and at times of peace than war. Acts of suicide are not only as ancient as humanity itself but feature prominently in many important pieces of literature, particularly those by Shakespeare. In the beginning, Immanuel Kant (22 April 1724 – 12 February 1804), observed the existence of suicide, as a certain organic character within society (Stark and Bainbridge 1996), and Barraclough (1992) identified possible suicides in the Old Testament of the Holy Bible (Torgler and Schaltegger,2012). However, nowhere in the description of death and its aftermath is it implied that suicide is wrong or shameful (Barraclough, 1992). Durkheim's (15th April 1858 – 15th November 1917) research influenced our understanding of suicide including the methodological philosophies required in addressing one of the most important social developments in history. Durkheim (15th April 1858 – 15th November 1917) acknowledged the importance of social situations being understood better through the close examination of human behaviour collectively (Durkheim, 1966,). Durkheim (15th April 1858 – 15th November 1917) believed social disorders could be reduced by social reforms and were not necessary for modern societies (Mondal, 2015). Durkheim’s work comprised a theoretical synthesis of earlier research regarding suicide as a social phenomenon, revealing that suicides were not associated with race, heredity, cosmic or psychological factors rather the level of social assimilation. He also believed that suicide and birth rates were related

outlining that fluctuating rates in suicides and births were attributed to the continual and isolated selfish nature of many community settings at that time (Durkheim, 1966). For example, Durkheim's view of integration denotes strength and resilience of individual connections and the stability of those community relationships in society. Durkheim positioned his understanding of social dissolution within societies in the context of suicide as varying levels of communal integration of groups in which an individual is associated (Durkheim, 1966 p. 2-3; as cited in Crossman, 2015). Durkheim (1897) identified a wide variety of emotional causes that affect individuals; (empathy, melancholy, anger and weariness) individual accounts cannot explain the differences in and within suicides regarding this as the proper object of sociological analysis. He opposes that suicide is established on a single order of facts as evident in its durability and inconsistencies. "Meaning that permanence would be inexplicable if it were not related to a cluster of distinct characteristics, associated with one another and simultaneously effective despite different attendant circumstances; and the variability proves the concrete and individual nature of those same characteristics since they vary with the society's individual character" (Durkheim, 1897, p. 51).

Durkheim theorizes that suicides directly or indirectly occur from either a positive or negative action by an individual that is deliberate and results in death. Suicide rates differ among several community environments on the basis of religion, family, politics and even professional groups, meaning that suicides are often represented an echo of the moral state of society. Durkheim further theorized that the rate of deliberate death was the result of a presence force wielding pressure on individuals. He further specifies groups are influenced by collective feelings for attempting suicide based on the groundwork of all individual feelings. In unassuming terms, Durkheim had a desire to shed light on what he deem 'social glue' that linked individuals within society or community, people would align

themselves to a group based on their moral obligations in society. Society was also an entity that existed on its own regardless of its individual member ideas, desire and hopes (Durkheim, 1966). Durkheim believed suicides occurred because of society's loss of control over individuals relating to the strengths and weaknesses within societies. Identified four basic types of suicides: altruistic, egoistic, anomic and fatalistic, each postulating a specific type of individual-society relationship. Having established the variation of the suicide-rate with the degree of integration of social groups, Durkheim believed that suicides occurring within particular groups were based on the level of integration of the individual. For example, individual values, beliefs, morals, meaning and purpose of life evolved because there was integration within society (Durkheim, 1897, p.10). Additionally, people who are in this position think only of themselves and are not incorporated into a group as such. People feel detached from society. This type (egoistic suicide) particularly affects those who have lost family; friends are retired or unemployed. Generally, when these situations occur, people experience a loss of work roles, ties and social bonds which in turn connect people to society (Mondal, 2015; Crossman, 2015). Simpson (2005) describes altruistic suicide where an individual's life is ruled meticulously by habit or tradition, religiously or politically resulting in the individual taking his own life due to higher orders. Historically this type of behavior is inherent in industries like the army or armed forces where patterns of obedience are still evident in modern day society. Dissimilar to anomic suicide this type results from too much integration or assimilation within society and people feel an obligation to do (suicide) so for example those who are identified as terrorists and undertake acts of suicide for the purpose of religion or political gains (Crossman, 2015). Whereas, anomic suicide relates to youth suicide or vulnerable youth due to breakdowns in society – regulation is too weak, which in turn impacts on young people feeling lost or alone, particularly young people who have experienced significant trauma sexually or physically and were raised in an alcoholic family

(Crossman, 2015). This type is evident among the wealthy including those divorced and are unable to adjust to forceful changes or upheavals occurring in their life. This tends to occur during industrial or financial crises (Mondal, 2015). Fatalistic suicide is the opposite of anomic suicide also known as over-regulation. People classified into this group were observed to suffer greatly from social rule and regulation and were severely oppressed by regulations. Durkheim associated this type with the slavery period, (assuming in colonial times) as evidenced by in the high rates of suicide at that time. Durkheim based his findings on particular connections an individual was associated to within broader society and groups in which they belonged. Indicating that when society fails to provide the basic requirements of attachment and/or regulation to human life health and wellbeing (mental) decreases therefore, predisposing those most vulnerable to self-harm and suicide. Durkheim believed that suicide was linked to society as a result of social implications as evident by the birth and unemployment rates of individual communities and broader society. Overall, the primary aim of Durkheim's research was to explore the relationship between people and society/community and so did this by identifying the different types of suicide through a sociological lens (Mondal, 2015).

11.8 Halbwachs theory on suicide

Halbwachs (1971) also a sociologist of the same period extended the work of Durkheim by exploring the effects of social isolation in relation to suicide suggesting that being alone is not the only precipitator for suicide, rather one must feel alone and demonstrate feelings of loneliness to enact suicide, Halbwach, supports the notion that when social connections become fractured and psychological changes take effect, suicides occur. Halbwachs' theory explores elements of risk factors and the association of these to different life changing events such as divorce, death, trauma, incarceration and homicides and the relevance of assessing individuals who may be vulnerable to risk

factors. Halbwach believes that for someone to be vulnerable to suicide they would exert feelings of disconnect personally and from the whole society with no purpose of living. Therefore, it is imperative to understand what occurs when someone suddenly experiences being alone particularly from a social point of view, otherwise they are deemed to not have acquired the skill or control over their social environments. Individuals within society are respected members of a community who establish a sense of purpose in life and a reason to live, whereas some members of a community in bureaucratic structures may feel removed from meaningful participation and having established position within society. Therefore, it is immensely important to have a greater understanding of the social contexts of communities such as networks and relationships regarding suicide; these cannot be separated from the phenomena as they help to build and establish powerful resources for those most vulnerable within society (Keating et al., 2010).

Following on from Durkheim's general theoretical orientation Halbwach (1930 as cited in Hassan, 1992, p. 11), conclude from his study that suicide rates were higher among city dwellers (urban) who experienced a degree of social isolation, Halbwach replaces 'social isolation' in place of anomie and egoism (Durkheim's theory). One of the major limitations for Halbwach's (1930) research was demonstrating that suicides in cities varied in size and remained so over time. Whereas in 'Suicide and Homicide' compiled by Henry and Short (1954) they argue hypothetically, suicide and homicide are the same kind of economic determinism, meaning the acts of aggression for both cannot be differentiated regardless of the source of frustration.

To be able to address suicide within Australia effectively action must focus on the root causes of psychological distress that sit within the broader contexts of society: social, economic, political and cultural to create healthy societies. There are strong links

associated with social backgrounds of individuals in regards to their level of disadvantage and social injustices (Joffe, 1996; Wilkinson & Marmot, 2003) that require strategies to overcome poverty, violence, unemployment, homelessness and discrimination (Wilkinson & Marmot, 2003). While it is clear that psychological distress and suicide co-exist efforts to affect change need to focus on broader conditions contributing to psychological distress and ill health (Keating et al., 2010).

11.9 Additional theorists on suicide

Henry and Short (1954) believe that the two acts of homicide and suicide respond in a similar way to economic forces of frustration. For instance, suicide differs positively and homicide negatively with position in the status hierarchy, on the other hand suicide varies negatively and homicide positively with the strength of external restraint over behaviour (Henry & Short, 1954). Henry and Short (1954) argue that the amount of external restraints placed on individuals impacts on their level of place in hierarchy in which homicides increase. An example is someone who is involved in a meaningful relationship is exposed to higher degree of external restraint then those who are not in a meaningful relationship. Gold's (1958) study on the other hand builds on Henry and Short's philosophy in their research titled 'suicide, homicide and socialization'. The aim of this study was to develop a system that projected predictors of risk for someone contemplating suicide or homicide. Gold argued that the decision to suicide or homicide is related to the process of socialization as a child (developmentally) and class of position in society. The level of violence among working class people results in homicide whereas suicide occurs among middle class people. Therefore, the decision to end one's life was influenced by childhood socialization, stratification levels and processes among the working class or middle class concerned. Gipps and Martin (1964), in their study titled 'Status, Integration and Suicide' progressed Durkheim's theory "suicide varies inversely

with the degree of integration of social groups" by conducting experiential research by observing situations in which relationships reflect stability and resilience within societies. Overall this finding supports Durkheim's theory above. Schneidman (1975) refines Durkheim's classifications of suicides by examining notes left behind by those who suicided. Schneidman (1975) classifies suicides as: egotic, dyadic and ageneratic. Egotic is defined as personal torment and Carr and Hassan (1987) unresolved psychological struggles; dyadic are conflicts with significant others and ageneratic relate to one's relationships, belonging to a group or generation. Similarly, French Sociologist Jean Baechler (1979), identified different types of suicides: escapist (flight, grief and punishment), oblative (sacrifice and transfiguration), Ludic (the ordeal, the game) and Aggressive (crime, vengeance, blackmail and appeal) (Hassan 1992, p.13). According to Hassan (1992), suicides, are rational solutions to particular situations and existential problems. In two different studies conducted by Pope (1976) titled 'Durkheim's Suicide: A classic analyzed' and Danigelis and Pope (1979) titled Durkheim's theory of suicide as applied to the family social forces' aimed to understand the underlying links between egoism-anomie and suicide. Findings indicated the following the larger the number of people in a group setting, increased interaction, and a stronger sense of shared feelings, integration-regulation the sense of life and meaning and belonging for an individual is much stronger. Generally, the more content people are the less suicidal they are – equally social control and suicide are related (Hassan, 1992). Anthropologist Emanuel Marx (1976) worked with North African youth in Israeli immigrant towns on violent behaviour and found there was a social framework to this violent behaviour indicating that it occurs more frequently among those who are dislocated, transported or socially engineered individuals from another culture or geography in what Colin Turnbull (1972) also an anthropologist refers to as disordered societies. Marx refers to this as appealing violence when someone is crying out for assistance are unable to address or fulfil their

purpose in life without help or support and cannot convince their friends or family to assist them or share responsibilities resulting in repeated attempts of suicide to desperately gain support from friends and/or family. This in turn leads to further self-harming behaviours to self and others as illustrated in an Aboriginal community of Raukkun in South Australia where a young Aboriginal man had attacked his brother with an axe early in 1989…. reprimanded by a local policeman's wife saying "sorry I'll never do it again: I'll only hurt myself" (Tatz, 2011, p. 5). Tatz (2011) states much of the human values (love, affection, respect, systems of law and religion) that are imbedded and passed now through generations and cultures are not inherent in humanity these days. Turnbull (1972) propose these values are characteristics of 'ordered societies' as such found in the Ik Mountain People of Kenya and Uganda. This group of people originally hunter-gatherers were forced to exist as farmers were not allowed to hunt, and had to cope with drought and poor land while struggling to survive. Similarly, the catastrophic experiences of Aboriginal and Torres Strait Islander people being removed from their traditional land onto white settlements and missions resulted in the breakdown of values and of systems were evident in the types of self-harming behaviours being observed and reported in Aboriginal communities (Tatz, 2011) further supported by Chief Pietacho statement in 1996.

11.10 Limitations of historical theorists

Durkheim explored the rates of suicide between Protestants and Catholics, asserting Catholics had lower rates of suicide because of greater social control and normal levels of integration, whereas, Protestants had lower levels of integration. Limitations exist in Durkheim's interpretation firstly, because the data he obtained was from previous research and secondly, the differences between Protestant and Catholic religions were limited to mostly German-speaking Europeans. Religious structures were essential to the

moral framework of society whom withheld their support of death by suicide because of retaliations by means of scriptures or consequences imposed on families left behind. As a result underestimations of suicides would exist in this era (van Popel & Day, 1996). Nevertheless, Durkheim's work influenced many of the control theory or sociological study. Some critics of Durkheim's regard his research a logical error or even an ecological fallacy some dispute whether his work really contained an ecological fallacy. Others on the other hand believe he committed an empirical error rather than a logical error. An example of Durkheim's work in 1869 was to research the rates of suicide in various countries by exploring commonalities of social links (beliefs, values, norms, and traditions) between countries and if they influenced a higher or lower rate of suicide. Durkheim relied heavily on official suicide statistics for each country. The problem with this is statistics will be determined by the coroner's decision and their role in classifying each death and potentially these may not reveal the true meaning of the data which can be concealed or misinterpreted by researchers. Durkheim's breakthrough from a sociological perspective came about when he considered individual problems as possibly greater than the individual alone, consequently Durkheim's review of the overall trend of suicides supersedes individual cases (Ward, 1907). Durkheim wanted to better understand the social factors that may influence a person to commit suicide. As a result Durkheim was able to influence his followers in understanding suicide as a societal fact like teenage pregnancy and violent crimes rather than a heinous moral crime Suicide is not solely the choice of individuals who are sick and deranged, but at times can be the result of societal pressures that have become too difficult to handle (Durkheim, 1895, p. 10).. Some argue that Durkheim was a positivist, whereas more recent evaluations support him as a realist. Sociologists support Durkheim's fundamental approach to exploring suicide however some question his interpretations of his findings (Ward, 1907).

Durkheim's theory is helpful, in understanding Aboriginal suicide and mental health for this study. Durkheim's concept of integration has resonance with the research because it takes account of all the characteristics of Aboriginal communities in south west Queensland which have been investigated for this study. This research has shown that when Aboriginal suicides and mental health is negative, analysing this situation through the social and emotional wellbeing framework speaks back into Durkheim's concept of integration. Aboriginal individuals who are well connected within Aboriginal communities coupled with those Aboriginal communities not being fractured and are healthy; reduce the incidence of suicide and mental health. Alternatively, Aboriginal communities suffering the long-term impacts of colonization and where support is minimal or difficult to access, presents risks for Aboriginal mental health and suicide. Durkheim's study was brought into question because of the data and the way in which the data was collected and read. The accuracy of data with regard to suicide and in particular Aboriginal suicide continues to need refining. Interpretations of what counts as suicide is not always clear. As a sociologist Durkheim's research opened up other ways to understand suicide. This has been an important factor for this research. Aboriginal suicide and mental health does need to be understood within the larger context of structural, environmental, cultural and social aspects (Sheehan, Martin, Krysinska & Kilroy, 2009) as many Aboriginal communities in this study are situated in towns where racism and discrimination are prominent resulting in Aboriginal communities struggling to receive basic health services. This is most evident when many of the participants in this study have spoken of feeling that it is all beyond their ability or control. Again, there is resonance with Durkheim's work and the concept of regulation. Community dynamics in relation to the larger sociological contexts can lead to senses of fatalism, a further theoretical concept offered by Durkheim reflected in this research.

CHAPTER 12 - CONCLUSION

Bringing it all together

It is evident from the most recent and available data that suicides within Australia are on the rise and more noticeably for the Indigenous populations of Australia. Following an extensive review of the literature, both historical and contemporary information illustrates that suicide was not evident in Aboriginal communities before the 1960s however it is with caution that we must remember the history and the impact of policies imposed on Aboriginal people is well documented and written by non-Aboriginal people, there is limited information written by Aboriginal people. Furthermore, a greater part of the historical data reviewed prior to 1967 recorded by non-Aboriginal people (protectors, government officials) ultimately was either decisively misplaced or destroyed as it appeared to be of no value or interest at the time and this could fundamentally be due to Indigenous people not being recognized as people for that period in time. The colonial policies and practices from the past continue to negatively impact Aboriginal and Torres Strait Islander people's health and wellbeing, generation after generation this is evident and explains the inequity that still exists in all areas of health, workforce, and economy, social, political and educational outcomes within many communities. It is evident that traditionally in Aboriginal culture social and emotional wellbeing was intricately woven and tied to the social and family systems and relationships were overseen by cultural Lore, ceremony and spiritual practices within Aboriginal culture. This was supported by a strong sense of belonging to Country and land in which the family and community was connected as a whole. Over time historical policies have resulted in Aboriginal people experiencing racism, relocation, removal, violence and trauma for continual periods all from the effects of colonization and assimilation practices. The direct impacts of forcible being removed from communities, their country and their families. Indigenous people were slowly being denied their culture, their language, their rights and responsibilities as

human beings and as a race. Collectively these negative impacts compounded by the ongoing disadvantage of social and economic aspects continues to have detrimental effects on people's mental health as evident in Indigenous communities today. Furthermore, the unrelenting effects of grief and loss, abuse, family and domestic violence, substance misuse, relationship breakdown, dislocation and poverty further add to the complexity of Indigenous communities.

It is vitally important to recognize the cultural differences that exist in Indigenous communities to ensure that current funding, services and programs provided to Indigenous people do not compromise the genuine rights and responsibilities of the peoples culture, traditional practices, values and beliefs commonly adhered to. For instance, recognizing the uniqueness of Indigenous peoples experiences of grief and loss, trauma, dislocation, dispossession and removal through colonization and assimilation policies supports the enhancement of social, emotional and cultural wellbeing of Indigenous people and their communities in the future. Mainstream funding, services and programs that focus on combating suicide in Aboriginal communities do not formally acknowledge that intergenerational consequences particularly from colonization and dispossession continue to play a role in Aboriginal suicides. Durkheim's work in understanding the social impacts on suicide can be used to show how the impacts from colonization and dispossession have caused an erosion of social bonds, loss of collective identity and meaningful ties to a community that has created a weakening of the social structure of shared values, cultural traditions and social norms of Aboriginal people and communities today. Suicides in the Australian context were looked upon as an ethical problem and socially perceptions were shaped by the influences of religion. However, over time attitudes towards suicides have been changing and are looked upon as a social problem requiring further clarification and research. Therefore, with this in mind it is

worthy and of value from a research standpoint to explore historical archives about suicide and the relationship to cultures from both the perspective of Aboriginal and Torres Strait Islander populations in trying to understand if suicide was spoken through storytelling or even acceptable in Aboriginal or Torres Strait Islander practicing cultures. It is noticeably across many Aboriginal and Torres Strait Islander communities the lack of elders who are seen with importance of instilling cultural leadership and control which is not so obvious in contemporary times due to many not being alive today to continue with the role of passing down cultural knowledge. Engaging elders or people across both cultures who hold the stories are where the value lays in future research into Aboriginal and Torres Strait Islander suicide.

12.1 Limitations of the research

The first limitation of this research is that it was limited to the communities involved. This means that the findings cannot be generalized to other Aboriginal or Torres Strait Islander communities. There were a number of limitations for this research however they did not impact on the research being implemented and were identified as merely challenges and/or barriers during the process of the PhD journey. These challenges and barriers identified will be referred to in future research projects in which the researcher will encompass and improve on when conducting research with Aboriginal people and their communities. The first limitation was the recruitment of Aboriginal participants across the four communities, in the planning stages of the research the researcher had intended recruiting a number of participants across different age groups and sex but in actual fact there were less numbers recruited across all of the age groups and sexes. In hindsight it would have been ideal to capture more data from more Aboriginal participants however what was captured was sufficient. The second limitation was the availability of historical and contemporary information pertaining to each of the traditional owner groups across

the four communities in preparation for the write up of the literature review. It became evident that for some of the traditional owner groups there was plenty of literature however for others this was limited. This could potentially be due to the restriction of traditional knowledge being readily accessible. For the purpose of further research in this area using this approach could potentially provide new and additional insights from existing and other Indigenous groups in Australia and internationally and will be highly relevant if this study was replicated and used more widely among many Indigenous groups. This study has the potential to be replicated among other Indigenous groups both in Australia and internationally and as long as specific cultural considerations and Indigenous protocols are respectively embedded and supported by local communities.

12.2 Recommendations

1. Employing a social and emotional wellbeing approach to Aboriginal research into suicide has the potential to be replicated not only among other Indigenous groups in Australia but Internationally while supporting Indigenous specific cultural considerations and protocols applicable to and supported by local communities

2. This approach could potentially provide insights for other Indigenous groups in Australia and internationally and will be highly relevant if such an approach is used more widely

3. Build capacity of Aboriginal and Torres Strait Islander people and communities by educating parents, guardians and young people about suicide, bullying, mental health, child developmental stages

4. Design and implement intervention programs that are culturally specific to Indigenous groups at risk of mental health illness and suicide

5. Access funding to convene and facilitate community forums on suicide and mental health specific to Aboriginal and Torres Strait Islander people and communities

6. Disseminate key findings from this research through a number of approaches such as publications, conferences, workshops and

7. Suicide in Aboriginal communities is on the rise accompanied by intergenerational trauma, substance misuse, poverty, disempowerment, disengagement and disadvantage within the larger social and health context.

8. Historically suicide and self-harm did not appear to exist prior to the 1960s; and there is a difference in understandings and shifts in attitudes towards suicides today. The negative effects from emotional distress, violence, self-harm, substance abuse, anti-social behaviour, behavioural and disciplinary problems are all compounded by the ongoing experiences of social and economic disadvantages further impacting on the risk of social and emotional wellbeing of Aboriginal people and their communities.

GLOSSARY

Attempted suicide: self-inflicted harm where death does not occur, but the intention of the person was to die.

Aboriginal: A person of Aboriginal descent who identifies as an Aboriginal and is accepted as such by the community in which he or she lives.

Aboriginal and Torres Strait Islander health: Holistic concept, encompassing mental health and physical, cultural and spiritual health, considering land to be central to wellbeing. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations which constitute cultural wellbeing. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist.

Completed suicides: is a term used to refer to deaths by suicide to distinguish from attempted suicides and parasuicides.

Health: Health does not just mean the physical wellbeing of an individual, but refers to the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total wellbeing of their communities.

Holistic approach: A holistic approach to health incorporates a comprehensive approach to service delivery and treatment where coordination of a client's needs and total care takes priority. It is an acknowledgement that economic and social conditions affect physical and emotional wellbeing. Care therefore needs to take into account

physical, environmental, cultural, and spiritual factors for achieving social and emotional wellbeing.

Indigenous: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community with which he or she is associated.

Mental health: Capacity of the individual, the groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective or emotional and relational), the achievements of individual and collective goals consistent with the attainment and presentation of conditions of fundamental equality. Mental health is incorporated into the holistic approach to health care as defined in the definition of health.

Nemesis: "describes a rival who just somehow seems able to get the best of you. It can be someone you compete against, someone whose skills are nearly identical to yours and yet, your nemesis always seems to finish ahead of you, get a higher grade, and generally make you feel flustered. Nemesis can also refer to something that always causes you problems, like public speaking, the nemesis of those who get tongue-tied when nervous" (https://www.vocabulary.com/dictionary/nemesis).

Protective factors: Capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health.

Parasuicides are attempted suicides where there is no apparent intent to end life.

Postvention refers to care, interventions and other support services for individuals, families and communities after a suicide to limit the distress and future negative outcomes that can result from a death by suicide.

Resilience: Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, good communication and social skills, optimistic thinking, and help-seeking.

Risk factors: Factors such as biological, psychological, social and cultural agents that is associated with suicide/suicide ideation. Risk factors can be defined as either distal (internal factors, such as genetic or neurochemical factors) or proximal (external factors, such as life events or the availability of lethal means - factors which can 'trigger' a suicide or suicidal behaviour).

Self-injury: Deliberate damage of body tissue, often in response to psychosocial distress, without the intent to die. Referred to as non-suicidal self-injury, or self- harm.

Suicidal behaviour: Includes the spectrum of activities related to suicide and self- harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk- taking behaviours as suicidal behaviours.

Suicidal ideation: Thoughts about attempting or completing suicide.

Suicide: The act of purposely ending one's life.

Suicide prevention: Actions or initiatives to reduce the risk of suicide among populations or specific target groups.

Torres Strait Islander: A person of Torres Strait Islander descent who identifies as a Torres Strait Islander and is accepted as such by the community in which he or she lives.

Suicide: death determined by the coroner as a result of self-inflicted harm where the intention was to die.

Self-harm: any behaviour that involves deliberate injury to oneself. Self-harm may be an attempt at suicide although it is not necessarily so. It is usually a response to distress.

Suicidal behaviour: acts such as suicide and attempted suicide. This also includes suicide related communications such as verbal or nonverbal statements expressing suicidal intent.

Suicidal ideation/thoughts: thoughts about, or plans for, taking one's own life that may or may not lead to a suicide attempt

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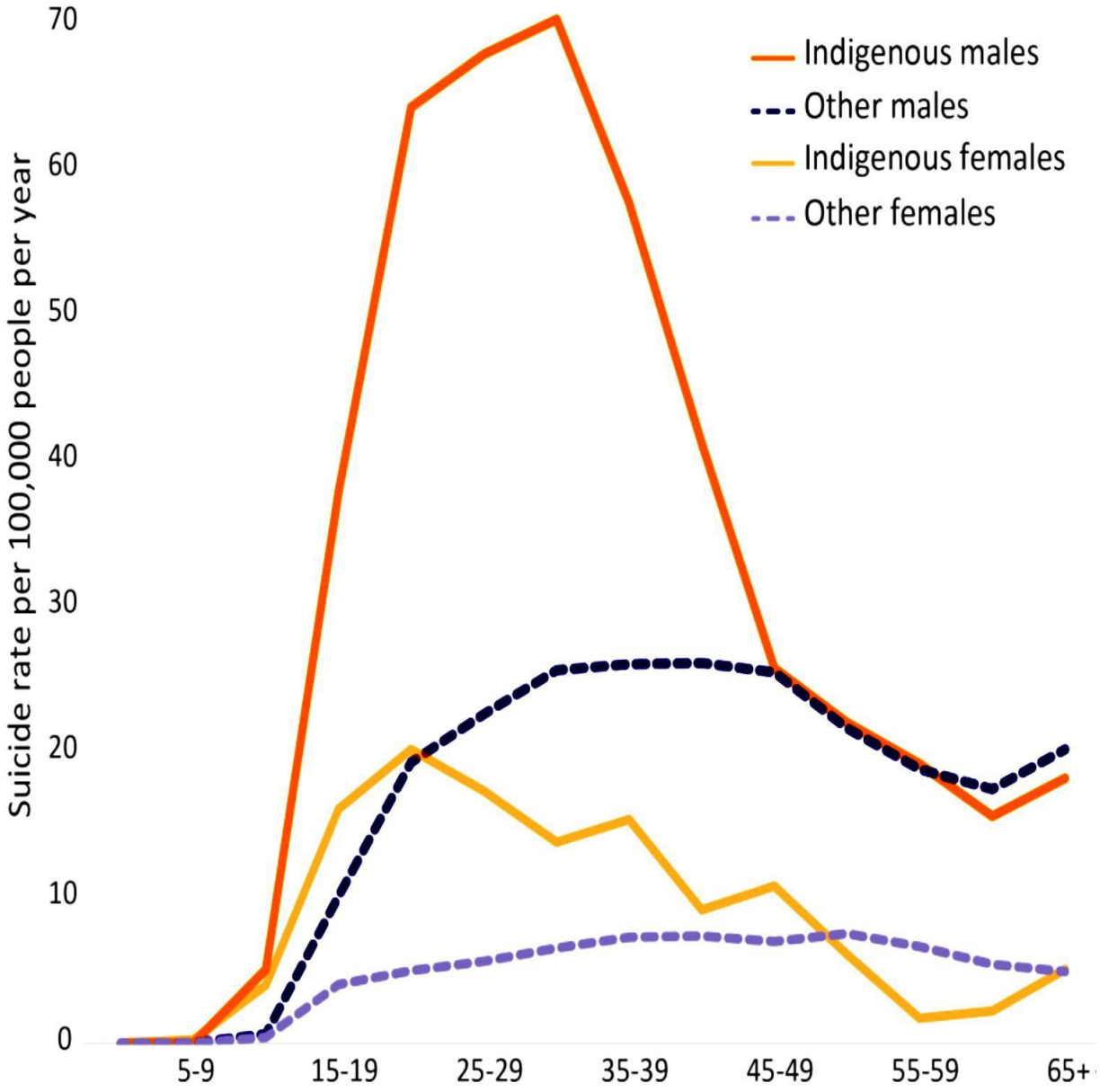
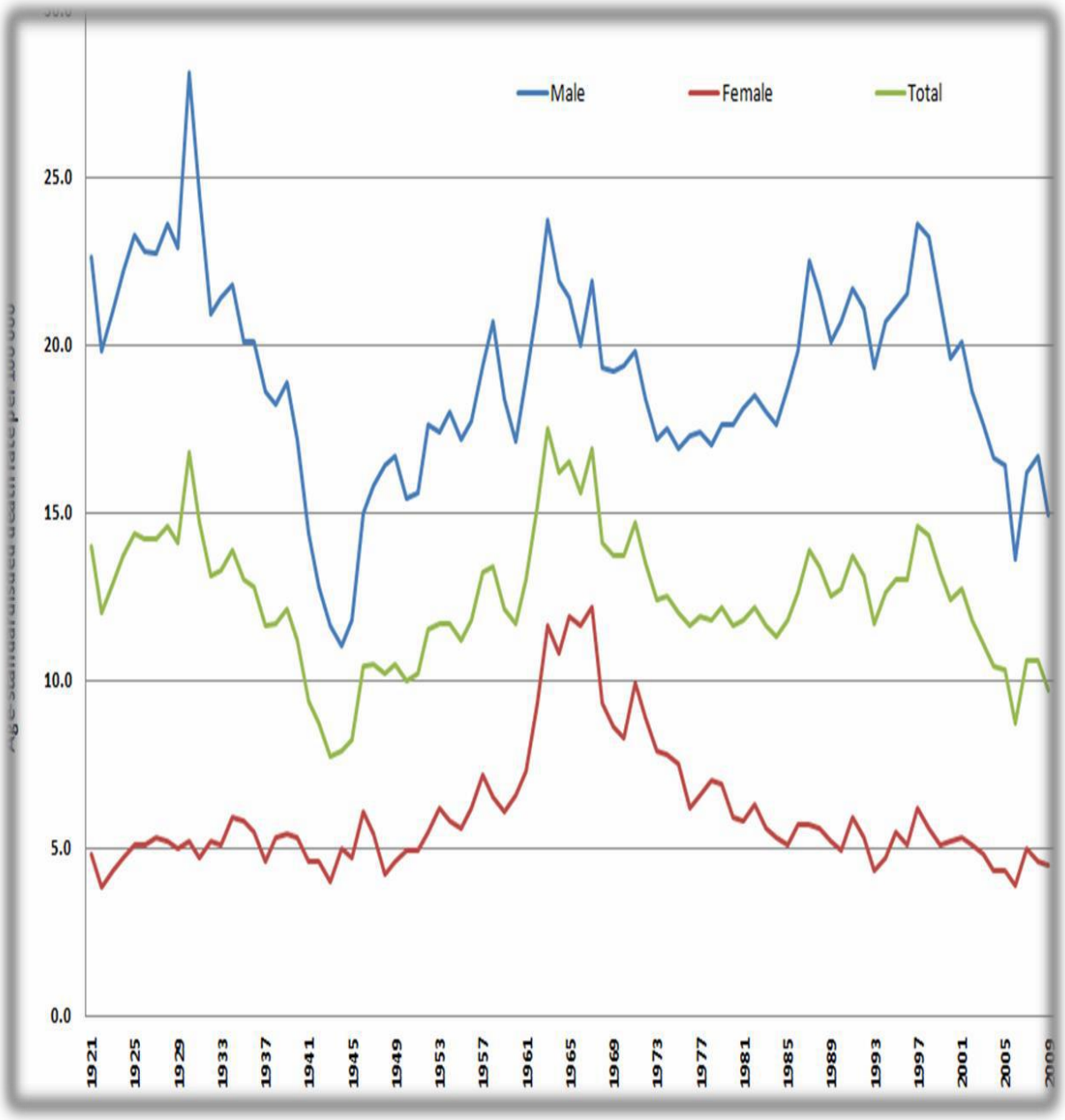
Appendix 1

Appendix 1.1 Suicide rates by age 2001 - 2012



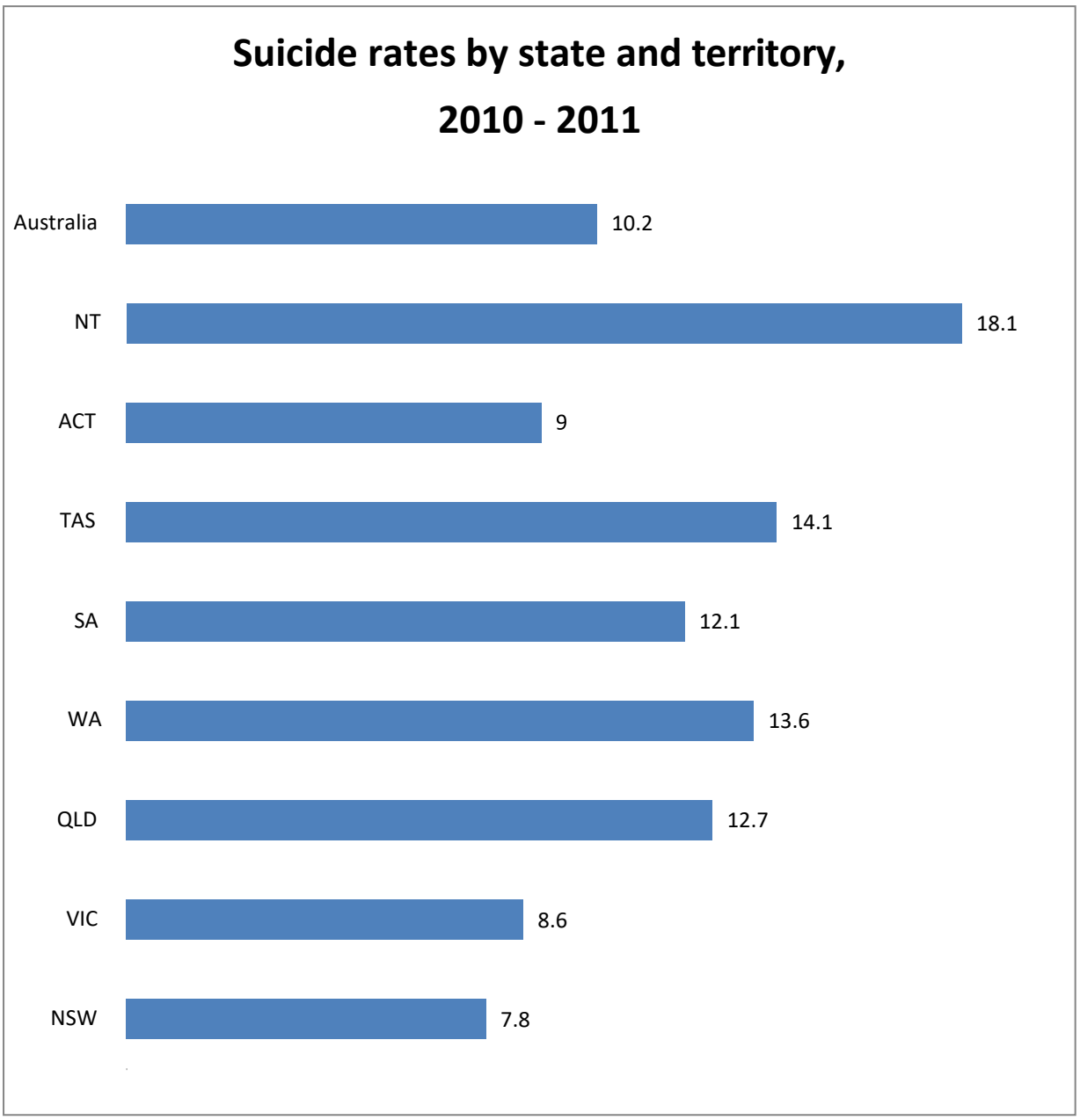
(Source: ATSISPEP analysis of unpublished NCIS data).

Appendix 1.2 Age-standardised death rate by sex—suicide, 1921– 2009

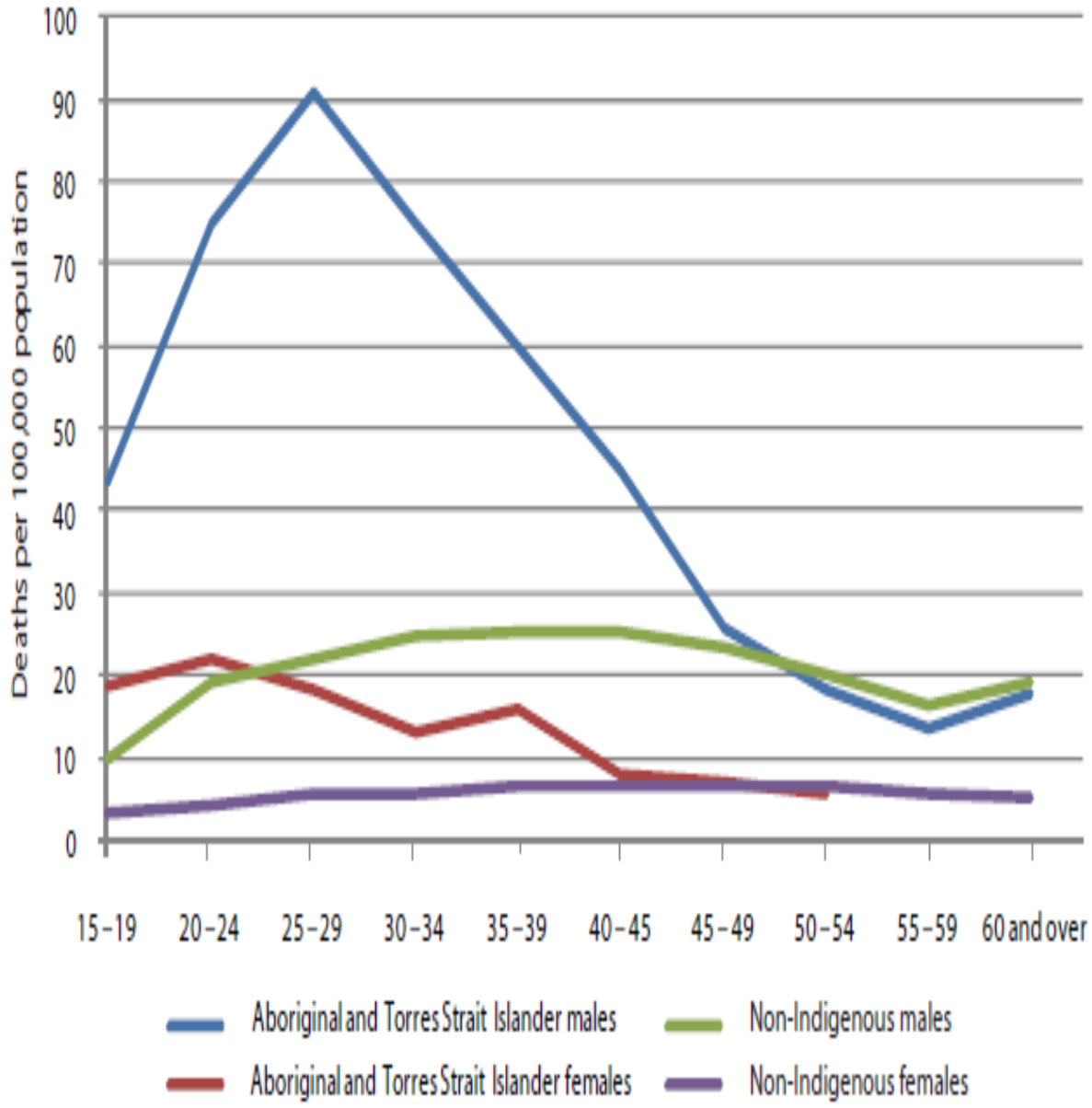


(Source: Simon-Davies, 2011)

Appendix 1.3 Suicide rates in Australia by state and territory, 2010-2011

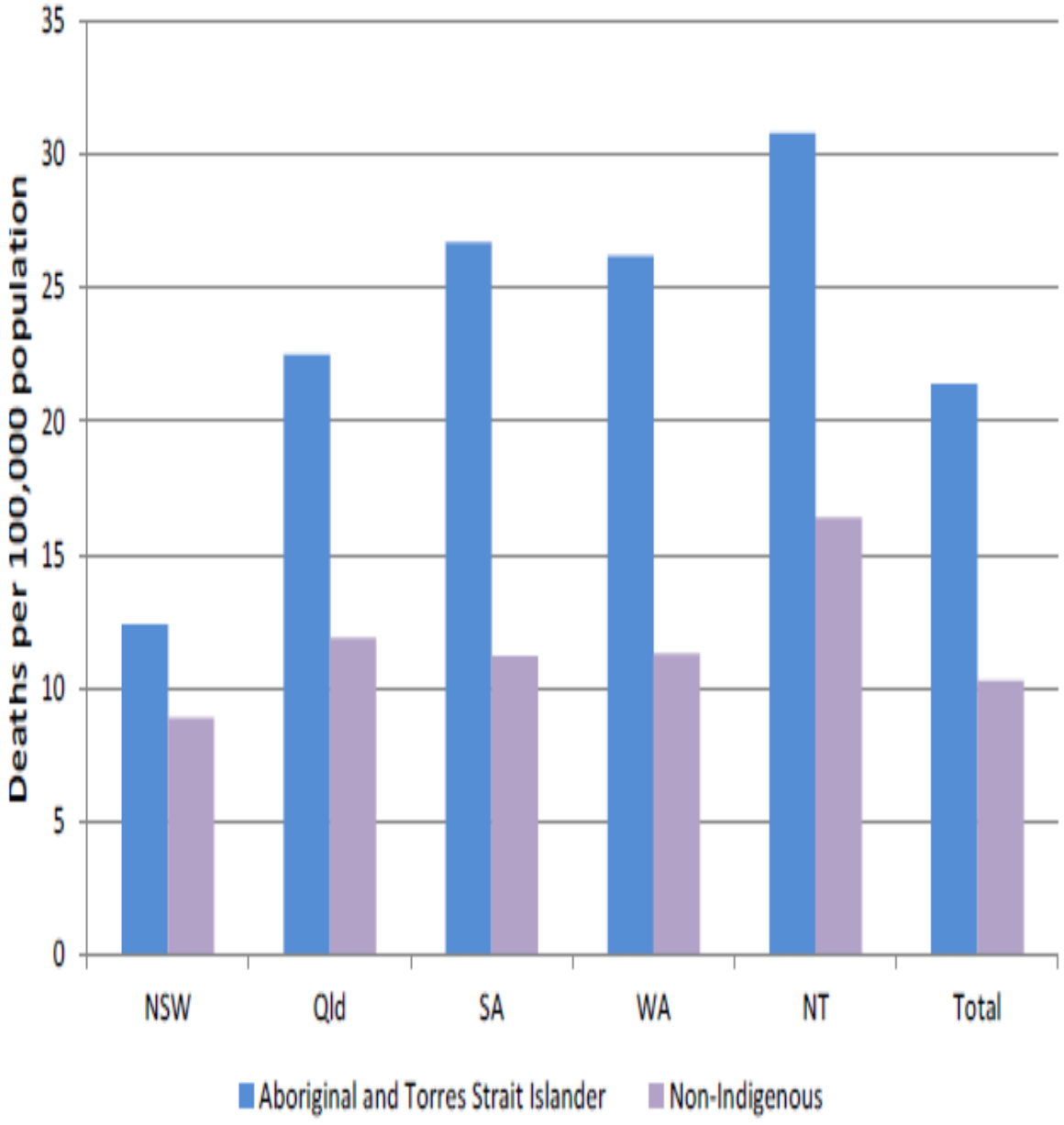


Appendix 1.4 Age-specific rates by Indigenous Status & Sex, NSW, Qld, SA, WA, NT, 2001-2010 (Australian Bureau of Statistics, 2016).



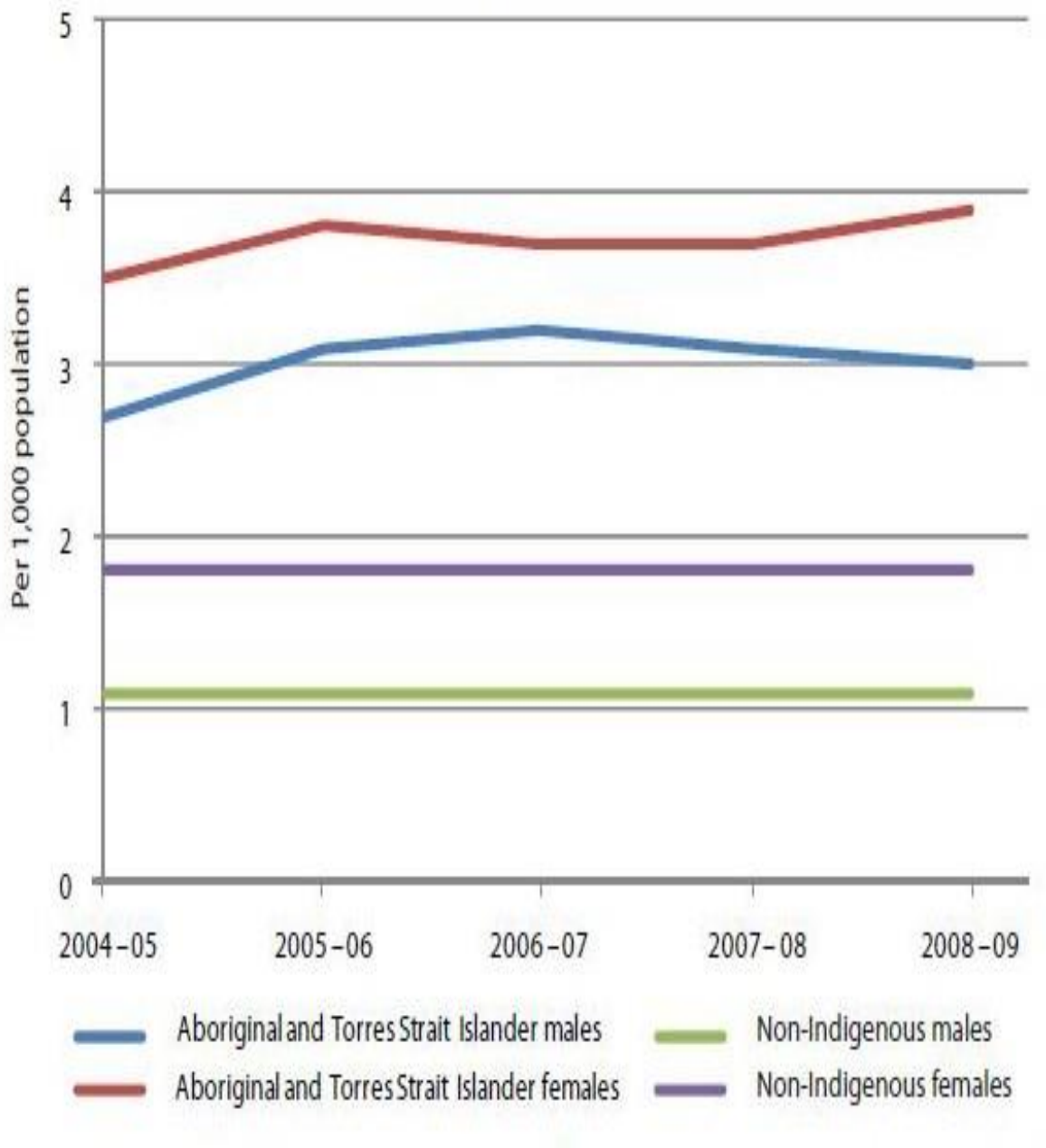
(Source: Sven et al, 2014)

Appendix 1.5 Age-standardised Suicide Rates by Aboriginal status – NSW, Qld, SA, WA and NT, 2001-2010



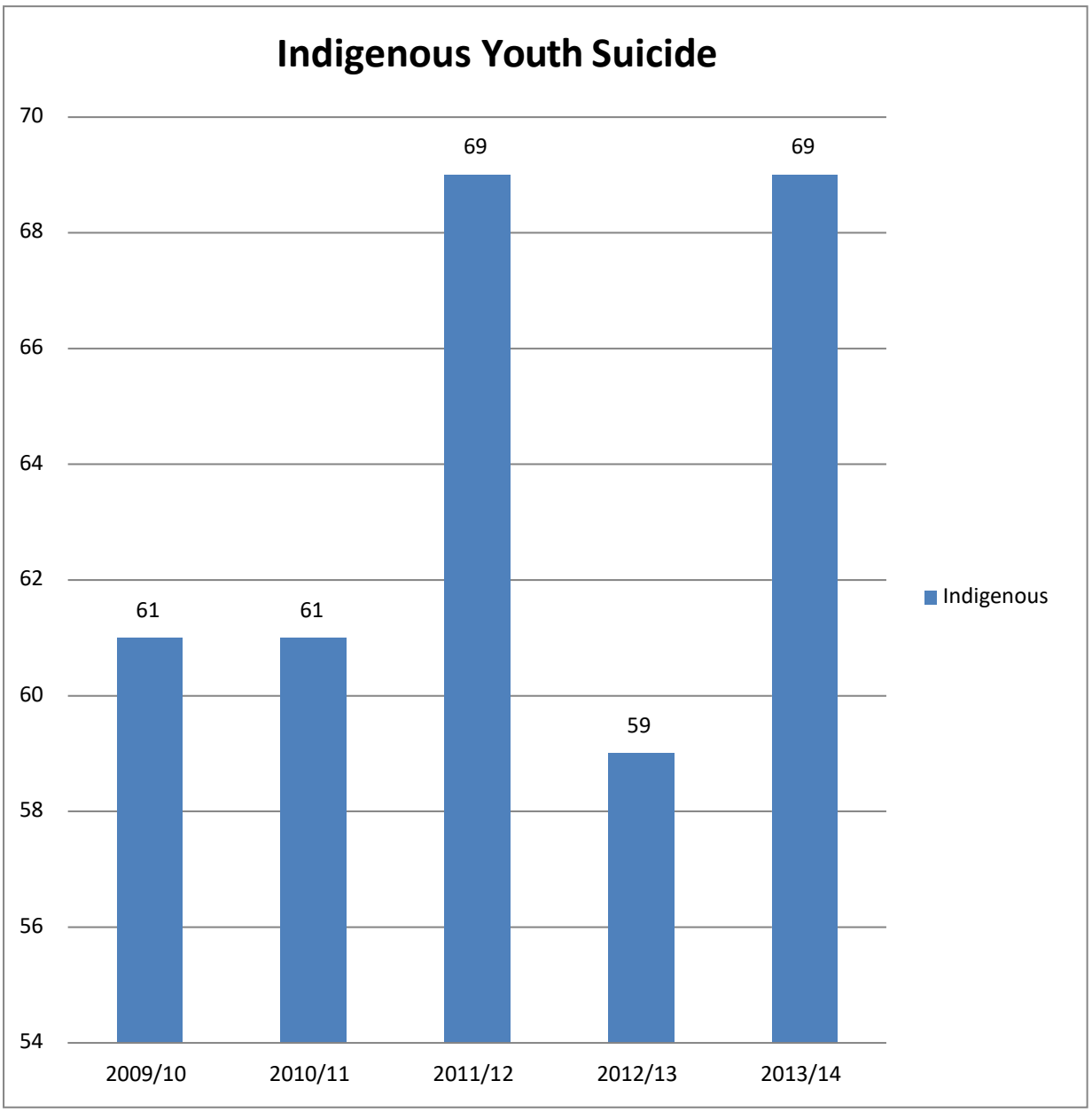
(Sven et al, 2014)

Appendix 1.6 Age-standardised Non-fatal Hospitalisations for Intentional Self- harm – NSW, Victoria, QLD, WA, SA and public hospitals in NT.



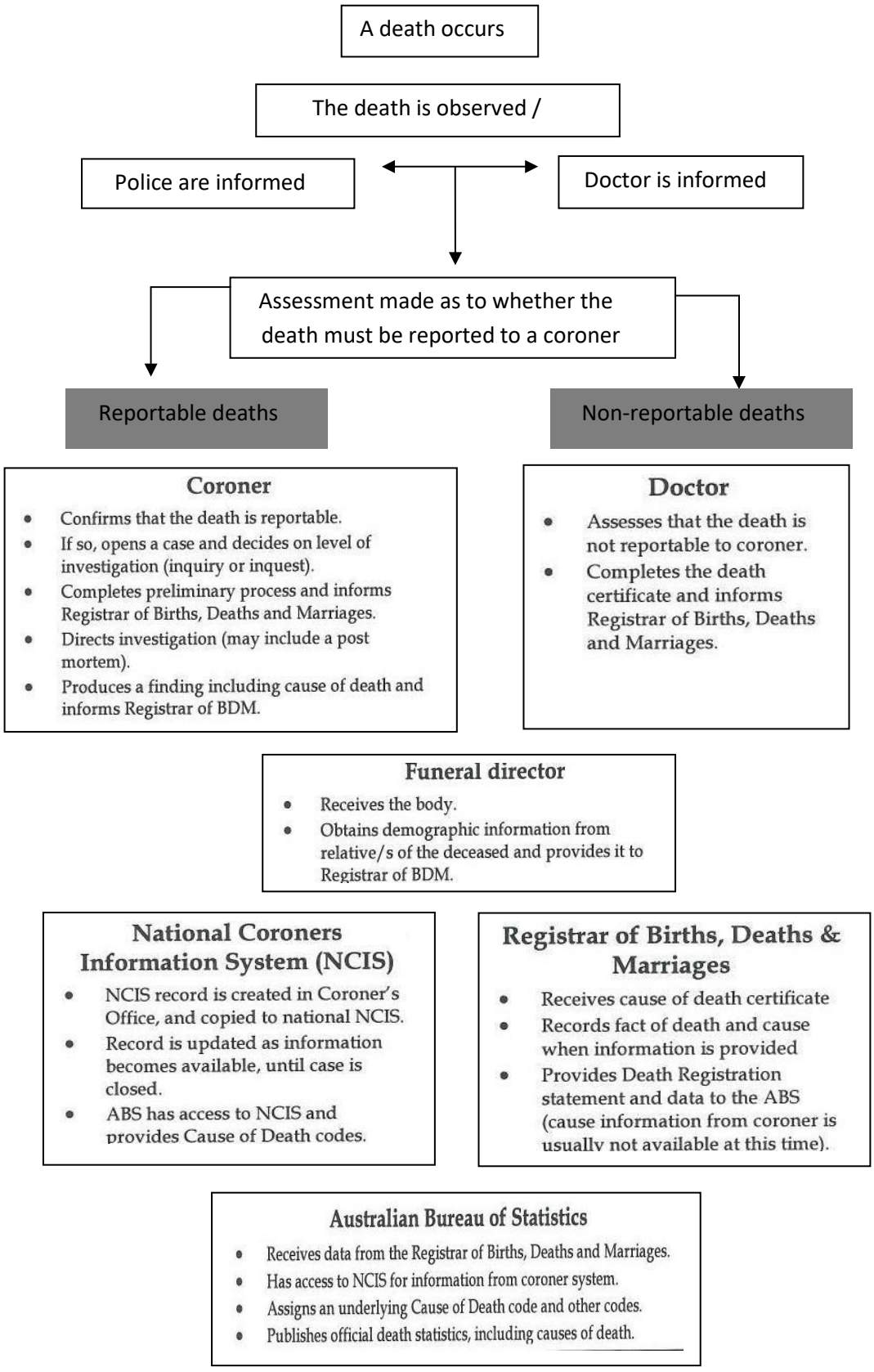
(Source: Steering Committee for the Review of Government Service Provision, 2011)

Appendix 1.7 Summary of Indigenous suicide in Queensland, 2009-2014



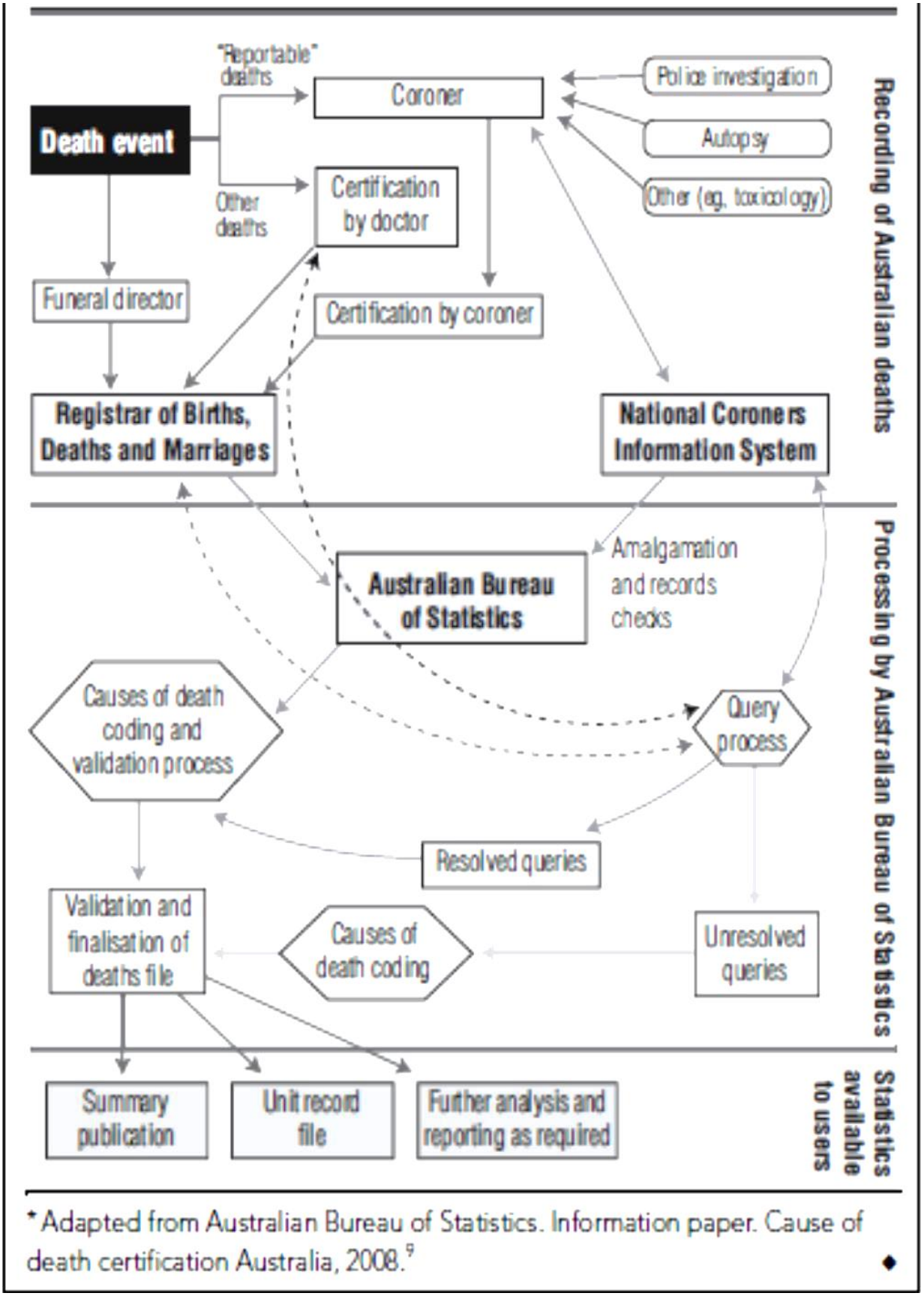
(Source: Commission for Children and Young People, 2013).

Appendix 1.8 Flowchart Causes of Death data collection



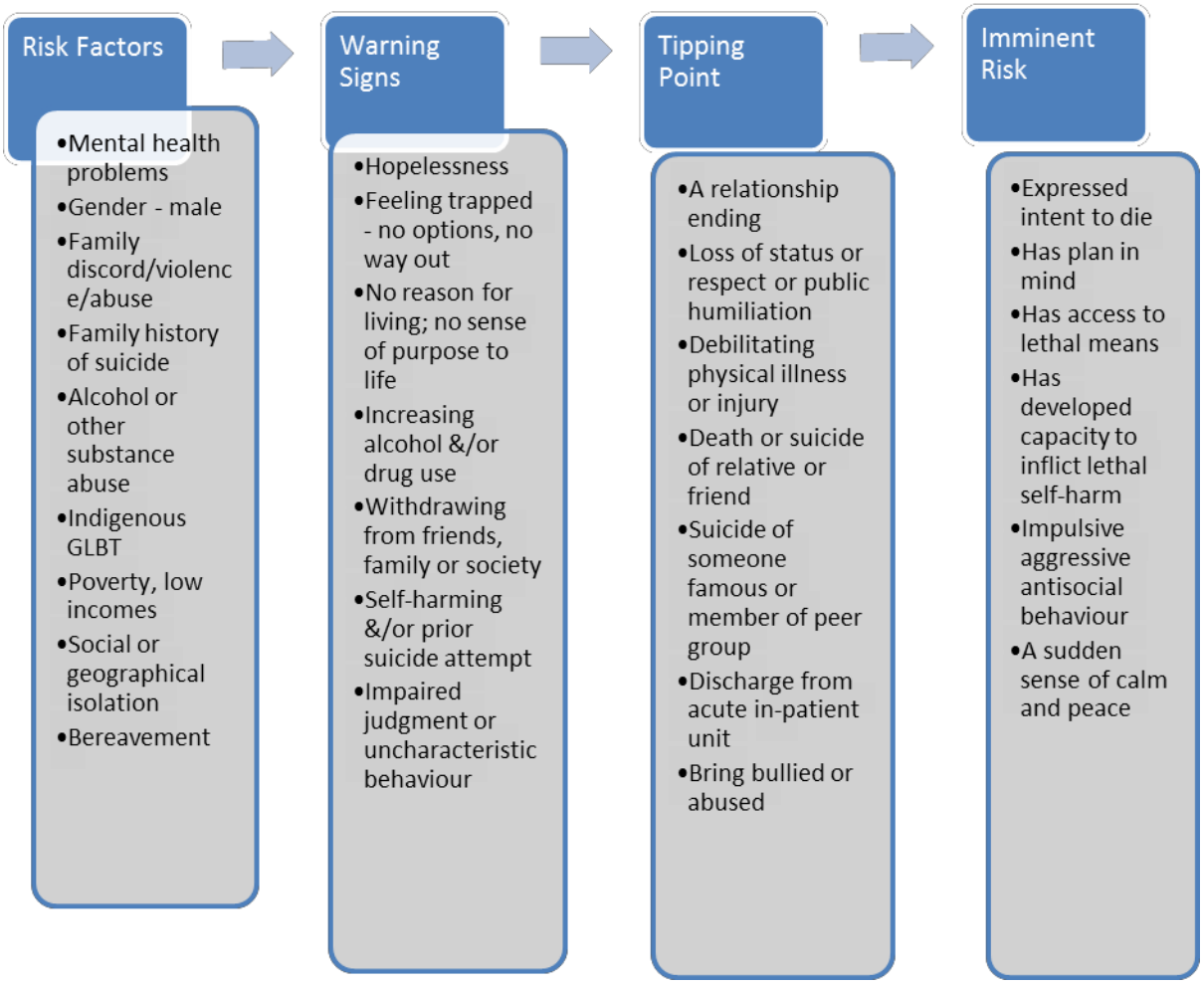
(Source: AIHW, A review of suicide statistics in Australia, (2009), p. 19)

Appendix 1.9 The Australian mortality statistics system



(Source: De Leo et al., (2010), p. 452)

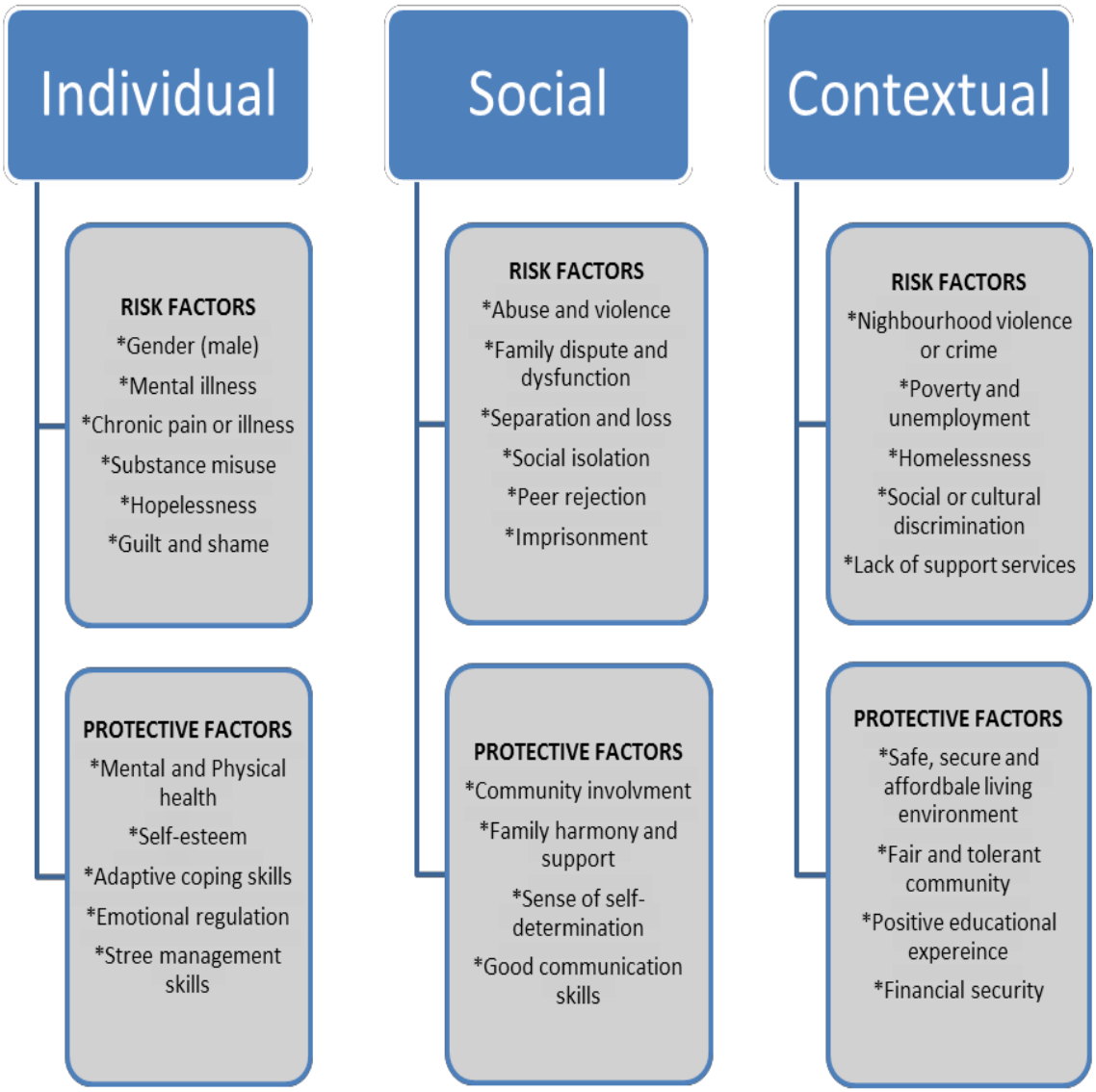
Appendix 1.10 The transition from risk factors to the point of imminent risk



(Source: Bycroft, (2010) cited in Lifeline Australia, 2011).

Appendix 1.11 Risk and Protective Factors at the Individual, Social and Contextual levels

(Department of Health & Ageing, 2007).



(Source: Lifeline Australia, 2011)

Appendix 1.12 Conceptual Social and Emotional Wellbeing Framework

'If we don't have good SEWB (physical, social, emotional, spiritual and cultural) we're at risk of mental ill -health and/or suicide'