

Indigenous Dreaming: How Suicide in the Context of Substance Abuse has Impacted On and Shattered the Dreams and Reality of Indigenous Communities in Northern Territory, Australia

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LEONORE HANSENS

PhD Student Charles Darwin University.

Objective: To identify factors that contribute to the clustering of suicide and contagion effect operating within these clusters to validate the unique phenomenon existing in the Northern Territory.

Methods: National Coroners Information System (NCIS) external cause of death, intentional self-harm data from 2001 – 2005 were examined and Indigenous status was identified and verified. NCIS data containing ICD 10 codes were analysed to provide data on location of suicide within zones and health districts for the NT using statistical local areas (SLA's) and other identifiers. The specific location of the death within the community was also obtained by the same method. Another source of data was obtained from the Australian Bureau of Statistics – Confidentialised Unit Record File (CURF) data to identify co-morbidities for all causes of external and sudden death including suicide for all ages in the NT from 1997 – 2000.

Results: Prevalence rates within “hotspots” based on Statistical Local Areas of the NT were identified with rates of suicide in 2002 for Tiwi Islands 261.6 per 100,000; Tanami's 136.2 per 100,000 and East Arnhem 66.9 per 100,000. Analysis of the 2001 – 2005 NCIS data supports the evidence of “clustering” and the unique feature of “echo clusters” in Indigenous communities in the NT. ICD-10 coded NCIS data revealed that 65% of suicides occurred in or around the home, 22% occurred in bushland or campsites adjacent to the community and 13% occurred in institutions or in a prominent place in the town or Indigenous community. Analysis of the CURF data for all external causes of death for Indigenous people from 1997 – 2000 in the NT provides evidence of the definitive role (from 45% - 70%) alcohol and other substance use plays in co-morbid mental, physical and behavioural disorders in external cause of death.

Discussion: Some communities appear as “hotspots” for suicide and then recover before another cluster of suicides; others experience “echo clusters” and appear to remain in the grip of suicide and are communities “at risk”. The way the Indigenous culture is brought to bear on any death means the necessary relocation of the household after the death of a loved one in the

home. The impact of the relocation and mobility after a suicide has multiple implications on Indigenous families and may be another factor in contagion effect of suicide from one family group to another and one community to another. Underlying co-morbidities at the time of death provide further evidence of the complex picture of suicide and other sudden death with co-morbid substance use and mental health conditions being most prevalent.

Conclusion: The cultural requirements that impact on an Indigenous family after a death, particularly a suicide, are in the context of a vulnerable community in a time of crisis. The social, emotional and economic consequences of suicide on an already deprived and disadvantaged people are apparent in the burden of co-morbidity existing within the Indigenous communities.

Suicide in Indigenous communities in the Northern Territory has so rapidly disrupted and destroyed Indigenous families, culture and communities that it has been impossible for Indigenous Elders to make sense of and incorporate this phenomenon into Indigenous Dreaming or Law. The current research at Charles Darwin University into clusters of suicide and contagion effect of suicide within Indigenous communities in the Northern Territory, Australia is a beginning in understanding this tragic issue from both Indigenous and non-Indigenous worldviews¹. This research also chronicles the narratives and social constructs behind the responses to Indigenous suicide in the political and bureaucratic reality of the NT and is providing disturbing evidence of the shattered spirit of Indigenous people. The Indigenous Elders I have spoken to in the Northern Territory insist that suicide is not part of their culture and therefore it poses an impossible reality to incorporate into their culture, law and their “Dreaming”.

This article, the third in a series, presents data which provides an indication that suicide is different in Indigenous communities be they urban, rural or remote². The preliminary data also highlights the devastation and havoc that suicide is wreaking in these communities and that unique and uniform approaches to suicide prevention and service provision must be developed urgently across the NT. Hanssens et al (2007)

identified that a higher than normal distribution of suicide clusters has occurred in the NT Indigenous population. The clusters identified are evenly distributed across space, that is, urban, rural and remote geographical locations in the NT. The distribution is also across time, that is, the eleven-year period of the study 1996–2006, providing evidence that clusters are an enduring feature of Indigenous suicide in the Northern Territory. A unique phenomenon, referred to as “echo clusters”, has been demonstrated on the Tiwi Islands community and as the term suggests they are subsequent but distinct clusters of suicide occurring after an initial cluster. This phenomenon has resulted in eight clusters within eleven years on the island community. Whereas, in other locations in the NT, a cluster of two or more suicides within an eighteen-month time period and within the same community and tribal group, provide evidence of the cluster phenomenon¹. Aputimi (2007), an Aboriginal Mental Health Worker on the Tiwi Islands, claims that in 2002 there were ten Tiwi Island people who completed suicide from the island with four dying on the mainland in other communities³. Evidence of clusters appears to be widespread throughout all regions, and there is a community perception of suicide clusters with communities unanimous in their concern about a “copycat” contagion element connecting the suicides^{3, 4}. Other researchers suggest that Indigenous people tend to cluster well before any overtly suicidal stimulus enters the cluster group⁵.

It is important to state that for almost seven years prior to commencing this research I coordinated a response to completed suicides and serious suicide attempts in my role as coordinator of the Life Promotion Program DHCS 1999–2006. I developed a positive professional relationship and collaborated with the NT Coroner’s Office during this period to deliver an inter-agency model of response to suicide. I was therefore intimately aware that suicides were occurring in clusters but needed to obtain reliable evidence to prove the phenomenon existed¹. In collaboration with my Indigenous colleagues I was providing reports to management referring to the cluster phenomenon but it was only as I began sourcing data from the National Coroners Information System and also the local data from the NT Coroners Office database that there emerged irrefutable evidence of these cluster suicides⁶.

In 2006 at the commencement of my PhD with Charles Darwin University I supported SBS Video Journalist, Angela Bates, who developed a story on “Suicide in Aboriginal Communities”⁷. It was shown on Living Black on 17th May 2006, Series 5: Episode 11. I was interviewed to provide the research background on the issue in the Northern Territory. Since the SBS story went to air the tertiary services that were previously unavailable to the Aboriginal Mental Health Workers (AMHW’s) on the Tiwi Islands have been set in place as an acceptable and reliable referral pathway for their Indigenous clients into the mental health system. A psychiatric nurse is now permanently based on the Island and a psychiatrist visits on a regular basis. Since the provision of tertiary services to support the existing secondary and primary services on the island the suicides have dramatically decreased. The SBS story and its outcome demonstrates the need for a comprehensive tertiary level of mental health service provision to be rolled out to Indigenous people and communities across the Northern Territory³.

This in no way suggests that the primary services (community night patrol and crisis intervention committee) or secondary services (Aboriginal Mental Health Workers) were not adequate. Rather, they simply required the same tertiary service and referral pathway that all suicidal and mentally ill people require. The AMHW’s were often required to keep watch on suicidal clients and were working a twenty-four hour day, seven days a week, with burn-out being a major issue³. The SBS story highlighted these needs, which resulted in the services being provided commensurate with the identified need. My Indigenous colleagues and I have since used this story for presentations at workshops and conferences to raise awareness of the issues of Indigenous suicide in all communities in the Northern Territory and Australia. Recent research in Scotland has highlighted the same issues with the poorer social classes suffering greater deprivation resulting in higher suicide rates across all geographical locations whether urban, rural or remote. Stark (2007) and his colleagues used four variables to identify deprivation: unemployment, lack of a car, overcrowding and social class (status). It found that deprivation is associated with higher rates of suicide at all levels of population density, in all age groups but particularly in men⁸. More than a quarter of Indigenous people in Australia live in remote or very remote locations and have similar deprivation with “very little or very restricted access to goods and services and opportunities for social interaction” particularly, Drug and Alcohol or Mental Health services⁹.

Methods

The Northern Territory Coroner’s Office supplies complete data to the National Coroners Information System (NCIS) and the Victorian Institute of Forensic Medicine (VIFM), which includes the full text of coroners findings, autopsy reports, toxicology reports and police narratives¹⁰. This information is available to researchers who apply to the VIFM for access to the data. Ethics approval for this research was obtained from the Charles Darwin University Human Research Ethics Committee (HREC), and then submitted to the Victorian Institute of Forensic Medicine HREC. Once the approval was obtained an Access Agreement was then signed between both institutions with full privacy and confidentiality clauses as a condition of use of the database. Charles Darwin University is currently the only research institution within the Northern Territory that has access to the NCIS database, which has allowed research into Indigenous suicide in the Northern Territory to be fully investigated¹.

From July 2000 until June 2006 there were 1,832 cases on the NCIS database from the Northern Territory with 279 having been coded as intentional self-harm at either case notification or case completion¹⁰. The ‘presumed’ intent of the deceased is recorded when the case is first notified to the Coroner’s Office and then it is again coded based on the decision made by the Coroner in the Finding when the case is closed. Deaths coded as “intentional self-harm” are affected by a range of factors relating to the collection, coding and processing of cause of death data and often depend on the amount of information available to the Coroner. The National Coroner’s Information System now provides the International Classifications of Diseases 10th Edition (ICD-10) codes, as an additional data

source within its database and includes ICD-10 Cause of Death codes (primary and underlying codes) and Australian Standard Geographical Classification (ASGC) Residential location codes. Researchers, with basic training from NCIS, are now able to ascertain multiple co-morbidities relating to cause of death, for example mental and behavioural disorders due to substance misuse; post natal depression and unspecified dementia and so on. The remaining ICD-10 Codes provide the statistical local area and geographical location of death and the exact place of death within the town or community without having to search through coroner's records manually¹⁰.

As in other jurisdictions in Australia the post-mortem reports contain summaries of information describing the death, and include demographic data of the deceased, cause of death, circumstances surrounding the death, witness statements from next of kin and others, police reports, medical records, and autopsy reports with toxicology results. The NT Coroner authorises the autopsy, which is carried out at the Royal Darwin Hospital Forensic Pathology Unit and all reports are forwarded to the NT Coroners Office. The method developed by NCIS to code the "Cause of Death" is rigorous in both its approach and its validation and permits the consistent coding of nine major categories of ICD-10 codes to be entered into the database after the Coroner has made the decision on cause of death. The Coroner's office in each jurisdiction has expended funds on training staff to correctly code and input the detailed information on every completed file. A quality assessor at NCIS, VIFM then checks this data therefore providing an accurate and reliable system for the storage and retrieval of coronial information for researchers, policy makers and the community alike in our various roles in untimely death prevention¹⁰.

Confidentialised Unit Record File (CURF) data was also obtained from the Australian Bureau of Statistics (ABS) to provide a broad spectrum of co-morbidities associated with external causes of death in the Northern Territory. Of the nine main ICD-10 coded co-morbidities the selection of the five most common co-morbidities for each group was made. This provides a variety of data from external causes of death relating to co-morbid conditions in the context of mental and behavioural disorders. Analysis of all external causes of death data has not been cross-analysed with suicide deaths because, even at the broad level, the numbers then became too low and too ineffective to be estimated from an analysis of published data and estimates of the "not-published" data. The "not-

published" (NPs) items were estimated in accordance with the ABS rules to maintain the confidentialized nature of the data. The NPs were replaced with estimates, that is, ABS uses NP when the value in the cell is one or two (always) and three or four (randomly). This can have some effect on the minutiae of accuracy but the data is primarily provided to present overall trends in co-morbidity in the Northern Territory¹¹.

Results:

(National Coroners Information System Data)

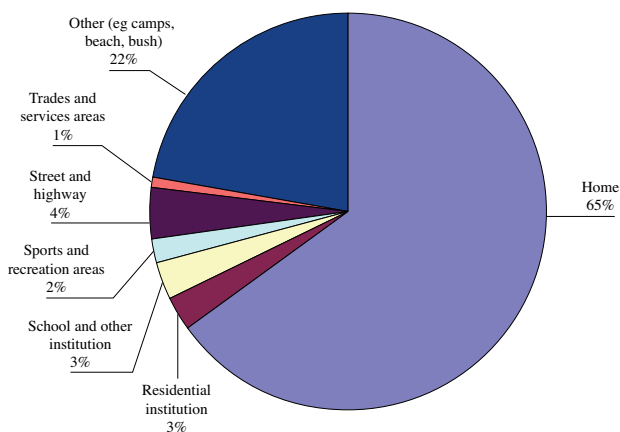
Place of death data / Intentional Self-Harm NCIS, VIFM (2001 – 2005).

The pie chart (below left) identifies that 65% of completed suicides occur in or around the home and that 22% occur adjacent to the community in bushland, camps or beach sites and that 13% either occur in an institution or in a prominent place within the town or Indigenous community. The place of suicide within the home of the suicide victim will have lasting effects on the family of the victim. The impact on the family is not only an emotional one from extreme trauma and grief but also a physical and financial burden with the family nearly always compelled to leave the family home after the completed suicide for cultural reasons. This is consistent with cultural requirements after the death of a loved one that ceremonies must be conducted in and around the home before the home can be re-occupied. It means that the family must find lodgings elsewhere and often with extended family who may already be under pressure for space within their home or outstation. Many families have had to live in makeshift dwellings or tents after vacating their homes after the death of a family member. Preliminary data from focus group interviews with community members suggest that the relocation of families is yet another factor that puts the whole community under stress, particularly after a sudden and traumatic suicide death.

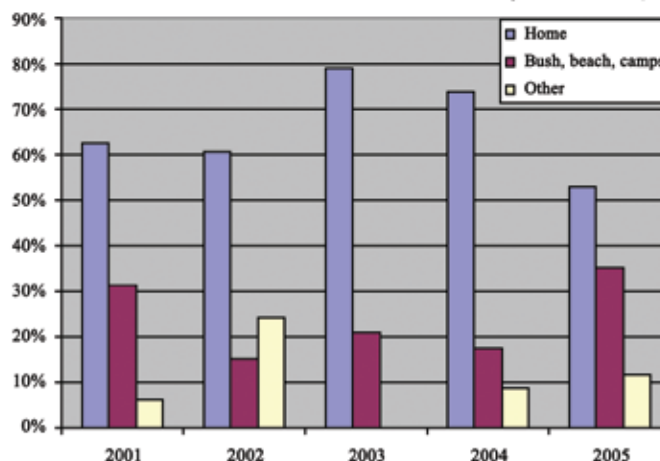
Place of death data / Intentional Self-Harm NCIS, VIFM (2001 – 2005).

The graph below provides consistent evidence that suicide deaths are occurring in the home. This has repercussions on Indigenous communities and Northern Territory towns as they may have the issue of relocation of whole families. The relocation adds to the financial costs of a funeral and the extraordinary emotional stress and financial burden facing the

Place of Suicide Incident 2001–2005 (n=108)



Place Location of Suicide within Town or Community 2001–2005 (n=108)



family. The impact of suicide on a family is always processed with feelings of doubt, fear, guilt, anger, blame, shame, extreme sadness and traumatic grief¹². But the added cultural component in the Northern Territory requires that we provide support with a more sensitive approach to reduce the impact of the death whether by suicide or other sudden death. This data will have implications on NT housing authorities and community government councils who are required to provide public and emergency housing to the majority of Indigenous people in the NT.

Often the whole Indigenous community grieves at the same time, collectively, and after a death it will involve the Indigenous council making decisions about restrictions, for example, restricting access in and out of the community during “sorry business”; restricting sales of alcohol immediately after the death and during and after the funeral. It is particularly important that people away from their homeland, in prison or in hospital, are given an opportunity to go to the funeral to pay their respects. Otherwise there can be a perception from the family or community that the person who missed attending the funeral had something to do with the death, whether the death is by suicide or other sudden death. Again there could be issues of (self) blaming to contend with for not attending the funeral and could also be a risk factor and lead to further suicides. These issues build tension within the community while it is in “shutdown mode”, and vulnerable people, particularly the young or people connected to the deceased person are at increased risk. The cultural safety of the whole community experiencing the aftermath of a suicide might mean that the whole community is deemed ‘at risk’ and safeguards and response plans need to be set in place to assess suicide risk within the community. Suicide bereavement is often described as complicated grief but in Indigenous communities that often takes on a whole new meaning as contagion effect or “copycat” suicides can occur and a cluster of suicide can result with the whole community in a crisis.

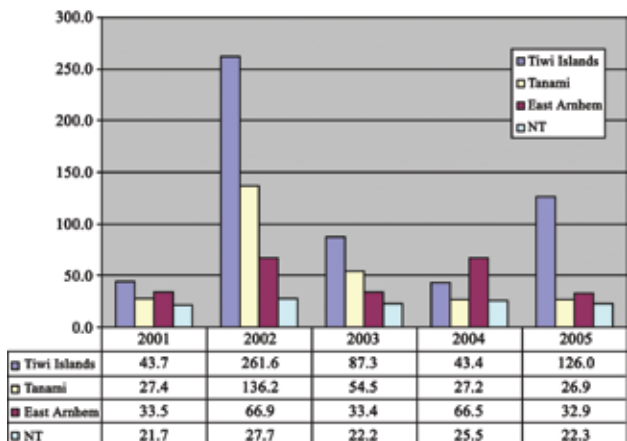
Currently there are few services in the Northern Territory that are aware of, or can meet the requirements of, this emotional burden, family distress and situational crisis that accompanies a suicide or traumatic death. A coordinated bereavement service is necessary to provide the brokerage required to meet this identified gap in the response to completed suicide particularly for Indigenous families and communities. The cultural safety and security of Indigenous people after a completed suicide or

other sudden death, for example homicide or a natural or man-made disaster, have not been fully explored. The postvention services required to provide bereavement care and support to the surviving family, friends and community members of the person who died by suicide or other sudden death should be allocated commensurate with need⁴. This is an important issue within a collective community where so many funerals are occurring with unresolved grief and loss resulting in many communities being in a constant state of bereavement due to “sorry business”. Many of the deceased bodies are “waiting in line” for burial because the community cannot cope physically or financially with the number of funerals.

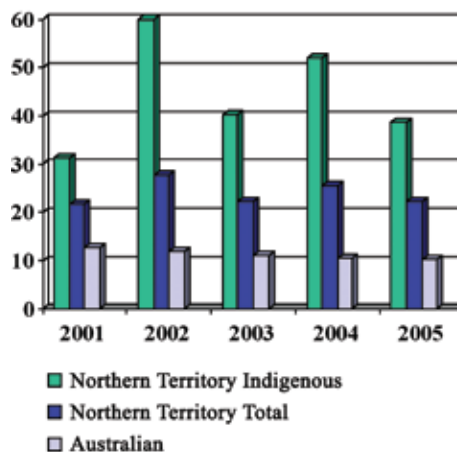
Statistical Local Area / Intentional Self-Harm – NCIS, VIFM. Population estimates data ABS (2001 – 2005).

The graph (below left) demonstrates some “hotspots” for Indigenous suicide in the Northern Territory and also again confirms the “echo clusters” on the Tiwi Islands¹. The dramatically high rates, particularly for the Tiwi Islands and the Tanami, are hidden within the high but reasonably consistent rates of completed suicide in the Northern Territory. These are not the only “hotspots” in the NT but they demonstrate the efficacy of the research, which allows the drilling down into the NCIS data to identify these “hotspots” and “echo clusters” of Indigenous suicide very quickly. Analysis of the NCIS data provides evidence to suggest that some suicide clusters were encapsulated within very tight timeframes, for example six suicides within a four-month period on the Tiwi Islands community in 2002¹. The evidence that suicides are clustering and that contagion are operating has been a clearly “identified need” and what is required now is a level of interventions “commensurate with need” to be allocated⁴. This data can have immediate policy and planning implications for government and non-government strategic development in reducing Indigenous suicide in the Northern Territory. The recent strategic planning day conducted in Darwin in mid-September by the Northern Territory Suicide Prevention Committee and facilitated by ORYGEN Monash University need to tap into local researchers and local institutions, for example Charles Darwin University and Batchelor Institute, to provide accurate data and a timely evidence base for suicide prevention^{1, 4}. It also requires the collaboration of the Northern Territory Coroner to support an evidence-based Alcohol and Other Drugs Program, and the Mental Health Directorate to provide appropriate services and

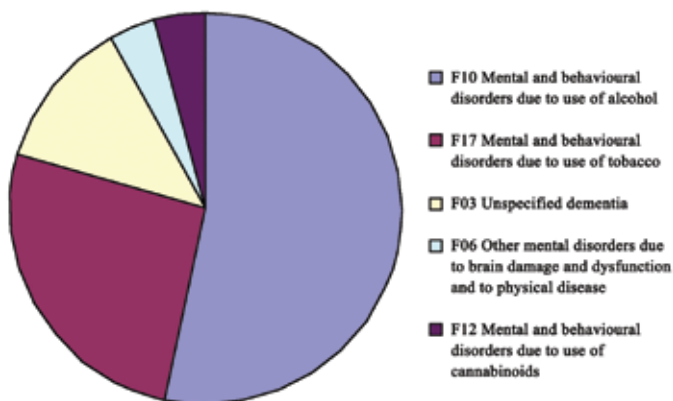
Geographic Location – Northern Territory Indigenous Rates of Suicide 2001–2005



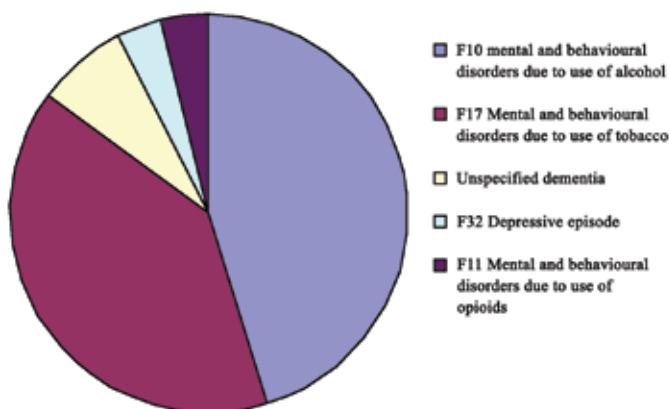
Suicide Rate per 100,000 (2001–2005)



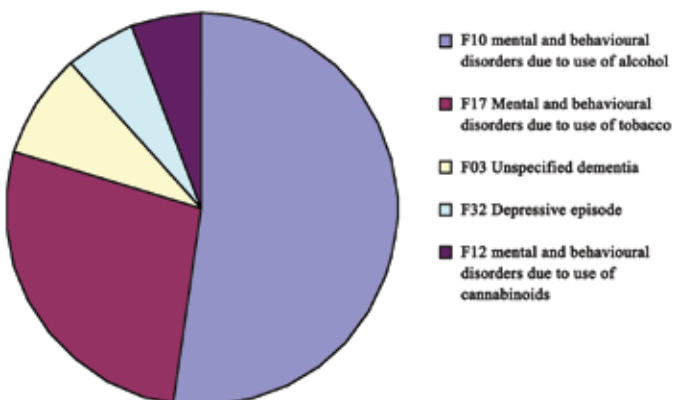
**Indigenous Males and Females Deaths – All Ages
Comorbidity 1997–2000 (n=347)**



**All Northern Territory Indigenous Female Comorbidity
All Ages (n=63) 1997–2000**



**All Northern Territory Indigenous Male Comorbidity
All Ages (n=85) 1997–2000**



referral pathways uniformly across the Northern Territory.

NT Indigenous Suicide rates appear to be consistently almost double the total NT rate and several times the national rate per 100,000 (crude) 2001 – 2005.

**Intentional Self-Harm – NCIS, VIFM.
Population estimates data ABS (2001 – 2005).**

While the overall suicide rate appears to show some stability and towards a decline in the Northern Territory, notwithstanding the innovative ways that suicide deaths can be recorded, the Indigenous rate of suicide is still consistently almost double the total rate in the NT and several times the national rate¹³. This has much to do with the method used by Indigenous people (86% by hanging) since a hanging cannot be insinuated to be accidental and is rarely suggested not to be self-inflicted. Therefore the Indigenous suicides are at least, in most cases, recorded accurately and the only issue in question may be Indigeneity, for example the deceased may not be recorded as an Indigenous person either at birth or death. The NT Indigenous deaths that occur outside the boundaries of the Northern Territory, but which are recognised as suicide deaths within the person’s community of origin, still remain problematic, as the data record will not show up in the Northern Territory Coroner’s data. This is because all deaths that require a coronial inquest are referred to the Coroner with the jurisdictional responsibility associated with the geographical location of the death. These issues above provide the potential for inaccuracies, that is the recording of “Cause of Death”; identifying the “Indigenous” status of the deceased; and a death outside the NT to impact on the reliability of data¹⁴.

Results:

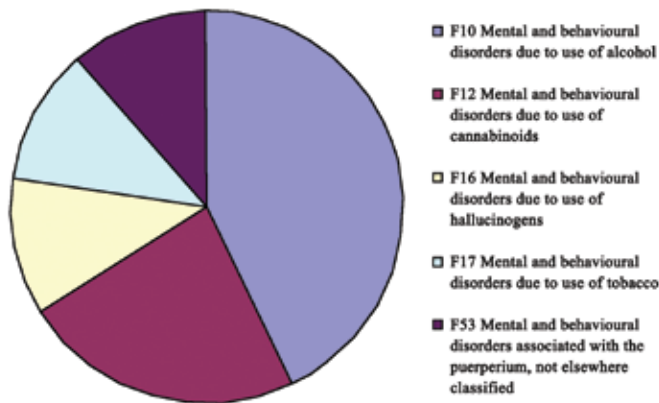
(Confidentialised Unit Record File data)

CURF data obtained from ABS 1997 – 2000.

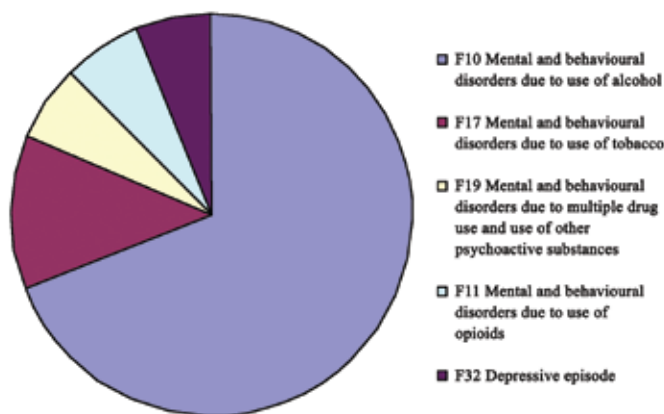
The first graph (top left) provides combined CURF data for Indigenous males and females of all ages (n=347) 1997–2000. The next two graphs provide gender specific data for the same years with firstly, Indigenous females (n=63) all ages then secondly, Indigenous males (n=85) all ages. The last three graphs (right) provide combined NT Indigenous male and female data and age breakdown 1997–2000, firstly 15–24 years (n=35); secondly 25–34 years (n=80); and thirdly 35 years and over (n=224).

There were some differences in co-morbidities between male and female Indigenous mortality data and there were some age-related differences between Indigenous young men and older adult men, particularly the items that appear for the 15–24 and the 25–34 year olds. As expected the co-morbidities in the young (15–24yrs) and early Indigenous adults (25–34yrs) were more significant and correlate with the high suicide rates in these age groups. The previous research found that 82% of Indigenous suicide victims were in the 15–35 year age group and it could be suggested from the CURF data that suicide in this age group is more likely to be spontaneous and in the context of alcohol and psychoactive substance use¹. Westerman (2007) also found a strong relationship between impulsivity and suicide risk¹⁵. Whereas, in the older age groups 35 years and over (n=224) there appears to be the likelihood

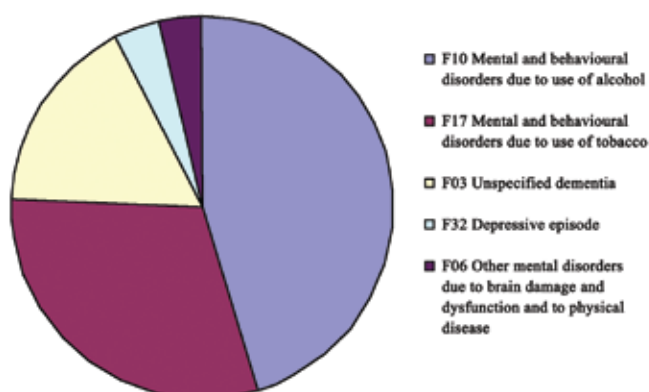
**All Northern Territory Indigenous Males and Females 15–24 years
Comorbidity (n=35) 1997–2000**



**All Northern Territory Indigenous Males and Females 25–34 years
Comorbidity (n=80) 1997–2000**



**All Northern Territory Indigenous Males and Females 35 years plus
Comorbidity (n=224) 1997–2000**



of some physical impairment or brain damage from long-term substance misuse.

The differences are particularly obvious in the items that appear for mental and behavioural disorders due to the use of alcohol, with 65% prevalence in older adults and 45% prevalence in younger adults. Hanssens (2007) demonstrated the strong correlation between alcohol and hanging 71%; and alcohol and all methods of suicide 77% in the previous research⁴. A different picture was seen for other drug use with a larger use of cannabinoids and hallucinogens in the young 30% and the preference for less in the older adults, that is 20%, but with multiple drug use including opioids. Mention should be made of the causal relationship between cannabis use and psychosis with a causal pathway to suicide that has been demonstrated in other research¹⁶. Indigenous women tend to smoke tobacco more, drink less alcohol compared to men, and use less other substances. Whereas, Indigenous men tend to consume more alcohol, tobacco and other substances, with the health impacts of alcohol consumption increasing as they age, resulting in either depressive episodes, alcohol related dementia, brain damage or dysfunction and premature death. Previous research by Hanssens et al (2007) revealed that males represented 91% of Indigenous suicide in the Northern Territory and that alcohol was present in 77% of all completed suicides^{1, 4}. Research in Western Australia has validated the above findings with suicide being the most common alcohol-attributable cause of death for Indigenous males in the Northern Territory¹⁷.

Analysis of CURF data provides evidence of the strong role that co-morbidity of mental disorders and substance abuse plays in mortality related to “external causes of death” among Indigenous people in the NT. Multiple cause of death data from CURF is currently an untapped source of data for research and presently rarely used in the NT or elsewhere in Australia. The analysis of external causes of death data has not been cross-analysed with suicide deaths, instead deaths by suicide are just one of the several “external causes of death”. It would be useful to cross-analyse instances of suicide by mental and behavioural disorders, substance use, etc, but the numbers in the NT are far too small in the dataset (CURF 1997–2000) to undertake this level of analysis. Yet the analysis, so far, can add to complete the picture of morbidity and mortality where multiple causes of death occur as conditions that contribute to premature death of Indigenous people including suicide¹⁸. There is otherwise a lack of combined data on the incidence and prevalence of mental and behavioural disorders in the context of substance use among Indigenous people in the Northern Territory.

Discussion

The data in stage one of this research provides a baseline and an overall picture of the unique factors associated with Indigenous suicide in Northern Territory, Australia. The data is used to raise the issues with some crude testing for trends and phenomena within the Indigenous population being studied. The data quality, validity and reliability are also examined in the context of the cultural component of the study, for example the mobility of the population within the NT. The difficulty of coding “Cause of Death”, “Location of Death” and “Statistical Local Areas” for Indigenous peoples and communities is another

unique issue that may affect the rigour of the study. The former means that the person providing the data (usually the Coroner) and the person inputting the data (usually the Coroner's clerk) have certain procedures to follow and quality checks to make¹⁰. The latter is part of an ongoing effort by the Australian Bureau of Statistics to improve the collection of Indigenous data in general, particularly births and deaths¹¹. Sometimes the code in the field and the coding framework does not always fit with the "on the ground reality" of Indigenous settings. These complex settings involve cultural obligations, cultural restrictions and cultural reciprocity; extended family groups, tribal groups and language groups within the one community. For example, the mobility for cultural reasons resulting in a person being banned from a community; community violence and family fighting resulting in families having to leave a community and live on a nearby outstation with extended

the deceased, it is necessary to conduct the psychological autopsy interviews with the "next of kin". As yet the Northern Territory Coroner has not given his permission to Charles Darwin University to conduct these interviews, which are vital to provide this data.

The coronial inquest into the deaths of "The Tiwi Four" in 1998 highlighted Indigenous suicide as a public health issue of tragic proportions and illustrated the grave underlying social problems in the Northern Territory. Some of the problems outlined in the inquest report in 1999 were: alcohol abuse across the community; marijuana abuse; violence especially family violence; family breakdown; weakening of traditional and cultural values; lack of employment, sense of hopelessness and low self-esteem especially among young men. A judge presented a similar picture in 1977 when he made the following statement to describe youth in and around Alice Springs. It was



family or relatives. But when there is a death of a member of the community, cultural obligations require that all members of the community and relatives of the person must attend the funeral as a sign of respect. The deceased person may have died elsewhere but will be buried and recognised as a death in their community¹⁴. Therefore the data presented is used to contextualise the investigation into clusters of suicide and whether a contagion effect is operating within those clusters in Indigenous communities of the NT⁴.

The analysis of NCIS data including the ICD-10 codes has provided further evidence of the tighter relationship between the location of the suicide within the community and the time between deaths. With the data showing that sixty-five percent of Indigenous suicide victims are dying in or around the home strongly supports the hypothesis of contagion effect as most of the deaths were in full view of and having a direct impact on the family and the community. But to gain irrefutable evidence of this phenomenon and its impact on the family of

used again to describe youth on the Tiwi Islands in 1999 and used in the recent Wilde, Anderson report in 2007 to describe children in the Northern Territory thirty years later:

"... In dealing with Aboriginal children one must not overlook the tremendous social problems they face. They are growing up in an environment of confusion. They see many of their people beset with the problems of alcohol; they sense conflict and dilemma within; they find the strict but community-based cultural traditions of their people, their customs and philosophies set in competition with the more tempting short-term inducements of our society. In short the young Aboriginal is a child who requires tremendous care and attention, much thought, much consideration"¹⁹.

The thirty years from the initial writing of this statement to the carnage of suicide which began in NT Indigenous communities in the early 1990s continues into the 21st Century. Hunter et al describes a similar situation in North Queensland where children have grown up witnessing suicide,

nearly always a body hanging²⁰. As with the past fifteen years in the Northern Territory these children are having childhoods of turmoil and social chaos in the aftermath of each suicide; cluster of suicides; or waves of suicide that wash over their communities. Without adequate support after witnessing a completed suicide these children are highly at risk of self-harm and imitation particularly given the level of risk they live with as a constant in their lives. Young people and children witnessing this event not only become desensitised, but suicide, particularly hanging, is now becoming enculturated into the Indigenous adolescent culture. These suicide deaths by hanging occurring around the home are becoming a learned response to the distress and rejection many male youth and men are facing in Indigenous communities today⁴.

They have an environmental risk of suicide from a 'community at risk' that regularly witnesses a body hanging within the home, on the verandah of the home or nearby in bushland. Indigenous suicide most often occurs within or around the home environs with most (65%) dying at home and 22% dying in bushland or camps in riverbeds or beaches located near the community. Other places suicides occur in Indigenous communities, that is 13%, are located at landmarks, for instance a tree, a water tower, power pole or a football oval in full view of the whole community. In the light of these statistics, with most suicides being completed around the home or not far from the community, with or without other family members around, the efficacy of a twenty-four hour suicide watch plan is viable and culturally appropriate considering the close knit structure of Indigenous families and communities. Initial focus group interviews with Elders, and other community leaders verify that most suicides occur in the context of family drinking within drinking circles or clusters, with the inevitable family conflict resulting in perceived rejection. The role modelling of this behaviour, though justified in many cases, has long-term consequences on the ability to solve problems which are adverse life events. The community at risk, crisis intervention model developed by the Life Promotion Program (Top End) NT, provides initial evidence that suicide intervention training can be provided to people from each family, tribe, language, and clan group. They are then equipped to provide the "person at risk" with a formal or informal suicide watch, to be maintained by sober persons within the family or group from the community⁶. This primary intervention can be initiated until an assessment is conducted by the Aboriginal Mental Health Worker (secondary intervention) and psychiatric assessment conducted by the nurse or psychiatrist (tertiary intervention)³.

While presenting the data and drawing conclusions is important, it is essential to be mindful as a researcher of the cultural pitfalls and ambiguities of the data. For example, unemployment is a non-Indigenous construct but could be equated to a loss of land, purpose or will to live in an increasingly hostile environment²¹. Hunter et al (1999) and other researchers suggest exploring the meaning behind the data, beyond the non-Indigenous interpretation²². For example, what does unemployment and deprivation mean to an Indigenous man?^{1,8} What does a suicide death mean in the home of an Indigenous family when their roots are in their whole "country"? Are the increasing rates of Indigenous male suicide over the past two decades, increasing poverty and high levels of substance abuse impacting on Indigenous communities responsible for the beginning of a decline in fertility rates in

Indigenous people in the Northern Territory?^{19, 23, 24, 25}. These issues are significant and are rarely considered when support is given to an Indigenous family after a completed suicide, and will be the subject of further focus group interviews.

This paper is the third in a series investigating factors that lead to clustering of suicide in Indigenous communities in the NT. It has explored factors that contribute to Indigenous suicide or could trigger cluster suicides or contagion at a community level. The data provides some evidence of the burden of co-morbidity, particularly mental and behavioural disorders in the context of substance abuse, which may impact on the way a community responds to a completed suicide providing a "community at risk" scenario. It has explored some primary, secondary and tertiary interventions and responses that have early evidence of making an impact on the Tiwi Islands' devastating suicide rates. We know that mainstream responses for Indigenous suicide don't work on their own from other research in Australia²⁶. It is important that these Indigenous communities have the capacity to strike the right balance of Indigenous and non-Indigenous responses to the shattering experience of suicide. Indigenous Elders are finding the experience of suicide too deeply troubling and difficult to incorporate into their Law, Dreaming and Culture in Indigenous communities in the Northern Territory.

When Pope John Paul II met with the Indigenous people of the Northern Territory in Alice Springs in 1986 he could see their tangible suffering but he could also see the beginning of a new Dreaming born out of their suffering and in his homily at the celebratory Eucharist he announced:

"You are like a tree standing in the middle of a bush-fire sweeping through the timber. The leaves are scorched and the tough bark is scarred and burned, but inside the tree the sap is still flowing, and under the ground the roots are still strong. Like that tree you have endured the flames and you still have the power to be reborn. The time of this rebirth is now"²⁷.

An Indigenous artist Mrs Miriam-Rose Ungunmerr-Bauman from Daly River, Northern Territory, picked up on that metaphor and illustrated the Dreaming through a painting called "Tree of Life" depicting the Cross and incorporating her Dreaming called Dadirri, meaning silence or stillness. Ungunmerr-Bauman (1986) says that "through the silence we feel at home with the peacefulness of the bush and that is how we get renewed when we are confronted with the pressures of today's way of life"²⁸.

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Drop-in Doctors Will Fail Without Support from Existing Services

The Fred Hollows Foundation welcomes the federal government's commitment of a further \$100 million to address health problems, including cataract blindness, in remote Indigenous communities but says the proposed Remote Area Health Corps will fail unless it is integrated with, and backed up by, existing local services.

The Fred Hollows Foundation is currently working with the federal government and other partners in Central Australia to address a backlog of 350 cases of people who need urgent eye surgery.

"One of the essential components of our program is the involvement of the existing health services in the area. They work side by side with extra specialists who are brought in to address the urgent need," says Alison Edwards, manager of the Fred Hollows Foundation's Indigenous Program.

"In our experience, funds spent on visiting specialists are only well spent when they are linked to well resourced local health services. It is the local services that do the necessary outreach and help patients to attend appointments, as well as the critically important after-care and ongoing preventative care."

The Fred Hollows Foundation is coordinating the Central Australian Eye Health Program, which involves the federal government, the Northern Territory government, Central Australian Aboriginal Congress, Anyinginyi Health Aboriginal Corporation and the Eye Foundation.

The program is tackling some of the key barriers which have prevented people from getting the treatment they need. As a result of improved screening through regular outreach activities, patient support services and the provision of transport and accommodation, around 40 patients from remote Indigenous communities have arrived in Alice Springs this week to undergo eye surgery.

Ms Edwards says the Program aims to develop a better model of eye health service delivery and financing that will hopefully eliminate the need for blitz-like activities in the longer term.

She also emphasises that the goal must be to attract doctors and specialists who are prepared to live locally and preferably work as part of the existing Aboriginal Medical Services and the public health system.

"We need to look at making it more attractive for people to work in remote areas on a long-term basis. It goes without saying that doctors and specialists who know the community and are known by the community, who have a long term commitment to the area and a passion for its future, will achieve the best results," says Ms Edwards.

For more interviews or more information contact:

Alison Edwards
 Manager – Indigenous Program
 The Fred Hollows Foundation
 08 8941 5145

Joe Boughton-Dent
 Media and Communications Coordinator
 The Fred Hollows Foundation
 Email: jboughtondent@hollows.org