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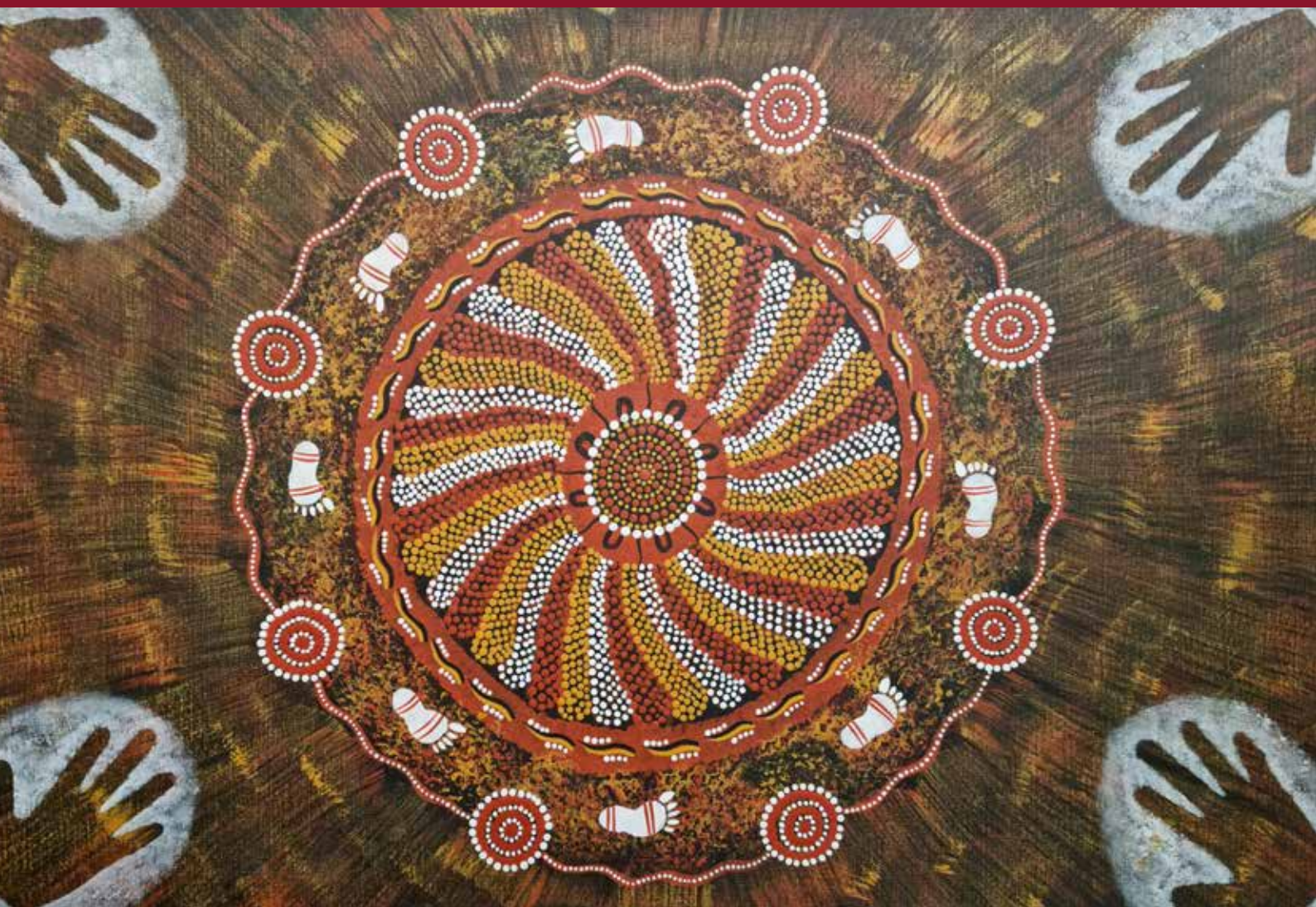
An overview of Indigenous mental health and suicide prevention in Australia

Greg Martin, Kirsten Lovelock and Brendan Stevenson



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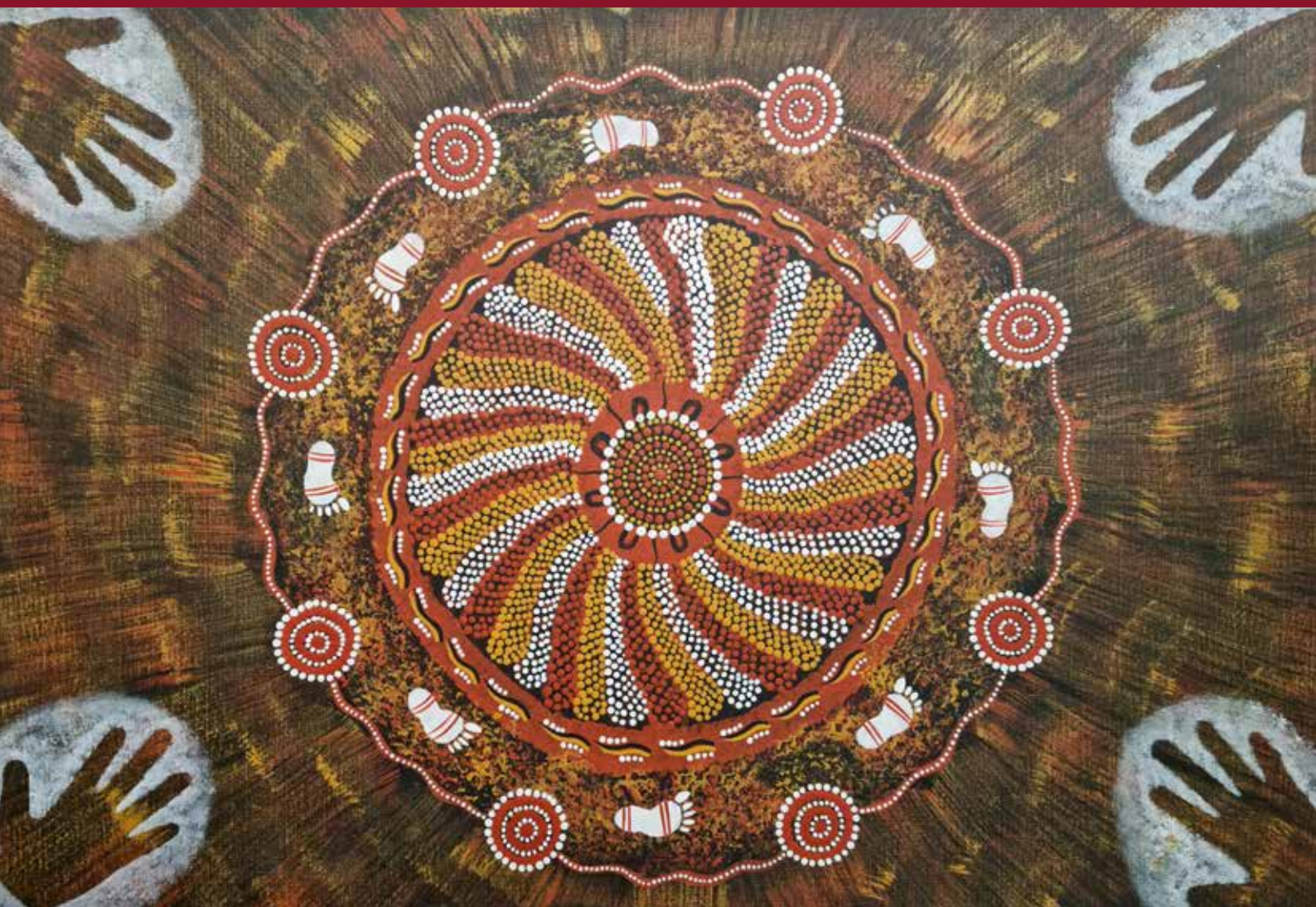

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ISBN 978-1-922802-29-3 (Online)
ISBN 978-1-922802-30-9 (Print)
DOI: 10.25816/gv9g-ge98

Suggested citation

Martin G, Lovelock K and Stevenson B, 2023. *An overview of Indigenous mental health and suicide prevention in Australia*. Catalogue number IMH 14, Australian Institute of Health and Welfare, Australian Government.

Any enquiries about or comments on this publication should be directed to:
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Published by the Australian Institute of Health and Welfare.

Please note that there is the potential for minor revisions of data in this report. Please check the online version at www.aihw.gov.au for any amendments.

Contents

About the cover artwork:

Artist: Linda Huddleston

Title: The journey towards healing

At the centre of the artwork is the Clearinghouse. The black half-circles are the people who come to the Clearinghouse for information about mental health and suicide prevention.

The waves of red, yellow and white dots surrounding the inner circle represent strength and healing.

The footprints represent the journey towards healing.

The red and white circles around the edge represent different programs and policies aimed at helping people heal.

The hands represent success and wellbeing.

Summary

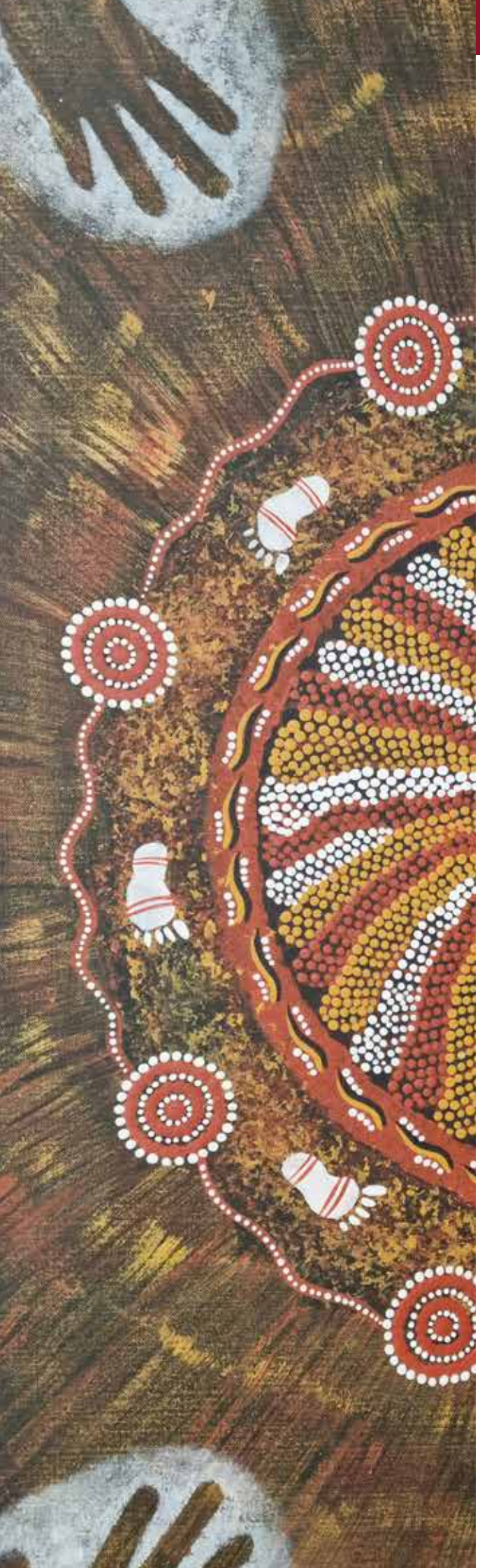
Aboriginal and Torres Strait Islander people (Indigenous Australians) are diverse, have a rich cultural history and deep connection to family, community, and culture. However, they have been burdened by the trauma of colonisation and their marginalisation in Australian society. This trauma continues to be transmitted across generations. Exposure to stressors such as institutional and cultural racism and socioeconomic marginalisation continues and plays out in all measures of mental health and wellbeing:

- In 2018–19, 31% of Aboriginal and Torres Strait Islander adults had high or very high rates of psychological distress – an increase of 4% since it was last measured in 2004–05 (ABS 2019b).
- Almost a quarter (24%) of Indigenous Australians reported a diagnosed mental health or behavioural condition in 2018–19 (ABS 2019b).
- In 2016–2020, suicide was the fifth leading cause of death for Indigenous Australians; the second leading cause of death for Indigenous males; and 10th leading cause of death for Indigenous females. It was the leading cause of death for Indigenous children in the same period (ABS 2021a).
- 'Mental & substance use disorders' were the leading cause of total burden and non-fatal burden among Indigenous Australians in 2018, with these disorders making up 23% of total burden, 42% of non-fatal burden (AIHW 2022a).

Indigenous Australians have a holistic conceptualisation of health, mental health and wellbeing, outlined by the social and emotional wellbeing (SEWB) framework. SEWB is affected by multiple, interconnected elements over the life course. Mental health and suicide prevention programs that are framed using SEWB recognise that emotional wellbeing is comprised of a balance between 7 domains of the body; mind and emotions; family and kinship; community; culture; Country; and spirituality and ancestors.

There are important protective factors for mental health, wellbeing and suicide, which can serve as a source of strength – aiding recovery and resilience when faced with adversity. Protective factors include unique aspects of Indigenous culture, such as connection to land, culture, spirituality, ancestry, kinship networks, family and community. Many risk factors for mental ill health and suicide are disproportionately or wholly experienced by Indigenous Australians, such as removal from family; loss of culture; and impacts of the Stolen Generations.

Improving mental health and wellbeing and preventing the suicide of Indigenous Australians are priorities for all Australian governments. The Fifth National Mental Health and Suicide Plan (2017–2022) saw all governments sign up to a set of actionable and agreed strategies to address social and emotional wellbeing, mental illness, and suicide for Aboriginal and Torres Strait Islander people. Meanwhile, the new *Closing the Gap* agreement in 2020 acknowledged the importance of governments working with Indigenous Australians to overcome the inequality experienced by Aboriginal and Torres Strait Islander people. It commits governments to a community-led, strengths-based approach to designing the policies and programs needed to drive outcomes.



1

Introduction

1 Introduction

For many Aboriginal and Torres Strait Islander people, social and emotional wellbeing is the basis of good physical and mental health. It is a holistic concept that encompasses the wellbeing of communities, families and cultures. Western medical health models do not generally appreciate the importance of social and emotional wellbeing, nor the impact of colonisation, racism and trauma on Indigenous Australians.

Suicide is a leading cause of mortality for Indigenous Australians. In 2018–19, almost a third (31%) of Indigenous Australian adults had high or very high levels of psychological distress, and a quarter (24%) of Indigenous Australians had a diagnosed mental health or behavioural condition (ABS 2019b).

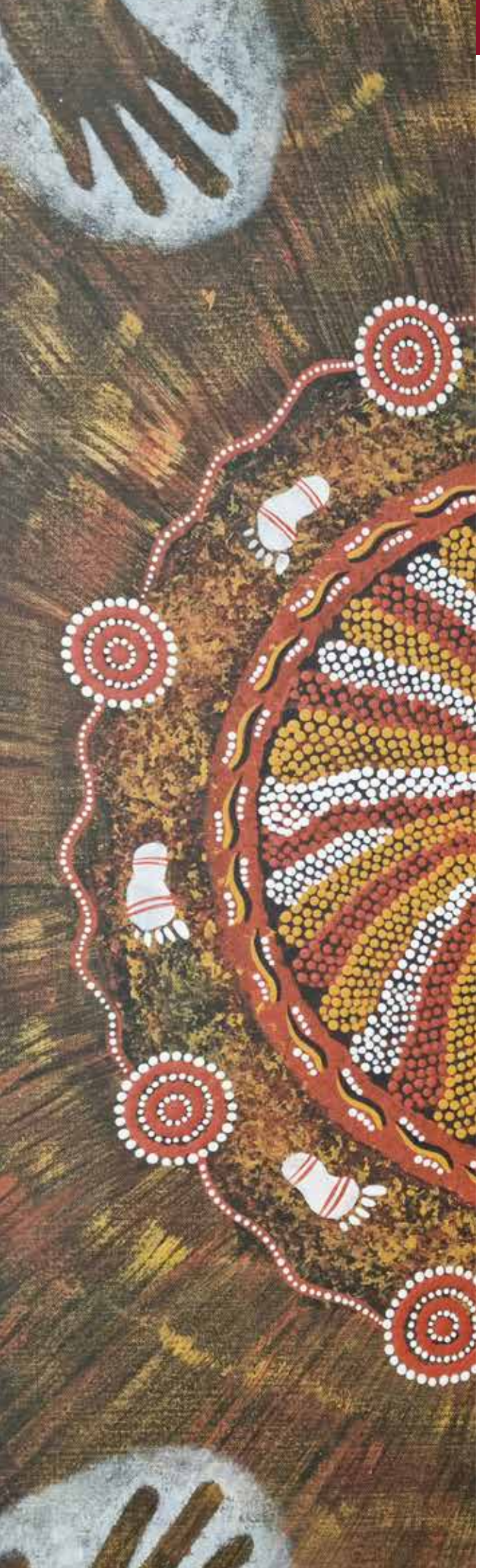
Understanding what works, why, and what does not work to improve Indigenous Australians' mental health and prevent suicide is a public health priority for all Australian governments.

The Australian Institute of Health and Welfare (AIHW) created the Indigenous Mental Health and Suicide Prevention Clearinghouse (the Clearinghouse) in 2021 to promote emerging research, programs, evaluations and policies relating to Indigenous mental health, suicide prevention and social and emotional wellbeing (see Box 4.1).

This Clearinghouse article provides an overview of Indigenous mental health and suicide prevention. It outlines:

- Indigenous Australian contemporary history, including cultural dislocation and intergenerational trauma
- the domains of Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB), and cultural determinants of health and wellbeing
- what we know about the status of Indigenous mental health, including mental health prevalence and trends, suicide and self-harm, barriers to services and data quality issues
- current policies and efforts to improve Indigenous mental health
- the protective and risk factors for social and emotional wellbeing, mental health and preventing suicides.

The article concludes with a summary of the key messages from this report – essential information for understanding Indigenous mental health, wellbeing and suicide prevention initiatives.



2

Background

2 Background

Aboriginal and Torres Strait Islander cultures are some of the oldest continuing cultures on Earth. The survival of these rich cultures is testament to community resilience and the strength of Indigenous Australians. Understanding past events, particularly the effect of recent history, provides an important foundation for understanding the wellbeing of Indigenous Australians.

Demography

Aboriginal and Torres Strait Islander people comprise a small but diverse proportion of the Australian population. Preliminary data from the 2021 Census estimates the Aboriginal and Torres Strait Islander population to be 984,000 (ABS 2022). In 2016, there were 798,400 Aboriginal and Torres Strait Islander people living in Australia, representing 3.3% of the Australian population (ABS 2019a). This included:

- Aboriginal people (91%)
- Torres Strait Islander people (4.8%)
- people who were both Aboriginal and Torres Strait Islander (4.0%) (ABS 2018).

Indigenous Australians are relatively young, with a median age of 20.3 years compared with 37.8 years for the non-Indigenous population (ABS 2018). The population is also more widely dispersed across Australia than the non-Indigenous population:

- 38% live in *Major cities*
- 44% live in *Inner regional* and *Outer regional* areas
- 18% live in *Remote* and *Very remote* areas combined (ABS 2019a).

History and context

It is important to understand how the past shapes the lives of Indigenous Australians today. Indigenous Australians have a long history of trauma, cultural dispossession, forced displacement and assimilation, which affects their physical, mental and social wellbeing.

Estimates of the population of Australia prior to European colonisation vary, from around 315,000 to over one million people. Archaeological evidence suggests that a population of 750,000 Indigenous peoples could have been sustained (ABS 2008). At least 250 different languages were spoken across Australia by Indigenous Australians (AIATSIS n.d.). As well as distinct languages, Indigenous family groups had different histories, spiritual beliefs and cultural traditions. Aboriginal people formed a nomadic society with an emphasis on relationships to family, language group and Country. Social, religious and spiritual activities were central elements of this culture, and all closely linked to Country (Dudgeon et al. 2014). Prior to European contact, traditional Aboriginal culture supported people through transitional times in life – through formal ceremonies at birth, initiation and death – which in turn supported healthy SEWB (Parker and Milroy 2014).

The oral histories of Torres Strait Islander people also point to their diversity. The different conditions on each island, or in each community, contributed to this diversity (Dudgeon et al. 2014). The culture is complex, with Australian, Papuan and Austronesian influences (TSIRC 2016).

Notwithstanding this rich diversity, Indigenous Australians are united through their shared history of colonisation. The colonisation of Australia involved forcible removal of Indigenous Australians from their lands and resistance led to massacre (Dudgeon et al. 2014). Introduced disease and, in some cases, deliberate poisoning or starvation, saw the population reduced even further. By the 1930s only an estimated 80,000 Indigenous people remained in Australia (Smith 1980).

The Royal Commission into Aboriginal Deaths in Custody acknowledged the great significance of the removal from lands for the ongoing wellbeing and livelihood of Indigenous Australians, describing the 'white invasion of Australia' as a cause of ongoing poverty and disempowerment (RCIADIC 1991). Colonisation was devastating for Indigenous Australians, leading to social disintegration and to chronic impairment of the collective wellbeing of many Indigenous communities (Dudgeon et al. 2022).

Little has been written about suicide in Indigenous Australian society prior to colonisation. Hunter and Milroy (2006) argue that suicide as it is understood today may have been unknown in traditional Indigenous Australian societies. The closest phenomenon was a type of 'self-willed' death, which was collectively accepted as an outcome of sorcery or some serious transgression against societal norms (Hunter and Milroy 2006). Similarly, little is known about rates of non-fatal intentional self-harm prior to colonisation. Although an important indicator of suicidal behaviour in the community, there is no agreed definition of intentional self-harm in scientific literature. Broadly understood, it is a form of self-injury that is socially unacceptable in the community (Grandclerc et al. 2016). This unacceptability makes it distinct from cultural practices, such as body modification through ritual scarification or 'mourning cuts' which had – and in some communities, still have – great social and cultural significance (Haebich 2008).

Following Federation, states and territories enacted legislation that was punitive and restrictive towards Indigenous Australians. There were laws concerning intermarriage and, in some states and the Northern Territory, the Chief Protector was made the legal guardian of all Aboriginal children, removing the rights of parents (Tatz 2001; HREOC 1997). Children were removed from their families and 'away from the contaminating influence of Aboriginal environments' (Dudgeon et al. 2014:8) (see Box 2.1). The National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families concluded that these actions, done with the intention of disrupting the perpetuation of community and culture, amounted to genocide (HREOC 1997).

Box 2.1: Stolen Generations

In the period from approximately 1910 to 1970, thousands of children were forcibly removed from their families and communities through race-based policies set up by state, territory and federal governments. It is estimated that anywhere between 1 in 10 and 1 in 3 children were affected by this practice (HREOC 1997). These Aboriginal and Torres Strait Islander children are known as 'the Stolen Generations'. There were an estimated 33,600 Stolen Generations survivors by 2018–19 (AIHW 2021a). The grief and loss caused by this practice affects most Indigenous families, and more than one generation.

Between 1995 and 1997, the Human Rights and Equal Opportunity Commission (HREOC) undertook a 'National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families'. The findings of the inquiry were published in the *Bringing them Home* report in 1997. The report made 54 recommendations to support healing and to redress the wrongs done to Aboriginal and Torres Strait Islander people (HREOC 1997). This report is now decades old, yet many of the recommendations are still to be enacted.

Intergenerational trauma

The effects of colonisation continue today as unresolved trauma, which can be passed down through generations and persists as a key psychological issue for Indigenous Australians (Gilbert 2007, cited in Dudgeon et al. 2014).

Trauma is not limited to the effects of colonisation and Stolen Generations. It is intensified by exposure to other stressors such as institutional and cultural racism and socioeconomic marginalisation. All these factors interrupt healthy and protective connections to family and kin and the continuity of family and kin relations (Dudgeon et al. 2021). Professor Helen Milroy, an Indigenous psychiatrist and adolescent and child psychiatrist, explains how trauma can be transmitted across generations:

> The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the association with parental physical and mental illness; disconnection and alienation from extended family, culture and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, the process of vicarious traumatisation where children witness the ongoing effect of the original trauma which a parent or other family member has experienced. Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity and early mortality (Milroy 2005:xxi).

Disconnection from family and kinship systems, from Country and from spirituality and cultural practices, and the loss of parenting practices, are sources of trauma that can be passed from caregiver to child (HREOC 1997). The loss of parenting practices is a particular issue for people who were removed to institutions as children, as often happened to members of the Stolen Generations.

Children whose parents grew up in institutions are at a higher risk of behavioural problems, depression and mental illness (HREOC 1997). Experts have argued that the loss of parenting practices is one of the most significant consequences of removal policies (HREOC 1997).

Frameworks for mental health

Social and emotional wellbeing

Social and emotional wellbeing (SEWB) is a term used by many Indigenous Australians to reflect a more holistic view of mental health. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (the Framework) aims to 'guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms (PM&C 2017:2). There are 9 guiding principles that underpin the Framework and describe core cultural values of Indigenous Australians:

- Health is holistic and includes cultural and spiritual health.
- Self-determination is critical to effective Aboriginal and Torres Strait Islander health services.
- Cultural understanding must guide health care.
- The history of trauma and loss must be recognised.
- Recognition of human rights.
- Racism and stigma are ongoing stressors.
- Recognition of the centrality of kinship.
- Recognition of cultural diversity among Aboriginal and Torres Strait Islander people.
- Recognition of Aboriginal and Torres Strait Islander strengths (PM&C 2017).

There are various models and conceptualisations of SEWB. Gee et al. (2014) and the Framework (PM&C 2017) describe Aboriginal and Torres Strait Islander SEWB as a model with 7 interrelated domains (see Figure 2.1). The concept of 'connection' expresses the various ways people experience these domains at different stages of their lives. The interruption of this connection is likely to lead to poor SEWB, whereas strengthening these connections will likely lead to an increased SEWB (Gee et al. 2014).

Figure 2.1: Aboriginal and Torres Strait Islander social and emotional wellbeing

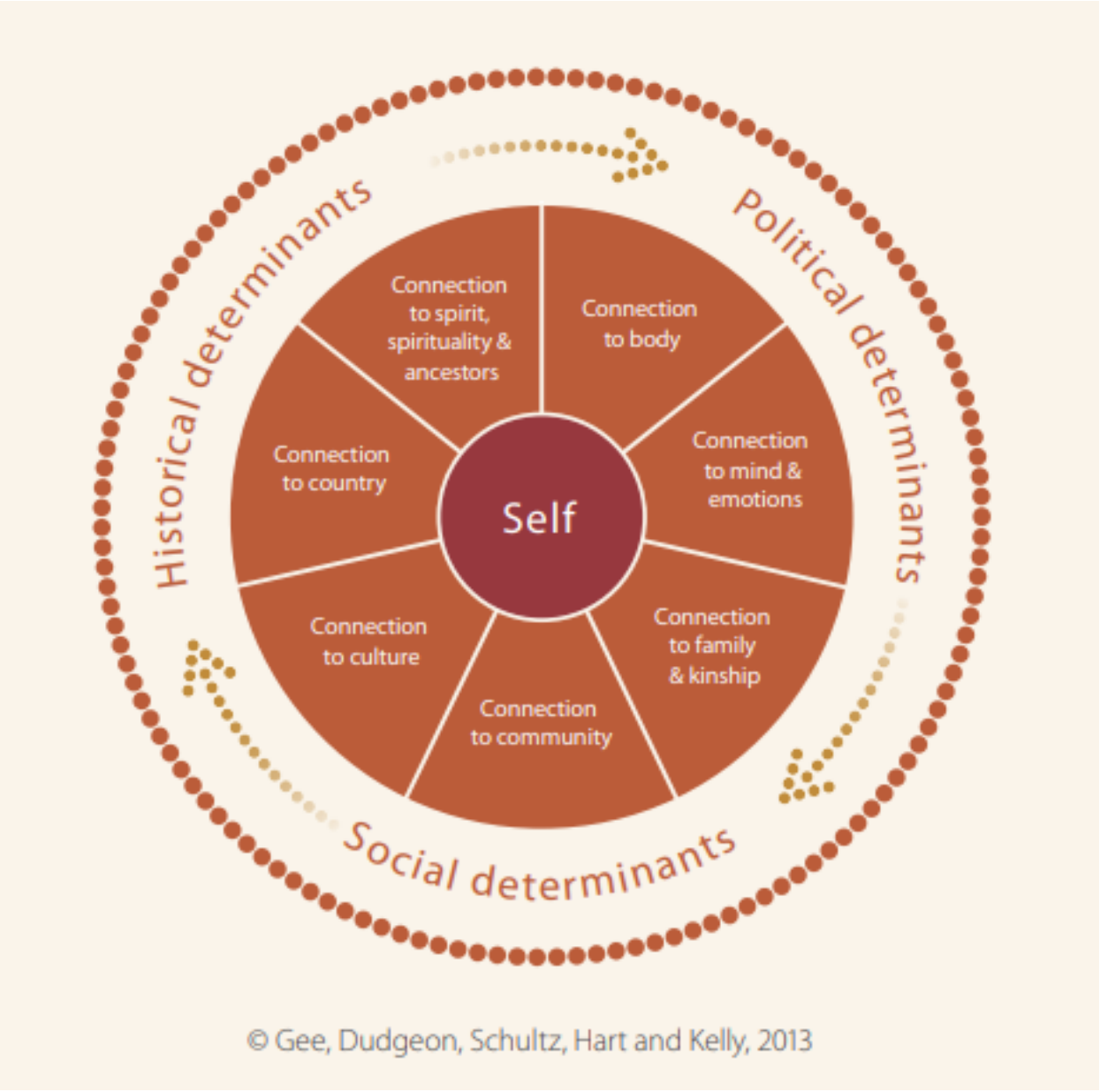


Image: PM&C 2017. Source: Gee et al. 2014.

The 7 SEWB domains and their definitions are:

- **Connection to body** – encompasses physical health and wellbeing; feeling strong and healthy and able to physically participate as fully as possible in life.
- **Connection to mind and emotions** – covers mental wellbeing, encompassing the whole spectrum of cognitive, emotional and psychological experience fundamental to an individual's experience of mental wellbeing.

- **Connection to family and kinship** – these connections are complex and diverse and are central to the functioning of Indigenous Australian societies. The domain recognises the importance of strong family and group relations, and kinship attachment systems.
- **Connection to community** – essential for cultural identity and the concept of self, these connections provide opportunities for individuals and families to connect with each other, offering a source of support and resilience.
- **Connection to culture** – helps to provide a sense of continuity with the past and maintain a strong identity by participating in practices associated with Aboriginal and Torres Strait Islander heritage.
- **Connection to Country** – 'Country' refers to an area on which Indigenous people have a traditional or spiritual association, with the sense of connection being a deep experience, belief or feeling of belonging (Dudgeon et al. 2014).
- **Connection to spirituality and ancestors** – provides 'a sense of purpose and meaning' and refers to 'a cultural group's traditional systems of knowledge left by the ancestral beings' (PM&C 2017; Gee et al. 2014).

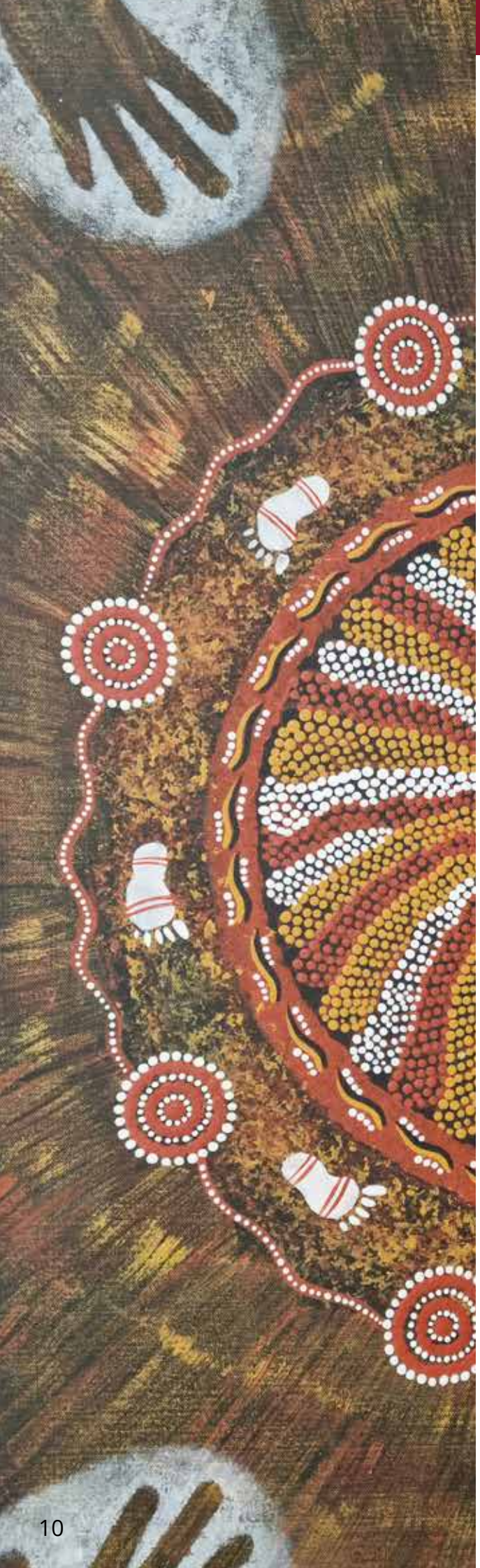
The SEWB framework was endorsed by the Australian Health Ministers' Advisory Council in 2004 (Gee et al. 2014). The term 'mental health' is not used widely by Indigenous Australians, as it is often associated with stigma (Healing Foundation and Emerging Minds 2020). In some literature, SEWB and 'mental health' are used interchangeably, which Gee and colleagues (2014) suggest subverts the stigma attached to the term and helps shift away from biomedical perspectives of mental health.

Cultural determinants

The importance of using cultural determinants as a way of framing health and wellbeing is increasingly acknowledged. The definitions and domains of cultural determinants encompass similar concepts to the SEWB framework (Lowitja Institute 2020; Karabena 2020; Salmon et al. 2018). Cultural determinants of health and wellbeing encompass cultural factors that promote a strength-based perspective of health and wellbeing; supporting resilience; a sense of self-esteem; stronger collective and individual identities; and assisting improved mental and physical health and wellbeing for individuals, families and communities (Lowitja Institute 2014; DoH 2017; Dudgeon et al. 2021).

The 6 cultural determinants of Indigenous health and wellbeing are:

- connection to Country
- Indigenous beliefs and knowledge
- Indigenous language
- family, kinship and community
- cultural expression and continuity
- self-determination and leadership (Karabena 2020).



3

What we know

3 What we know

Optimal social and emotional wellbeing is the basis of good health for Aboriginal and Torres Strait Islander people. Having good SEWB improves mental health and helps people to cope with daily stresses, to be resilient and to reach their full potential. This chapter presents available information relating to mental health and behavioural conditions; information on self-reported psychological distress among Indigenous Australians; and information on rates of suicide and on intentional self-harm.

Mental health prevalence and trends

Psychological distress

Psychological distress is a risk factor for suicide and substance abuse disorders (PM&C 2017). Psychological distress is not a 'mental illness' but contributes to mental ill health. Kelly and colleagues (2009:8) describe it as 'worry, restlessness and sadness' in response to stressful or difficult circumstances. Psychological distress can be a sign that someone is not coping and can trigger an episode of mental illness or worsen an existing condition (PM&C 2017).

Box 3.1: How is psychological distress measured?

Psychological distress is measured using the Kessler Psychological Distress Scale (K10). To measure psychological distress in Aboriginal and Torres Strait Islander surveys, the Australian Bureau of Statistics (ABS) uses a modified 5-item version of the K10. Five questions are asked, instead of the usual 10, with some modification of the questions to ensure they are culturally relevant to Indigenous Australians.

The questions explore how often people experienced negative emotions in the previous 4 weeks, with responses ranging from 'all of the time' (scoring 5) to 'none of the time' (scoring 1). Scores are totalled, yielding a minimum score of 5 and maximum score of 25. 'High' to 'Very high' scores are in the range 12–25 (ABS 2019b).

In the 2018–19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), most respondents reported 'Low' to 'Moderate' rates of psychological distress; however, almost a third of people (31%) reported 'High' to 'Very high' rates of psychological distress (ABS 2019b) (see Box 3.1). This was an increase of 4 percentage points since 2004–05 (27%).

The proportion of Indigenous Australians reporting High/Very high levels of psychological distress is almost 2.5 times that reported by other Australians (which was 13% for non-Indigenous Australians in 2018–19) (AIHW and NIAA 2022a). High or Very high levels of psychological distress were more common for females (35.1%) than for males (25.8%), whereas the proportions of High or Very high psychological distress did not vary greatly by age or by remoteness (see Table 3.1).

Table 3.1: Level of psychological distress by selected characteristics, Indigenous persons aged 18 years and over, 2018–19 (per cent)

	Low/ Moderate[(a)]	High/ Very high[(a)]	Total[(b)]
Sex			
Male	69.7	25.8	100.0
Female	62.8	35.1	100.0
Age			
18–24 years	66.5	29.7	100.0
25–34 years	67.1	30.6	100.0
35–44 years	66.5	30.8	100.0
45–54 years	64.1	33.3	100.0
55 years and over	66.2	29.6	100.0
Remoteness			
Non-remote	66.0	31.6	100.0
Remote and very remote	67.2	27.2	100.0
Total	**66.2**	**30.8**	**100.0**

(a) 'Low/Moderate' psychological distress includes scores of 5 to 11 and will include people who responded "None of the time' to all five questions on psychological distress, and 'High/Very high' include scores of 12 to 25.

(b) Includes missing responses.

Source: ABS 2019b.

The Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing (the Mayi Kuwayu Study) is an important longitudinal study about the culture and wellbeing of Aboriginal and Torres Strait Islander adults. It was created by and for Aboriginal and Torres Strait Islander people. The study aims to provide evidence about the importance of strong culture to health and wellbeing. The study has so far surveyed 9,691 Aboriginal and Torres Strait Islander people during the period 2018 to 2020. Recent analysis of the data reveals that 26.8% of participants indicated 'Low' levels of psychological distress, while 29.1% indicated 'Moderate' levels and 36.2% indicated 'High to Very high' levels of psychological distress (Lovett et al. 2020).

Mental health and social and emotional wellbeing data

The 2018–19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) asked whether people aged 2 years or over had a diagnosed mental or behavioural condition. Almost one-quarter (24%) of Indigenous Australians reported having a mental and/or behavioural condition, as follows:

- Anxiety was the most common mental health condition reported by Indigenous Australians (17%), with females (21%) more likely to report anxiety than males (12%).
- Depression, or feelings of depression, were the next most commonly reported mental health condition (13%), with females again higher (at 16%) than males (10%).

- Behavioural and emotional problems, which includes attention deficit hyperactivity disorder (ADHD); conduct disorders for children, adolescents and adults; other behavioural and emotional problems; schizophrenia-related problems; and intellectual impairment, were reported by 9% of respondents.

Across all age groups, except for children aged 2–14 years where behavioural and emotional problems were highest (11%), the most commonly reported conditions were anxiety and depression (ABS 2019b).

The NATSIHS also included a limited set of questions relevant to social and emotional wellbeing, including questions about culture and family connections and connection to Country. In 2018–19, 66% (314,170) of Indigenous Australians aged 15 and over identified with a tribal/language group or clan and 74% (357,420) recognised an area as homelands/traditional country (AIHW and NIAA 2022a).

Also asked were questions about experiences of racism and whether respondents, or a family member, had been removed. Results for 2018–19 show among Indigenous Australians aged 15 and over:

- 54% (214,200) reported that they and/or a relative had been removed from their natural family.
- 25% (109,350) felt that they had been treated unfairly in the last 12 months because they were Aboriginal and/or Torres Strait Islander (AIHW and NIAA 2022a).

In 2018–2020, Mayi Kuwayu Study participants were asked similar questions, with 52.6% of participants having had at least one member of the Stolen Generations in their family. Other findings from the study:

- 69.7% of participants reported 'A lot' or 'A fair bit' of life satisfaction
- 66.5% reported 'Very good/Excellent' or 'Good' general health status
- 78.0% reported feeling 'A lot' or 'A fair bit' in control of life
- almost half (47.8%) of the participants reported 'High' family wellbeing
- 35.9% of participants know their totem or Dreaming
- 37.9% reported no experience of discrimination, however 10.7% of participants reported moderate to high levels of everyday discrimination (Lovett et al. 2020).

The Mayi Kuwayu Study includes other wellbeing information such as cultural knowledge, identity, caring for Country and Indigenous language use (Mayi Kuwayu 2022; Lovett et al. 2020).

Through 'Burden of disease' analyses, the Australian Institute of Health and Welfare has examined the impact of mental health and suicide in terms of the number of years of healthy life for Indigenous Australians (AIHW 2022a) (see Box 3.2).

Box 3.2: Burden of disease analyses

Burden of disease analyses produce summary measures to gauge the impact of different diseases and injuries in terms of the number of years of healthy life lost due to illness (YLD) or premature death (YLL). In this way, the impact of conditions that can cause illness or disability can be compared. The summary measure used is the 'disability-adjusted life years' (or DALY).

Burden of disease analyses for Australia have included estimates of burden attributable to mental health conditions in the total Australian population, using data from national diagnostic surveys; however, equivalent data are not available for the Indigenous population. Indirect methods were used to estimate prevalence (AIHW 2022a).

'Mental & substance use disorders' (such as anxiety, depression and drug use) were found to be the leading cause of the total burden and non-fatal burden of disease among Indigenous Australians in 2018. 'Mental & substance use disorders' made up 23% (54,263 DALY) of total burden, 42% (53,238 YLD) of non-fatal burden and 0.9% (1,025 YLL) of fatal burden. The main causes of mental & substance use burden were anxiety disorders (23%), alcohol use disorders (19%) and depressive disorders (19%) (AIHW 2022a).

A change to the method of collection of these data means that they are not comparable to previous ABS Indigenous surveys, or the National Health Survey. For this reason, trend data are not available.

Comorbidity

Comorbidity refers to the co-occurrence of two or more disorders in a person at the same time. It is common among those with mental illness and leads to a considerably poorer quality of life, particularly as the number of comorbid conditions increases for a person (ABS 2015b). In the general population, among people with a mental and behavioural condition, 94% reported having a coexisting, long-term health condition (ABS 2015b). Common physical conditions reported by people with mental and behavioural conditions, included back problems (28%) and arthritis (24%) (ABS 2015b). Physical health problems are recognised as a risk factor for the social and emotional wellbeing of Indigenous Australians (Zubrick et al. 2014b).

Particularly common is the high prevalence of mental health disorders combined with alcohol or other drug use disorders. More than a third of people with an alcohol or other drug use disorder have at least one comorbid mental health disorder (Marel et al. 2016). Wilkes and colleagues (2014) suggest co-morbid substance misuse and mental health problems are more common among Aboriginal and Torres Strait Islander people. Among Indigenous Australians, mental health and substance use disorders are frequently treated separately, which results in a poor prognosis (Hunter 2003, cited in Wilkes et al. 2014).

The relationship between mental health and substance use disorders is complex and bi-directional. Both disorders may precipitate the other: that is, a mental health condition may lead a person to use drugs to relieve their symptoms and vice versa. Alternatively, drug use may trigger a mental health condition (AIHW 2022c). Additionally, common risk factors such as stress, poverty, or trauma, can contribute to a person developing both mental illness and substance use disorders (NIDA 2018).

Given the frequent co-occurrence of mental health disorders and alcohol and other drug (AOD) use disorders, Comorbidity Guidelines have been developed to assist AOD workers with managing these conditions (Marel et al. 2016). The Guidelines acknowledge that the majority of best practice evidence for the treatment of comorbidity has been developed within Western systems of knowledge. They urge AOD workers treating Indigenous Australians to create links with local Indigenous services and consultants to familiarise themselves with culturally appropriate practices. This limited evidence base is likely to contribute to the greater likelihood of poorer outcomes for Indigenous Australians who experience mental health and AOD use disorders (Wilkes et al. 2014).

Suicide and self-harm

Intentional self-harm

Intentional self-harm is recognised as an important risk factor for suicide (Murphy et al. 2012; Dickson et al. 2019). It is commonly defined as deliberately injuring or hurting oneself, with or without the intention of dying (AIHW 2021b).

Monitoring hospital admissions for non-fatal intentional self-harm assists us in understanding the nature of suicide and who may be at risk, and is important for suicide prevention efforts. In 2020–21, the rate of hospitalisations for intentional self-harm among Indigenous Australians was 326 per 100,000 population, 3 times the rate for non-Indigenous Australians (108 per 100,000 population). Females are hospitalised at higher rates than males, with the highest hospitalisation rate among Indigenous females aged 15–19 years (1,133 hospitalisations per 100,000 population) (AIHW 2021b). Between 2008–09 to 2020–21, hospitalisations for intentional self-harm increased for Indigenous Australians (from 203 hospitalisations to 326 per 100,000 population). The greatest rise was among Indigenous females aged 15–19 years (which increased from 455 to 1,133 per 100,000 population) (AIHW 2021b).

The data reported here from the National Hospital Morbidity Database represents admissions to hospital for people who have deliberately harmed themselves through self-poisoning or self-injury, with or without suicidal intent. Therefore, it includes suicide attempts and admissions for people who harmed themselves without suicidal intent. It is not possible to differentiate between these admissions in the data. Many self-harm events will go unreported because many people who self-harm or attempt suicide do not seek medical treatment. An understanding of the extent of suicidal ideation among Indigenous Australians is a critical data gap.

In Westerman and Sheridan's (2020) study of Indigenous Australians aged 13–17, 42% acknowledged frequent thoughts of suicide, with 23% of the overall sample considered to be at clear risk for suicide. Of these, approximately 20% had made a previous attempt on their lives. A high risk of self-harm among Indigenous Australian youth has been confirmed by other researchers (Dickson et al. 2019).

Suicide rates and trends

Suicide is a leading cause of mortality for Indigenous Australians. In 2020, 197 Indigenous Australians died by suicide (AIHW 2022b). Data are reported for 5 jurisdictions: New South Wales, Queensland, Western Australia, South Australia and the Northern Territory. These jurisdictions are considered to have adequate levels of Indigenous identification within their mortality data.

Suicide accounted for 5.5% of all deaths by Indigenous Australians in 2020 and was the 5th leading cause of death. In the same period, among all Australians, suicide accounted for 1.9% of deaths, and was the 14th leading cause of death (AIHW 2022b). The standardised suicide death rate for Indigenous Australians for 2020 is estimated to be 27.9 per 100,000 people which is more than twice the rate of non-Indigenous Australians (12.1 deaths per 100,000 in 2019) (AIHW 2022b).

In 2020, suicide was the second leading cause of death for Indigenous Australian males and the 10th leading cause of death for Indigenous females (ABS 2021a). Rates for Indigenous males and Indigenous females in 2016–2020 were 39.0 and 12.5 per 100,000, respectively (AIHW 2022b).

Rates of suicide were highest among young Indigenous people. From 2016 to 2020, for those aged 0–24 years, the suicide rate was 16.7 per 100,000 and 45.7 per 100,000 for those aged 25–44 years (AIHW 2022b). It was also the leading cause of death for Indigenous children aged 5–17 (ABS 2021a).

There are geographic differences across the states and territories. In 2016–2020, the highest rate was reported in Western Australia (with an age-standardised death rate of 33.3 per 100,000), followed by:

- Northern Territory (29.0 per 100,000)
- Queensland (28.0 per 100,000)
- South Australia (20.9 per 100,000)
- New South Wales (19.8 per 100,000) (AIHW 2022b).

Data are not available for Victoria, Tasmania or the Australian Capital Territory.

Barriers to services

Indigenous Australians face many inequalities in accessing health services, and may experience cultural, geographic, cost and availability barriers to using health and mental health services. Indigenous Australians face barriers that other groups do not (AIHW and NIAA 2022b).

In 2018–19, 30% (243,700) of Aboriginal and Torres Strait Islander people reported that they did not see a health care provider when they needed to on at least one occasion in the preceding 12 months (AIHW 2020c). The 2018–19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) asked Indigenous Australians who needed health care in the last 12 months about the main reasons they did not see a health care provider. Thirteen per cent of people needed to see a doctor and did not, and 10% needed to see a counsellor but did not. Reasons for not seeing these health providers varied, with the cultural appropriateness of the service featuring strongly as a reason for not seeing a counsellor (32%). Being too busy was frequently cited as a reason for not seeing a doctor in the last 12 months (33%), while the cultural appropriateness of the service was cited as a reason by 22% of people (AIHW and NIAA 2022b).

'Culturally [in]appropriate health services' included factors such as discrimination, language problems and distrust of the service or provider. Fear of discrimination and racism is commonly cited as a reason why Indigenous Australians do not use mainstream health services. In addition, fear of disrespect, judgement and government interventions – particularly from child protection agencies – are among barriers described in other studies (Lee et al. 2014; Nolan-Isles et al. 2021).

There are many reasons why Indigenous Australians do not seek help early. Lee and colleagues' 2014 study in NSW outlined personal fears or feelings of shame as a barrier to seeking help.

Aboriginal health workers in rural Victoria reported that some Indigenous Australians learn not to speak about their problems from an early age. Family members do not encourage sharing problems and some fear that speaking about problems will have repercussions for one's family. Even though they are aware their peers have similar experiences, many young people still find it difficult to share their feelings. Men, in particular, fear being considered weak (Isaacs et al. 2017). Older people subjected to elder abuse are similarly reluctant to ask for help. All groups have difficulty finding a safe person to trust. Access to suitable formal supports is limited; mainstream services may not feel culturally safe, and clients can expect long delays in getting an appointment (Isaacs et al. 2017).

Workforce and service challenges

Indigenous Australians comprise a very small percentage of the mental health workforce and hold less than 2% of jobs in the entire health sector (Lai et al. 2018). The inability of mainstream health services to effectively engage Indigenous communities was the driver for the creation of Aboriginal Community Controlled Health Services (ACCHS) (NACCHO n.d.). Many clients of ACCHS report 'feeling at home' and find the environment less judgemental (Lee at al. 2014). These services are operated by the local Aboriginal community to provide culturally appropriate health care that is holistic and comprehensive.

The National Aboriginal Community Controlled Health Organisation (NACCHO) reports that support for tailored, local social and emotional wellbeing work is often lacking, which results in unmet need in prevention and early intervention work for those at risk of mental illness (NACCHO 2019). In 2017–18, around two-thirds (68%) of services providing Indigenous primary health services reported mental health/social and emotional health and wellbeing services as a gap faced by the community they served (AIHW 2019).

More information on efforts to improve the cultural safety of the mental health workforce is available in the AIHW Indigenous Mental Health and Suicide Prevention Clearinghouse publication: *Improving Indigenous mental health outcomes with an Indigenous mental health workforce* (Upton et al. 2021).

Data quality issues

Many of the data sources used to monitor Indigenous mental health or suicide are subject to quality issues. These issues may relate to the quality of the Indigenous identifiers within the data, or the frequency and timeliness of reports or surveys. Data quality across many data collections is affected by propensity to identify. Historical and contemporary issues, and the associated discourses arising within identity development, can affect identification in national datasets (Griffiths et al. 2019). Perceptions about why the information is required; how it will be used; and how the information is collected can affect the likelihood that a person will identify or be identified.

The ABS conducts Indigenous-specific surveys approximately every 3 years, alternating between a social survey and a health survey. These surveys include a population sample across remote and non-remote areas of Australia and include discrete Indigenous communities. Undertaking these surveys is expensive and may place a burden on respondents, which limits the frequency with which they are undertaken. Complex and sensitive topics, such as assessing mental health prevalence, may be difficult to include in a population survey. Survey questions must be culturally appropriate, translatable, and there should be appropriate support for respondents.

Rates of intentional self-harm for Indigenous Australians in hospital data are generally under-reported. In a data quality statement for the National Hospital Morbidity Database, the AIHW (2020b) reported that:

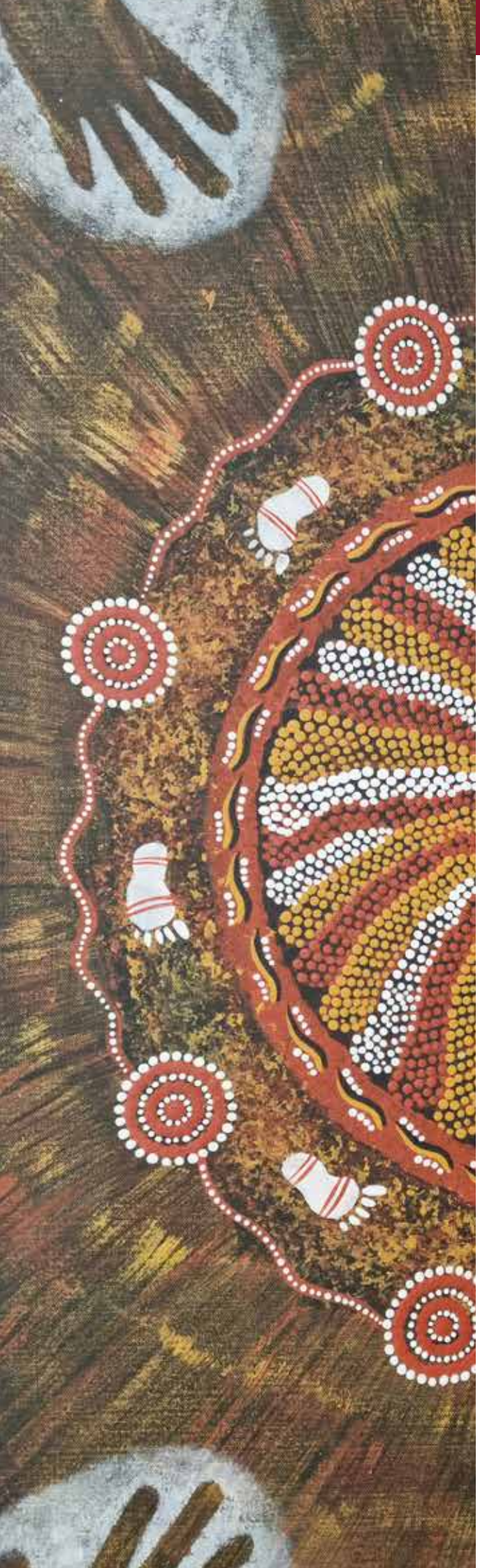
> in 2011–12, about 88% of Indigenous Australians were identified correctly in hospital admissions data, and the 'true' number of separations for Indigenous Australians was about 9% higher than reported.

Data on causes of death, including suicide deaths, are compiled and coded by the ABS. The AIHW maintains these data in the National Mortality Database. The reporting of death by suicide among Indigenous Australians is fraught with problems (Dudgeon et al. 2021) including the difficulty of ensuring timely, accurate identification and recording of suicides (CARC 2010). Indigenous status is not always accurately captured and there are many uncertainties in estimating and projecting the size and structure of the Indigenous population over time (ABS 2019a). There are also problems with capturing suicide related behaviour, such as non-fatal self-harm and suicidal ideation (Dudgeon et al. 2021).

Some key issues with Aboriginal and Torres Strait Islander mortality data are:

- Data are not reported for Victoria, Tasmania and the Australian Capital Territory due to the small number of deaths identified as Indigenous in these jurisdictions, and to some data quality concerns, which prevent robust analysis.
- Indigenous status is not reported in a small number of cases. In 2020, for example, 1,195 (0.7%) of registered deaths did not include Indigenous status (ABS 2021b). In the same year, the number of deaths registered where the person was recorded as being Aboriginal, Torres Strait Islander or both was 4,063.
- Deaths suspected to be suicide are referred to the jurisdiction's Coroners Court for investigation. The time taken for the coronial investigation may result in lag-times for finalising these data.

More information on data quality issues is available in *Investigating enhancements to Indigenous data in suicide-relevant data sets* (AIHW 2022d).



4

Policy context

4 Policy context

Inequality in health status for Aboriginal and Torres Strait Islander people has been driven by the poverty, social exclusion, economic disadvantage and discrimination that followed European colonisation. It was only following the 1967 Referendum that some states developed Aboriginal health programs to focus on the health needs of Indigenous Australians (VAHS n.d.). The 1967 Referendum provided for Indigenous Australians to be counted in the Census and the Commonwealth to make special laws in relation to Indigenous Australians.

Several important reports in the 1990s brought a focus on the mental health implications of past policies for Indigenous Australians. These include:

- the *Royal Commission into Aboriginal Deaths in Custody Report* (RCIADIC) published in 1991, which presented recommendations from the Royal Commission initiated in 1987
- *Ways forward: National consultancy report on Aboriginal and Torres Strait Islander mental health* released in 1995 (Swan and Raphael 1995)
- *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (1995), published as the *Bringing them Home Report* (HEREOC 1997).

The RCIADIC report (RCIADIC 1991) included a review of the efficacy of programs addressing the health needs of Indigenous Australians, highlighting the need to address Indigenous mental health. The *Bringing them Home Report* (HREOC 1997) helped highlight the consequences of forced removal policies on Aboriginal and Torres Strait Islander people and the inadequacy of existing mental health services to provide suitable support (Zubrick et al. 2014a).

The *Ways Forward* report (1995) prompted a better understanding of social and emotional wellbeing in policymaking by outlining the interrelating factors that affect the social and emotional wellbeing of Indigenous Australians. The report recommended a holistic approach to mental health and initiatives, including self-determination in mental health services development. Many of the themes of this report have been continued in subsequent mental health policy frameworks (Parker and Milroy 2014):

- The *National Strategic Framework on Social and Emotional Well Being 2004–2009* was released in 2004. Gee and colleagues (2014) recognised this work as legitimising Aboriginal and Torres Strait Islander concepts of health at a nationwide level.
- Australia's first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* was published in 2013 (DoHA 2013). Informed by community consultation, it outlined key goals and action areas that focused on early intervention, strengthening communities, and building integrated, holistic approaches.
- In the same year, the Australian Government released the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. The plan built on the 2008 Closing the Gap initiative, which had set out 6 key goals across the areas of health, education and employment to improve Indigenous Australians' quality of life.

In 2015, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) group proposed steps (presented as 9 guiding principles) to closing the mental health gap. This group comprised senior Indigenous Australians working in the areas of social and emotional wellbeing, mental health and suicide prevention. Most are based in or associated with national and state mental health commissions or other nationally important health bodies. The 9 principles are detailed in the *Gayaa Dhuwi (Proud Spirit) Declaration* of the same year (Gayaa Dhuwi 2020). It provides a framework for Indigenous Australian leadership in mental health and suicide prevention. The framework is underpinned by the holistic Indigenous conceptions of health, which encompass mental health and physical, cultural and spiritual health, and states that land and sea are central to wellbeing.

In August 2017, the Council of Australian Governments (COAG) released the *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) as a continuation of the work that had occurred in national mental health reform. The plan was the first time that all Australian governments had committed to regional-level consistency, and consumer and carer focus, in any planning, delivery, and evaluation of mental health services. It was also the first to specifically address and provide actionable and agreed strategies to 'address social and emotional wellbeing, mental illness and suicide' for Indigenous Australians (DoH 2017:v). One such action was the establishment of a clearinghouse to help strengthen the evidence base for improving mental health services and outcomes for Indigenous Australians (see Box 4.1).

Box 4.1: The Indigenous Mental Health and Suicide Prevention Clearinghouse

The AIHW Indigenous Mental Health and Suicide Prevention Clearinghouse ('the Clearinghouse' was established in 2021 in response to Action 13.1 of the *Fifth National Mental Health and Suicide Prevention Plan*. Action 13.1 outlines the requirement to strengthen the evidence base needed to improve Indigenous mental health services and outcomes. It specifies that governments should establish a clearinghouse of resources, tools and program evaluations to support the development of culturally safe models of service delivery (COAG 2017:34).

The Clearinghouse collects and commissions information about emerging research, programs, evaluations and policies relating to Indigenous mental health, suicide prevention and social and emotional wellbeing.

Given the increased focus on mental health in Australia during the past decade, the Clearinghouse serves an important repository function and builds the evidence base of what works and does not work in relation to Indigenous mental health and suicide prevention, including identifying gaps in the evidence. Experts in Indigenous mental health and suicide prevention, practitioners and policy makers have guided the development of the Clearinghouse and its publications.

For more information on best practice in Aboriginal and Torres Strait Islander mental health and suicide prevention see http://www.indigenousmhsp.gov.au.

In 2017, the Australian Government produced the renewed *National Strategic Framework for Indigenous Australians' Mental Health and Social and Emotional Wellbeing 2017–2023* (PM&C 2017). It accompanies the *Fifth National Mental Health and Suicide Prevention Plan* and the *National Aboriginal and Torres Strait Islander Health Plan 2012–2023.* It sets out:

> … a comprehensive and culturally appropriate stepped care model that is equally applicable to both Indigenous specific and mainstream health services (PM&C 2017:1).

In July 2020, following extensive engagements in 2019 with Aboriginal and Torres Strait Islander people across Australia, the *National Agreement on Closing the Gap* came into effect. It was ratified by the First Ministers of all Australian governments and the President of the Australia Local Government Association as well as by the Lead Convenor of the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks). The objective of the National Agreement on Closing the Gap is to enable Indigenous Australians and governments to work together to overcome the inequality experienced by Indigenous Australians and to achieve life outcomes equal to all Australians. This new partnership is reflected in the establishment of the Joint Council on Closing the Gap, and it is the first time a COAG Ministerial Council has included non-government representatives. The new alliance and commitment to collaboration with Indigenous Australians and communities is a significant step. It could be a pathway to driving change in mental health service provision and suicide prevention.

In 2021, the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* was released as the overarching policy document to guide all initiatives aimed at improving health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. The Health Plan refreshes the earlier 2013–2023 Health Plan and is the first national document to specifically address reforms and targets in the National Agreement on Closing the Gap. The new Health Plan has a stronger focus on development in partnership with Aboriginal and Torres Strait Islander people and communities, and on alignment with recent reforms in national health policies (DoHAC 2022). The Health Plan prioritises four high level categories: the enablers for change; focusing on prevention; improving the health system; and a culturally informed evidence base. The Health Plan will begin implementation in 2022 with a mid-cycle review in 2026 (DoH 2021).

In the 2019–20 budget, the Australian Government pledged the largest single investment into suicide prevention for young Australians – $461 million. Of this allocation, $15 million was specifically pledged to Indigenous suicide prevention. It included funding for:

- Indigenous leadership to create a culturally appropriate national plan
- a centre of excellence in childhood wellness
- adapting cognitive behaviour therapy (CBT) psychological treatments to include cultural traditions (DoH 2019).

A new national leadership body for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention – Gayaa Dhuwi (Proud Spirit) Australia – was established in 2020 and takes its name from the Gayaa Dhuwi (Proud Spirit) Declaration. The body of Indigenous experts and peak organisations has been entrusted with leadership and development of a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

Policy directions

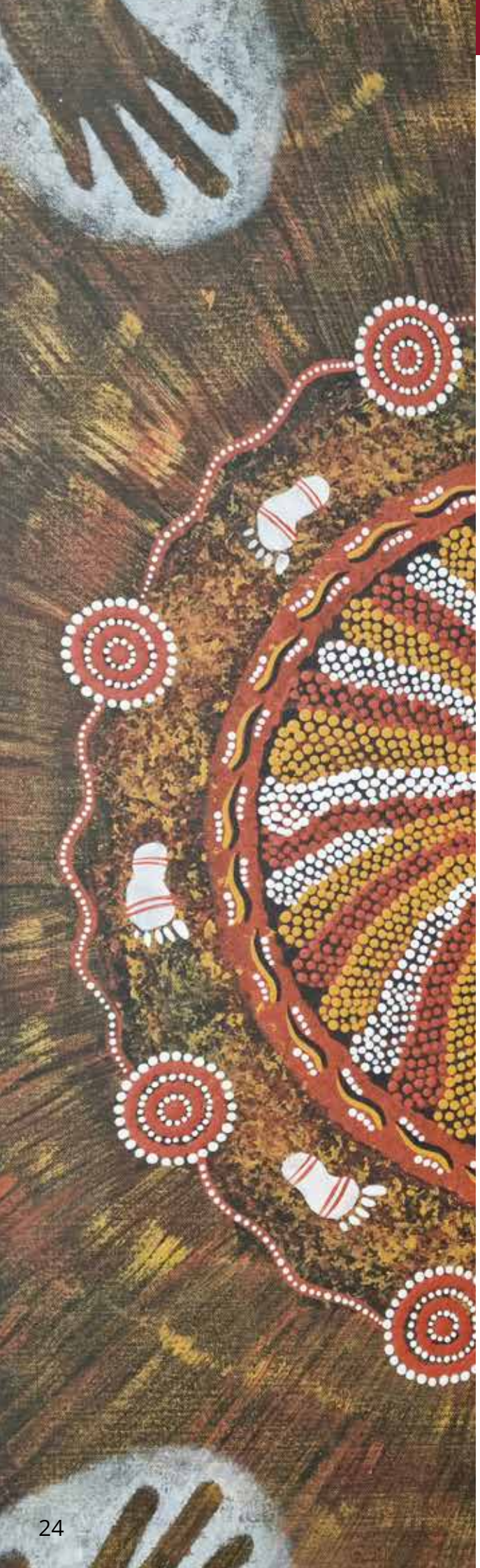
Some researchers have proposed that a 'radical reimagining' of policy is needed if we are to transform persisting Indigenous health disparities (Bond and Singh 2020). Others criticise the lack of progress in addressing the structural and systemic barriers needed to address mental health and suicide prevention (Lowitja Institute 2021; Dudgeon et al. 2020a). Consistent across these messages is the need for Indigenous leadership. Groves and colleagues (2022) encourage changes in policy, with a growing emphasis and importance given to self-governance for improving mental health and suicide prevention. However, factors such as the low numbers of Indigenous mental health workers remain a barrier to the use of mental health services by Indigenous Australians. Indigenous Australians have more trust in mental health services delivered by Indigenous mental health workers and professionals (Upton et al. 2021). While policies and strategies are in place to build the Indigenous mental health workforce, less than 2% of health workers across the health sector are Indigenous Australians (Upton et al. 2021).

Further, there has been some political inaction implementing recommendations arising from past inquiries. A Deloitte Access Economics review of the implementation of the Royal Commission into Aboriginal Deaths in Custody in 2018 found that only 64% of the recommendations had been implemented in full (PM&C 2018). Similarly, the majority of recommendations from the *Bringing them Home Report* have not been implemented (AIATSIS 2022; VACCA 2020). The Healing Foundation (2017) warned that this failure to act had created additional trauma and distress for Indigenous Australians. Others note that the separation of Indigenous children and young people from their families is continuing, with many removed to 'out-of-home care' (Dudgeon et al. 2021). Professor Megan Davis found that Indigenous children and youth are being removed from their families in increasing numbers (Davis 2019, cited in Dudgeon et al. 2021).

Many Australians consider that recognition of Aboriginal and Torres Strait Islander people in the Constitution is long overdue, aware that this recognition will advance Indigenous identity and improve social and emotional wellbeing (Lowitja Institute 2021; RANZCP 2018). The Lowitja Institute considers it would be a step towards addressing the health inequity between Indigenous and non-Indigenous Australians (Mokak 2015). Similarly, the Royal Australian and New Zealand College of Psychiatrists recognises that, until this recognition has occurred, discrimination will continue, and mental health will continue to erode (RANZCP 2018).

More information is available on these topics in the AIHW's Indigenous Mental Health and Suicide Prevention Clearinghouse. See:

- *Indigenous self-governance for mental health and suicide prevention* (Groves et al. 2022)
- *Improving Indigenous mental health outcomes with an Indigenous mental health workforce* (Upton et al. 2021)
- *Connection between family, kinship and social and emotional wellbeing* (Dudgeon et al. 2021).



5

Risk and protective factors

5 Risk and protective factors

Social and emotional wellbeing (SEWB), as outlined in the SEWB framework, is affected by multiple, interconnected elements over the life course. This chapter explores the foundational elements for wellbeing, along with risk and protective factors for SEWB.

Poor SEWB is associated with serious psychological distress (Kelly et al. 2009). In their formative outline of SEWB, Gee and colleagues (2014) note that many issues identified as SEWB problems, are also well-established risk factors for mental health disorders. They acknowledge that 'in some cases mental health disorders are likely to be symptomatic of greater SEWB disturbance' (Gee et al. 2014:63). Negative outcomes from serious psychological distress include intentional self-harm and suicide (Kelly et al. 2009). Noting these interrelated observations of risks for mental health, psychological distress and SEWB, this chapter explores these risks together. Risks and protective factors for suicide and intentional self-harm follow, and in many cases also coincide with those for suboptimal SEWB.

It is important to note that the likelihood of developing serious psychological distress when exposed to risk and protective factors will vary between Aboriginal cultures and Torres Strait Islander cultures, and between different Aboriginal cultures and communities (Kelly et al. 2009). It cannot be assumed that exposure to these various risk and protective factors will have the same results across different people, communities and cultures.

Foundational development

In their examination of children's development, Zubrick and colleagues (2014b) suggest there are 3 'major prompts of optimal SEWB' – being biology, expectations and opportunities:

- 'Biology' prompts physical development via key aspects of development such as crawling, walking and talking, and sexual maturation.
- Carers of children have 'expectations' in the form of values, attitudes and beliefs concerning their child's development.
- 'Opportunities' to engage in stimulating activities will have significant impacts on a child's social and emotional capacities (Zubrick et al. 2014b).

The same researchers outline facilitators and constraints on the development of optimal SEWB. The facilitators are:

- intellectual flexibility, such as having an easy temperament
- good language development, as speech problems increase the risk of emotional or behavioural difficulties
- emotional support, including encouragement, support and celebration when appropriate (Zubrick et al. 2014b).

Constraints on the development of SEWB are:

- stress: conditions which threaten or harm psychological or biological capabilities
- chaos, including lack of structure and unpredictability in daily life

- social exclusion, including rejection and non-recognition, through to bullying, vilification and racism
- racism, including greater ill health, poor self-esteem, self-harming behaviours and injury from racially motivated assault
- social inequality, resulting from the unequal distribution of societal resources (Zubrick et al. 2014b).

The extent of constraints is much greater for Indigenous Australians than for non-Indigenous people, and children may miss out on, or have limited access to, the factors supporting development. High levels of mental health problems inexorably follow (Zubrick et al. 2014b).

Protective factors for SEWB

There are important protective factors for social and emotional wellbeing, which can serve as a source of strength, aiding recovery and resilience when an individual is faced with adversity. Protective factors may reduce the exposure to risk or counteract the effects of risk factors (Rutter 1985, cited in Kelly et al. 2009). Protective factors include unique aspects and concepts of Indigenous culture such as connection to land, culture, spirituality, ancestry, kinship networks, family and community (Kelly et al. 2009, Zubrick et al. 2014b). Cultural continuity – being connected to one's culture through engagement in practices and values of one's indigenous heritage – flows from these connections and is recognised across the literature as a foundation for suicide prevention (Chandler and Lalonde 1998; Dudgeon et al. 2020b; Ketheesan et al. 2020). Dudgeon and colleagues (2022) also describe cultural continuity as being 'a whole-of-community protective force'.

Additionally, Kelly and colleagues (2009) flag the protective factors of:

- social cohesion – describing mutual obligations and the existence of trust within the social relationships of a community as a means of protection against stressors; and
- sense of wellbeing/resilience – referring to feelings of calmness, happiness, and energy as providing positive wellbeing and resilience.

Well-functioning communities support the economic and social wellbeing of families and children within that community. To this end, factors such as self-determination, which help promote a secure sense of personal and cultural identity, will foster a greater sense of wellbeing (Zubrick et al. 2014b). More information is available in the AIHW's Indigenous Mental Health and Suicide Prevention Clearinghouse publication *Connection to community* (Dudgeon et al. 2022).

A scoping review by Usher and colleagues (2021) explored characteristics related to Indigenous resilience. Many of the concepts identified are reflected in some of the earlier literature cited here, including the 'individual influences' of internal coping, of general self-esteem and of a 'self-concept'. Some aspects of resilience came from being within supportive family or community environments, including access to opportunities, positive role models and leadership in these environments. Cultural and community influences were also highlighted as a means of instilling cultural identity, and for their important role in providing support, affection and sharing resources in times of hardship (Usher et al. 2021).

Risks to SEWB

There are many aspects of everyday life that may cause stress, or conversely, offer support for optimal wellbeing. It is the discrepancy between stressors and the capacity to cope with these, and with other protective factors, that determine social and emotional wellbeing (Kelly et al. 2009). Factors that influence SEWB include:

- relationships with family
- conditions in the workplace and schools
- individual environments, both social and cultural
- income and social opportunities
- personal health
- access to health and other services (Kelly et al. 2009).

An upset, disruption or imbalance to these may be a cause for stress. Zubrick and colleagues (2014b) affirm that, while people may face a single traumatic event, it is the accumulation of multiple risks that can affect social and emotional wellbeing.

Chapter 2 of this report outlined the traumatic impacts of colonisation for Aboriginal and Torres Strait Islander people. Colonisation has been identified as the single most critical underlying determinant of psychological distress (Mowbray 2007).

Indigenous Australians have identified the risks to social and emotional wellbeing, as follows:

- widespread grief and loss
- unresolved trauma and abuse
- domestic violence
- removal from family
- impacts of the Stolen Generations
- substance misuse
- family breakdown
- incarceration
- loss of culture and identity
- poor physical health
- racism and discrimination
- social disadvantage (Kelly et al. 2009; Zubrick et al. 2014b; Beyond Blue 2022).

Many of these risk factors are disproportionately, or only, experienced by Indigenous Australians (Productivity Commission 2020). Racism is particularly harmful, occurring either systemically or interpersonally. The Australian Reconciliation Barometer report for 2020 found that experiences of racial prejudice by Indigenous Australians increased between 2018 and 2020 (Reconciliation Australia 2020). The report noted that the negative portrayal of Indigenous Australians by the media continues to occur frequently. Research has found that racism increases the risk of suicide among Indigenous youth (Priest et al. 2011). Conversely, a mortality study using Queensland suicide data found suicide rates to be lower in communities where discrimination was less prevalent (Gibson et al. 2021).

Protective and risk factors for suicide

Following an extensive literature review, AIHW (2022c) identified 17 key protective and risk factors that may contribute to suicide among Indigenous Australians. Some of these factors overlap with those identified above and are amenable to intervention and change. These factors were categorised as follows:

- demographic factors
- universal factors contributing to suicide
- factors specific to Indigenous Australians.

Demographic factors

Certain demographic factors confer greater risk for suicide. As described in Chapter 3 of this report, age and sex increase an individual risk of suicide.

- Suicide deaths are 2.4 times as common in Indigenous men than Indigenous women (AIHW 2020a).
- The highest rates of deaths by suicide occur among Indigenous men and women aged 15–44 (ABS 2021a). Dickson and colleagues (2019) cite studies of Queensland data finding Indigenous Australian youth (up to 24 years old) are up to 14 times more likely to die by suicide than other Australian youth in this age range.

Living in rural and remote areas results in greater levels of social isolation and poorer access to services (Productivity Commission 2020). While living in remote areas is associated with higher rates of suicide among Indigenous Australians (AIHW 2022c), AIHW has advised caution around such findings for remote areas, given small numbers of deaths and limitations in the population data for these areas (AIHW 2020a). Such complexities were also flagged by Dudgeon and colleagues (2022), who highlight the complex patterns of vulnerability and resilience in different communities.

The Productivity Commission's inquiry into mental health (2020) identified 'suicide clustering' as a risk. A suicide cluster is a series of suicide deaths or self-harming events that occur close in time and/ or in a similar location or community. The collectivist nature of Indigenous communities can serve to intensify the trauma associated with suicide, signalling the importance of suicide postvention services for the community as a whole (Dudgeon et al. 2022). Postvention services are support services and help to people bereaved by suicide.

Universal factors contributing to suicide

Many factors that contribute to suicide are not unique to the Indigenous Australian population. International and Australian research has confirmed that these factors are cross-cultural, affecting Indigenous Australians, as well as people of other cultures and contexts (AIHW 2022c). The universal factors identified by the AIHW (2022c) review were:

- **a history of suicidal ideation and intentional self-harm:** there is a greater risk of suicide for people who had thoughts or plans of suicide (known as suicidal ideation) or a history of intentional self-harm
- **maternal, infant, child and adolescent health:** child development can be affected by events in utero, with positive actions (such as avoiding drugs and alcohol), positive parenting and healthy behaviours in early childhood and adolescence tending to lower suicide risk

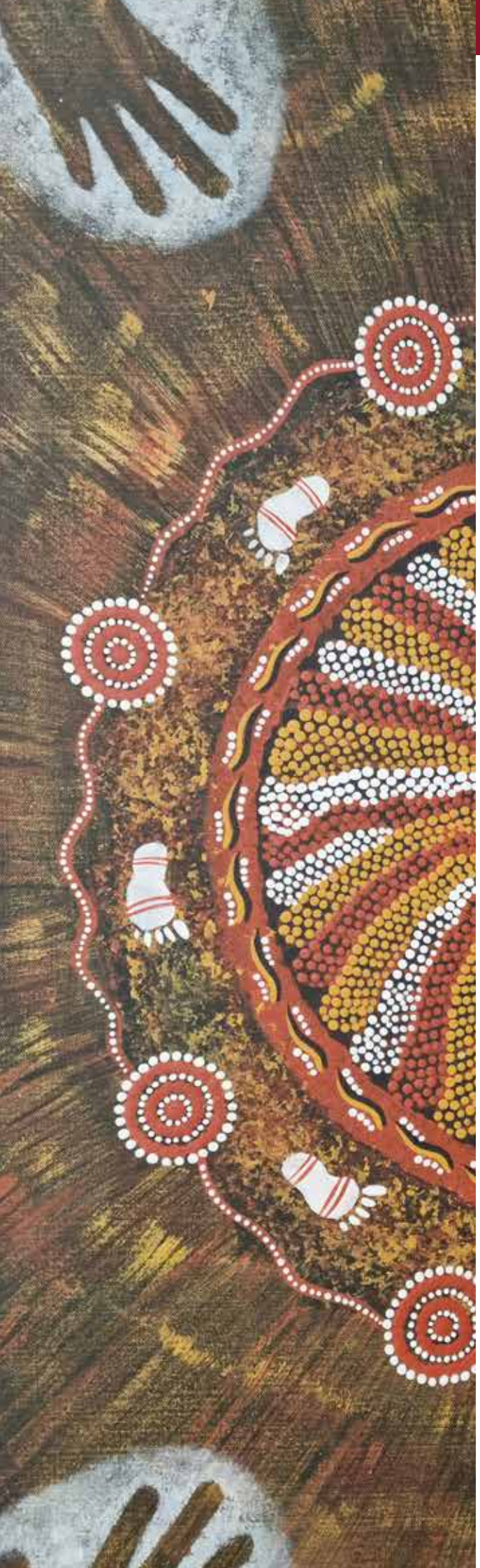
- **support networks:** family, community and peer support can reduce the risk of suicide, whereas experiences of family or domestic violence increase risk
- **discrimination:** racism and discrimination are strongly correlated with suicidal ideation, and negatively affect health (Paradies et al. 2015)
- **LGBTIQ+:** AIHW cited international evidence that lesbian, gay, bisexual, transgender, intersex, queer, and other non-binary or gender-fluid individuals (LGBTIQ+) are at an increased risk of suicide. The literature cited suggests that LGBTIQ+ people are up to 11 times more likely to attempt suicide than the general population (AIHW 2022c)
- **nutrition and food insecurity:** a poor-quality diet and food insecurity can increase risk of suicide, and food insecurity is associated with high levels of psychological distress (ABS 2015a) and is linked to suicide in indigenous populations in other locations (Hajisadeh et al. 2019)
- **barriers to employment:** AIHW cites international evidence for the association between unemployment and suicide, noting the personal and social benefits of employment and a higher income (PM&C 2019, cited in AIHW 2022c)
- **mental health and wellbeing:** positive mental health and wellbeing are flagged as a protective factor for suicide
- **access to mental health care:** access to adequate mental health care can contribute to suicide prevention, with culturally safe service provision an important factor
- **alcohol and drug use:** the most common diagnoses of people who die by suicide is substance-use disorders (Turecki et al. 2019). Moreover, alcohol and drug misuse are key risk factors for suicide in Indigenous communities (AIHW 2022a)
- **incarceration:** Indigenous Australians are substantially overrepresented in the criminal justice systems; incarceration exaggerates other risk factors for suicide and is significantly associated with post-traumatic stress disorder (PTSD) (AIHW 2022c)
- **housing:** 'Homelessness and unstable housing are significantly associated with a greater likelihood of suicidal ideation, mood disorders and anxiety disorders' (Noël et al. 2016, cited in AIHW 2022c); safe and secure housing is a key contributor to the wellbeing of Indigenous Australians (AIHW 2022c)
- **life stressors:** stressful life events, such as death of a family member or serious illness, are recognised to increase the risk of suicide, with greater risk if multiple stressors occur with a year (AIHW 2022c).

Factors specific to Indigenous Australians

The factors identified as contributing to suicidal behaviour specifically, among Indigenous Australians, were intergenerational trauma and the effects of colonisation including loss of culture, and disconnection from Country and spirituality (AIHW 2022c). Teachings of spirituality, especially in early childhood, are important foundations for a healthy self-identity, reinforcing social connections and strengthening links to the natural environment and to individuals' physical selves (AIHW 2022c).

Use of traditional language is cited alongside these factors as an additional element supporting SEWB. Traditional language can aid in understanding social and emotional wellbeing concepts, which cannot always be adequately translated into English and do not always align with Western clinical concepts (AIHW 2022c).

Dudgeon and colleagues (2022) describe connection to community, along with recognition of cultural continuity, as underpinning suicide prevention efforts that strengthen resilience and increase SEWB. Cultural continuity provides protection for the community by reducing psychological distress, suicide and suicide-related behaviour (Dudgeon et al. 2022).



6

Conclusions

6 Conclusions

This article has outlined the socio-historical-cultural factors that have shaped the lives of Aboriginal and Torres Strait Islander people. The history of dispossession and separation – from land, community and family – has had a profound impact on Indigenous Australians. It has resulted in intergenerational trauma; a trauma which is intensified by ongoing exposure to stressors such as socioeconomic marginalisation and institutionalised racism. For many Indigenous Australians, the legacy of the Stolen Generations has been significant levels of loss, grief, disempowerment, cultural alienation, unresolved trauma, and loss of identity. Understanding these factors is important for understanding the social and emotional context of Indigenous Australians.

Australian governments have only recently recognised the mental health implications of past policies for Indigenous Australians and have – even more recently – begun to embrace the need for Indigenous leadership to enable the necessary intervention and policy changes. Political inaction is hampering progress, with many of the recommendations from key enquiries late last century still to be enacted, which has created additional trauma and distress for Indigenous Australians. The mental health and suicide statistics speak to a pressing need to act to improve the social and emotional wellbeing of the Indigenous Australian population.

The 'holistic' concept of Aboriginal and Torres Strait Islander social and emotional wellbeing (SEWB) recognises the importance of connection to land, culture, spirituality and ancestry to the health of an individual. It recognises the right to self-determination and the need for cultural understanding. The Indigenous cultural views and practices embodied by the connected domains of SEWB need to be incorporated into mental health treatments and suicide prevention initiatives. Programs that are framed using SEWB recognise that emotional wellbeing requires a balance between the 7 domains of the body; mind and emotions; family and kinship; community; culture; Country; and spirituality and ancestors.

The importance of self-determination in the treatment of Aboriginal and Torres Strait Islander mental health, and in suicide prevention efforts, cannot be emphasised enough. Unfortunately, the demand for Indigenous health and mental health practitioners exceeds their availability – a shortage that limits access to Indigenous health workers and, for many Indigenous Australians, acts as a key barrier to accessing health services. This demonstrates the importance of widespread and embedded cultural understanding among the entire health workforce.

Success is an outcome of engaging and collaborating with Indigenous Elders and communities and asking – and acting on – what they think should be done. The diversity of Indigenous Australians, both across and within locations; the different languages spoken; and different cultural norms, means that many programs need to be adapted when implemented in a different context. Of fundamental importance will be robust evaluations to share the learnings from these programs and to expand the evidence base for long-term and ongoing improvements for the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

Acknowledgements

The AIHW Indigenous Mental Health and Suicide Prevention Unit assisted with writing this paper. It was commissioned for the Indigenous Mental Health and Suicide Prevention Clearinghouse. The Clearinghouse is funded by the Australian Government Department of Health and overseen by the Indigenous Mental Health and Suicide Prevention Clearinghouse Steering Committee.

We acknowledge the traditional custodians of all the lands of Aboriginal and Torres Strait Islander peoples. We honour the sovereign spirit of the children, their families, communities and Elders past, present and emerging. We also wish to acknowledge and respect the continuing cultures and strengths of Indigenous peoples across the world.

We thank the Indigenous Mental Health and Suicide Prevention Clearinghouse Steering Committee and Fadwa Al-Yaman for their advice and guidance on this report during its development.

Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
CBT	Cognitive behavioural therapy
The Clearinghouse	Indigenous Mental Health and Suicide Prevention Clearinghouse
COAG	Council of Australian Governments
Coalition of Peaks	Coalition of Aboriginal and Torres Strait Islander Peak Organisations
DALY	Disability-adjusted life years
The Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
The Framework	National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023
HREOC	Human Rights and Equal Opportunity Commission
K10	Kessler Psychological Distress Scale – 10 items
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer, and other non-binary or gender-fluid individuals
The Mayi Kuwayu Study	Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSILMH	National Aboriginal and Torres Strait Islander Leadership in Mental Health
PTSD	Post-traumatic stress disorder
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SEWB	Social and emotional wellbeing
YLD	Years of healthy life lost due to disability
YLL	Years of life lost

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This report provides essential information and statistics on mental health, suicide and self-harm among Aboriginal and Torres Strait Islander people. It outlines contemporary Australian policy responses and directions, and risks and protective factors for mental health and suicide prevention. It explores evidence of best practice in mental health and suicide prevention.

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Stronger evidence,
better decisions,
improved health and welfare