



The aftermath of Aboriginal suicide: Lived experience as the missing foundation for suicide prevention and postvention

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Abstract

This paper aimed to highlight the systemic and theoretical barriers for Aboriginal and Torres

Strait Islander people who have been bereaved by suicide. Incorporating the lived experiences of two advocates, Leilani Darwin and Julie Turner, and professional experiences of Matthew Trindall and Laura Ross, the paper explores the importance of including Aboriginal lived experiences in programs for Indigenous suicide prevention. Informed equally by an analysis of the lived experience and suicide prevention literature and the common themes presented throughout the lived experience accounts, it is recommended that more Indigenous-specific research is conducted in the sphere of lived experience in suicide bereavement, as well as dedicated effort to mentor and develop Aboriginal and Torres Strait Islander people with lived experience and support them to influence and design prevention strategies at a local level.

Keywords: Suicide, Aboriginal and Torres Strait Islander, social and emotional wellbeing, lived experience.

Acknowledgements. Input from the wider Aboriginal community was included via a workshop held with representatives of Aboriginal communities and Aboriginal community controlled health organisations within the four NSW Life Span trial regions.

Introduction

Aboriginal and Torres Strait Islander suicide rates remain high in Australia, with Indigenous Australians being more than twice as likely to die by suicide than non-Indigenous Australians (Australian Bureau of Statistics, 2016), with young Indigenous people (aged 15-24) being particularly vulnerable and over five times more likely to die by suicide than their peers (Dudgeon et al., 2016). Suicide is devastating for all who it affects but due to the extensive kinship systems in Aboriginal and Torres Strait Islander communities an individual suicide can arguably have even wider-reaching effects on their broader community, and suicide-related trauma is further compounded when multiple suicides happen within the same kinship network (Hanssens, 2007). This Indigenous experience of suicide as an overwhelming and sometimes constant social problem driven by underlying and ongoing impacts of racism and colonisation is different to a non-Indigenous experience of suicide, and understanding the difference in this experience has much to teach us about how to best support Aboriginal and Torres Strait Islander people, families and communities who are at risk of or bereaved by suicide.

This paper, led by Taylor-Jai McAlister, a proud Wiradjuri woman from Nyngan, New South Wales (NSW) Australia, and co-authored by four other Aboriginal and two non-Indigenous writers, explores the concept of suicide bereavement in the context of Aboriginal and Torres Strait Islander culture and knowledge systems, following Hanssens' (2007) and Murray's (2001) guiding principles: respect for Aboriginal and Torres Strait Islander people's differing knowledge of grief; understanding bereavement through a Social and Emotional Wellbeing (SEWB) context; cultural obligations surrounding death; and the understanding that following a suicide the whole community is at risk' and further, the risk of suicide clusters and contagion within communities following a suicide (Hanssens, 2007). As well as the direct impacts on the greater community following a suicide, it is also necessary to highlight the extreme vicarious trauma and burnout experienced by Aboriginal and Torres Strait Islander people working in the suicide

intervention sphere (Hanssens, 2008; Hanssens, 2007). In exploring experiences of suicide for Aboriginal and Torres Strait Islander people through the perspectives of two Aboriginal women bereaved by suicide, and insights from the professional perspectives of two Aboriginal health workers, this paper aims to present a case for greater structural inclusion of Indigenous lived experience perspectives on suicide and suicide bereavement as important contributors to prevention and postvention efforts. The lived experiences of suicide included in this paper are those of the four Indigenous authors, shared in their own voices to ensure an ethical approach to inclusion.

In 2013, the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was launched, with a focus on reducing the impact of suicide on Aboriginal and Torres Strait Islander communities. However, the suicide rate remains disproportionately high for Aboriginal and Torres Strait Islander people, indicating a need for greater investment, better informed implementation of the Strategy, and more targeted support for the families and communities left behind. There are limitations in the applicability of currently funded approaches to large scale suicide prevention efforts to Aboriginal and Torres Strait Islander suicide prevention, such as LifeSpan, the Australian Systems Approach to Suicide Prevention. These limitations - lack of inclusion of primordial prevention, social and emotional wellbeing and recognising the role of trauma - reflect a scientific and biomedical approach in research and suicide prevention evidence. The developers of LifeSpan acknowledge that general population activity involving mainstream service responses is not sufficient to meet the needs of Aboriginal and Torres Strait Islander people and communities (Ridani et al., 2016). There is also scant literature on the value of including lived experience in program design (an emerging concept in general population suicide prevention), particularly for minority populations such as Aboriginal and Torres Strait Islander communities, or the valuable contribution that Indigenous lived experience could make to improving suicide prevention and postvention efforts.

The Need for Aboriginal and Torres Strait Islander Leadership Inclusion in Suicide Prevention

Recently, there has been a shift towards increasing Indigenous leadership in suicide prevention, with the government funding the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). The Project was established following a recommendation for an evidence-based framework for Aboriginal and Torres Strait Islander suicide prevention in the Closing the Gap Clearinghouse's report "*Strategies to Minimise the Incidence of Suicide and Suicidal Behaviour*" (2013), with the aim of completing a comprehensive review of suicide prevention programs for Aboriginal and Torres Strait Islander people. The ATSISPEP team included experts in every aspect of suicide prevention from service providers to community leaders and had a high level of cultural governance. The ATSISPEP Report, "*Solutions that work: What the evidence and our people tell us*" (Dudgeon et al., 2016), identified that strategies for the general population do not sufficiently address the complexities and diversity of Aboriginal and Torres Strait Islander people. Furthermore, the complexities of suicidal behaviour in these communities require targeted interventions that incorporate kinship systems present in Aboriginal and Torres Strait Islander cultures.

Among many important factors, the ATSISPEP Report also identified lived experience as a necessary component of Aboriginal and Torres Strait Islander suicide prevention programs to ensure that Aboriginal and Torres Strait Islander people lead service design and delivery, based on the finding that programs which included cultural and 'lived experience' elements were more effective. However, the Report also found limited examples of empirically evaluated best-practice programs that are also Indigenous-led and culturally appropriate, with the ATSISPEP Report identifying only eight promising programs out of a potential 88. This lack of culturally appropriate, evaluated programs echoes recent systematic reviews of Aboriginal and Torres Strait Islander suicide prevention that found a

paucity of effective evaluations of Indigenous-specific programs; specifically, there has been only one intervention to date that significantly decreased suicidal behaviours in Aboriginal or Torres Strait Islander people, with no other programs resulting in a significant decrease in suicidal behaviours (Clifford, Doran, & Tsey, 2013; Ridani et al., 2015).

Researchers have proposed that the failure of programs to reduce suicidal behaviours in Aboriginal and Torres Strait Islander people may be attributed to lack of engagement, due to a history of oppression and government systems that implement programs for Aboriginal and Torres Strait Islander people without any Aboriginal and Torres Strait Islander input (Skerrett et al., 2017). The ATSISPEP Report identified cultural governance as a critical success factor for any Aboriginal and Torres Strait Islander suicide intervention program - mainstream models of mental health tend to emphasise individual sources of disorders, whereas Aboriginal and Torres Strait Islander models of mental health consider the broader contextual influences on mental health (Skerrett et al., 2017), as seen in the Aboriginal and Torres Strait Islander use of a 'Social and Emotional Wellbeing' framework. The ATSISPEP Report defines social and emotional wellbeing as connecting "the health of an Aboriginal and Torres Strait Islander individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry" (Dudgeon et al., 2016; Gee, Dudgeon, Schultz, Hart, & Kelly, 2014). Likewise, the Closing the Gap report (2013) also recommended the development of programs based on social and emotional wellbeing, arguing programs that are not culturally safe and competent are less likely to be effective (Dudgeon et al., 2016).

Connection to land, culture, spirituality, ancestry, community and family are commonly identified as protective factors for Aboriginal and Torres Strait Islander people (Gee et al., 2014; Social Health Reference Group, 2004), and an understanding of social and emotional wellbeing and its importance can enrich and enable culturally appropriate suicide bereavement and prevention programs. Purposefully including lived experience input in service design and improvement as well as drawing from evidence-

based practices, and incorporating Aboriginal and Torres Strait Islander culture and approaches would enhance outcomes by ensuring program design is fully informed by those who have had direct experience with the service responses typically associated with suicidality and bereavement.

Given the lack of effective, evaluated Indigenous-led programs that include social and emotional wellbeing and the disproportionate impact of suicide bereavement on Aboriginal and Torres Strait Islander communities, as well as the increased risk of suicide experienced by those bereaved by suicide, inclusion of Indigenous lived experience is an essential part of Aboriginal and Torres Strait Islander suicide prevention.

Learning from Lived Experiences

The personal narratives included in this paper highlight the different experiences of suicide for Aboriginal and Torres Strait Islander people, as well as the need for Indigenous-specific suicide programs and Indigenous lived experience inclusion and involvement to ensure better outcomes.

Julie Turner and the Loss of her Child to Suicide

Julie Turner is a proud Wakka Wakka woman from Cherbourg, Queensland, Australia and a mother who lost a child to suicide 11 years ago. The impact of her child's suicide is still profound.

It happened 11 years ago, but it feels like 11 minutes ago.

Following her 17-year old daughter's death in 2006, Julie dedicated her life to ensuring her experiences could help others bereaved by suicide. Julie has contributed to suicide prevention in multiple ways: notably she established *Motivational Minds*, an Aboriginal and Torres Strait Islander youth empowerment program that aims to address mental health issues and prevent suicide. Despite Julie's own grief, she uses her own experiences of suicide bereavement to ensure the experience for others is appropriately supported, and Julie is an avid advocate for the inclusion of lived experience in suicide bereavement programs.

The death of a child by suicide is an enormous tragedy and what follows afterwards is the horrible despair and pain which is thought by many to exceed all other bereavement experiences. It feels particularly frightening to a single parent, for there is no partner to bridge the gap of isolation. My parents were deceased, all my siblings lived interstate and although I had friends, many did not understand the loss of a child to suicide.

Julie's lived experience highlights the need for a better understanding of suicide bereavement. Suicide bereavement grief has been shown to be different to grief from other losses, with differences being specifically attributed to suicide bereavement identified in four main categories: struggling with the meaning of death (Grad & Zavasnik, 1996; van der Wal, 1989-1990); high feelings of guilt around preventing the death (Kovarsky, 1989; McNiel, Hatcher, & Reubin, 1988; Silverman, Range, & Overholser, 1994-1995); high feelings of anger (Bailey, Kral, & Dunham, 1999); and lower levels of informal support following bereavement (Pitman et al., 2017). The bereavement process for an Aboriginal and Torres Strait Islander person is additionally impacted by cultural factors, in that the loss of someone to suicide may trigger feelings of mistrust of the non-Indigenous community and mainstream health and social services that remain culturally insensitive and immersed in colonial attitudes and practices.

The intergenerational trauma that Aboriginal and Torres Strait Islander people are exposed to throughout their lives is exacerbated in times of grief, and a mistrust of non-Indigenous services is a continuous barrier for Aboriginal and Torres Strait Islander people who are bereaved by suicide in seeking help from non-Indigenous services. Julie believes that finding other Aboriginal and Torres Strait Islander people with lived experience is essential for support. This is particularly so for suicide bereavement, and the legitimacy of the input of people with lived experiences is heightened in tight-knit cultures and communities such as Aboriginal and Torres Strait Islander communities.

Finding a support group was a lifesaver. The people who later became my family and who I felt could understand me were other Aboriginal people who had lost someone to suicide. You

could never understand the grief of losing a child to suicide until you have been through it.

The positive impact of lived experience on the healing journey for Aboriginal and Torres Strait Islander people is highlighted in Julie's story, and the ATSIPEP Report's strong recommendation to include those with lived experience in suicide prevention programs and services reinforces this. One such program identified by ATSIPEP is the Kimberley StandBy Response Service, a locally adapted, nationally funded program located in Western Australia. Kimberley StandBy is an Indigenous-run initiative that contacts Aboriginal and Torres Strait Islander families affected by suicide and coordinates services in a culturally appropriate way. As identified by the ATSIPEP Report, suicide prevention and postvention programs which carry the legitimacy of Aboriginal and Torres Strait Islander lived-experience voices improve engagement with the program and provide a culturally-safe healing process for Aboriginal and Torres Strait Islander people (Dudgeon et al., 2016). In short, who deals with families and how connections are made is important.

A white woman came to tell me that my child had died. I will always remember that day...

ATSIPEP identified many barriers to help-seeking for Aboriginal and Torres Strait Islander people, including institutionalised racism, mistrust of non-Indigenous services, and culturally inappropriate services, noting that services that are not Aboriginal and Torres Strait Islander governed and led were less effective. Julie was informed of her daughter's suicide by a non-Indigenous woman, which added to her trauma as for some Aboriginal and Torres Strait Islander people, it is preferable that another Aboriginal and Torres Strait Islander person contacts and informs the next of kin of a person's death. Additional distress might be caused for an Aboriginal and Torres Strait Islander person depending on who and how they are informed. Consideration of cultural protocols in suicide postvention and options for an Indigenous person to inform next of kin could help avoid adding to the existing trauma felt by a family member bereaved due to suicide, and the inclusion of lived experience could inform services regarding cultural safety and improving

the use of cultural protocols around deaths. Insights from people like Julie who have experienced culturally unsafe services can improve the capacity of these programs to better address the needs of Aboriginal and Torres Strait Islander people. Engaging with culturally unsafe programs is likely to be of little use and may even be damaging to families bereaved by suicide. It is therefore necessary to acknowledge not only the risks of non-Aboriginal workforces using culturally unsafe practices but also systemic gaps in the implementation of Aboriginal and Torres Strait Islander led programs and the ongoing need for increased development of an Aboriginal mental health workforce.

Leilani Darwin and the Loss of her Mother as a Child

Leilani Darwin is a proud Aboriginal woman from Queensland, Australia. Leilani's mother died by suicide when she was 10 years old, and as a result Leilani grew up living between foster homes and family members. Driven by her lived experience of suicide bereavement, Leilani began to contribute to the field of Aboriginal and Torres Strait Islander suicide prevention, with a focus on empowering and educating Aboriginal and Torres Strait Islander youth. Leilani's focus on youth is linked to her personal and professional experiences and a subsequent belief that early intervention, education in cultural healing practices and understanding how culture can keep your spirit strong is the best approach for an effective reduction in Aboriginal and Torres Strait Islander suicides. Leilani, in partnership with local Elders, community and young people, designed the UHELP program that uses a strengths and culturally based approach to suicide prevention. "Culture was at the forefront of every single thing that we did...it was culturally informed and that buy-in and agreement from the community was continued through the whole project".

Leilani is a strong advocate for cultural governance in the Aboriginal and Torres Strait Islander suicide prevention sphere, including having the lived experiences of people impacted by suicide as a critical success factor in the development of all suicide prevention programs. This has been particularly relevant in her development of the program and remembering

her experiences as a young person who was suicidal.

My story began as I was growing up with a single mother who was an alcoholic, suffered from depression, regularly self-harmed and was acutely suicidal. When I was just 10 years old I lost my mother to suicide. I lived in foster homes growing up, throughout my childhood I was exposed to many things that a young person should never have to deal with or understand. Those experiences have influenced and affected my adult life. My lived experience has given me the unique opportunity to connect with young people in a way that enabled them to trust me and share their own thoughts of suicide.

Challenges Working in Suicide Prevention for Indigenous People with Lived Experience

The differential impact of working in suicide prevention for Aboriginal and Torres Strait Islander people due to connection to their country, community and culture, as well as their lived experience which tends to involve significantly more exposure, needs to be considered to ensure that Indigenous-led programs are sustainable and that Aboriginal and Torres Strait Islander people working in the field are given appropriate support.

Working in this sector has sometimes also had a negative impact on my well-being and resulted in another diagnosis of depression and the need for treatment, the reality of this work for everyone is that it's damn hard.

As in Leilani's experience, working in this sector as an Aboriginal woman with her own experience of suicide loss can further exacerbate vulnerability and lead to an experience of continuous grief through professional exposure to suicide deaths. Aboriginal and Torres Strait Islander people working in this sector commonly report that there is no 'knock off'; an Aboriginal and Torres Strait Islander person who works during the day supporting their community is often required to continue that support for people in their wider kinship and social network after hours due to the combination of their cultural obligations and professional experience. Research in non-Indigenous settings shows that

these conditions can lead to burnout in the mental health workforce (Kee, Johnson & Hunt, 2002; Paris & Hoge, 2010), and this may be an area requiring greater attention in the Indigenous workforce. Holistic interventions are needed to support staff, including training, clinical cultural supervision and support that are designed, led by and for communities to support health workers who might be in this expanded natural helper role.

In my experience, the cultural impacts and implications of working in this sector are complex and need to be considered by all workplaces to ensure staff don't burn out and that their cultural needs are considered. I myself have suffered from mental illness and disconnection from my culture. Through my healing journey I have a much stronger connection to culture and my sense of identity.

Leilani recalls that a crucial factor in her healing journey was the strength she gained from her connection with culture and Aboriginal people, and culturally appropriate healing is particularly necessary for Aboriginal and Torres Strait Islander people with lived experience of suicide bereavement. Cultural healing requires a strengths-based approach that acknowledges the community; in this way, the kinship networks that make communities more vulnerable in a time of suicide can also be the community's biggest strength. Aboriginal people are from a collective culture in which communities are built around support and connection, and teaching communities how to appropriately support each other via the input of people with lived experience is essential to a culturally-safe way to support Aboriginal and Torres Strait Islander people.

Aboriginal Mental Health Workforce Development

Matthew Trindall, an Aboriginal man of the Gomeroi Nation in Narrabri North West, NSW, works as the Clinical Leader for Aboriginal mental health in La Perouse, Sydney and has had ample experience with the barriers for Aboriginal and Torres Strait Islander people in the workforce for suicide prevention.

Workforce development in the Aboriginal mental health and wellbeing sector remains a priority for

Indigenous suicide prevention programs. A current program with a 20-year history is the Djirruwang program that is a specific Aboriginal mental health training, education and workforce development program funded through the NSW Ministry of Health. The workforce program is designed to develop pathways for the Aboriginal mental health workforce across all of NSW and provide career opportunities for existing trainees and graduates of the program.

I'm a graduate of the Djirruwang program, which enabled me to complete the traineeship in my local community and transition to the local community mental health team in Narrabri. The invaluable experience and exposure to mental health was vital for professional development, but the trials of working in your local community with friends and families created burnout and I became disenfranchised by the system. A lot of aspiring Aboriginal mental health workers have lived experience and face many challenges when confronted with the mental health industry because of unresolved trauma and their lived experience.

Whilst training, education and workforce development provide career opportunities for aspiring mental health workers, there remain many barriers that deter Aboriginal people from the sector. It is common for Aboriginal workers to empathise with *walking in two worlds* with community and workforce expectations, whilst finding a balance.

The Aboriginal mental health workforce is also a relatively new industry compared to other disciplines, requiring ongoing investment through innovation and collaboration with partner organisation and community engagement to maximise the effectiveness of Aboriginal workers in suicide prevention programs.

Laura Ross is a Wamba Wamba Muthi Muthi woman from Deniliquin NSW, with bloodline and kinship ties to the Gunditjmara and Wiradjuri Peoples. She began her career in mental health ten years ago, as the Aboriginal mental health trainee with the Deniliquin Mental Health, Drug and Alcohol (MHDA) team. In her current role of Coordinator, MHDA - Aboriginal People for the Murrumbidgee Local Health District (MLHD), Laura provides support to the Aboriginal workforce, ongoing support to all MLHD staff around Aboriginal MHDA and

cultural protocols, Aboriginal community engagement and education, and clinical leadership. Laura describes the flow-on effect from lower workforce capacity and high turnover related to burnout as a result of constant exposure to vicarious trauma.

It is a 24 hours a day, 7 days a week job because we go home to more of it at the end of the day. It's high intensity and hard work, and the average work lifespan of an Aboriginal mental health clinician is about 3 years before they reach burnout.

As reflected above, even where scant funding is made available to implement or continue culturally safe mental health and suicide prevention services, identified Indigenous health or mental health positions may be unfilled for extended periods due to low workforce supply, leaving a gap in service delivery and continuing the vicious cycle of burnout for those Indigenous people already working in mental health roles.

Conclusion

A recent comprehensive review of the evidence around lived experience inclusion in suicide prevention (Suomi, Freeman, & Banfield, 2017) indicated that a co-design framework is necessary for the effectiveness of suicide prevention programs, and involvement of people with lived experience should be apparent at each stage of the development and built strategically into policy, program and implementation. Emerging Australian lived experience networking groups such as Roses in the Ocean provide training, readiness assessments and skills to support non-Indigenous people with a lived experience of suicidality and bereavement to use their personal experience to effect change (Roses in the Ocean, 2017). The existence of advocacy groups that auspice lived experience participation and representation such as Australian charity Roses in the Ocean means that the organisation can be funded to support individuals with lived experience to contribute to Government policy design and provide advice on suicide prevention. However, no such network currently exists for an equivalent group supporting Aboriginal and Torres Strait Islander lived experience, despite the obvious need.

The suicide rate for Aboriginal and Torres Strait Islander people remains significantly higher than the non-Indigenous Australian population, yet there remains a lack of empirically evaluated programs specifically designed, led by and for Aboriginal and Torres Strait Islander people. The lived experience of Aboriginal and Torres Strait Islander people bereaved by suicide, which is qualitatively distinct from other bereavement grief, appears to be significantly underutilised. ATSIPEP strongly recommends a strengths-based framework for suicide prevention programs, and the success of any program in the Aboriginal and Torres Strait Islander suicide prevention sphere requires the cultural governance and involvement of the community members it is targeting. Echoing this, interventions that have been identified as promising or have demonstrated success in decreasing suicide deaths have done so by incorporating local community knowledge and cultural practices and the lived experience of Indigenous people impacted by suicide and loss. In the context of significant current investments nationally in suicide prevention, it is recommended that these investments be leveraged to further develop the voice of strategic lived experience to inform more effective suicide prevention specifically targeted to Aboriginal and Torres Strait Islander communities. Additionally, mainstream services and funding bodies must acknowledge and use the knowledge of Aboriginal and Torres Strait Islander people with a lived experience of suicide and suicide loss to improve outcomes in suicide prevention.

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Rachel Green is the Director of LifeSpan, the Black Dog Institute’s large scale suicide prevention framework, currently being implemented in NSW and funded by the Paul Ramsay Foundation. Her professional expertise includes mental health policy and program development with the Department of Health and Ageing and the Department of Prime Minister and Cabinet, establishment of the National Mental Health Commission, as well as

production of the first annual National Report Card on Mental Health and Suicide Prevention and design of the Contributing Life Framework. A champion of strategic lived experience inclusion, Rachel is also driven by personal experience with suicidality and loss.

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