

National Aboriginal and Torres Strait Islander  
**Leadership in Mental Health**  
Together we are strong

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To: Martin Rocks  
Social & Cultural Determinants of Indigenous Health Working Group  
My Life, My Lead – Implementation Plan Advisory Group (IPAG) Consultation 2017  
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**National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) Submission on the Social and Cultural Determinants and Indigenous Mental Health Problems and Suicide**

Dear Mr Rocks

On behalf of the NATSILMH members, please find the above as an attachment to this letter.

For the information of the Department of Health, NATSILMH is a core group of senior Indigenous people 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 mental health bodies.

NATSILMH's aim is to help restore, maintain and promote the social and emotional wellbeing and mental health of Indigenous peoples by advocating and providing advice and leadership in these areas. It also aims to reduce the high rates of suicide among Indigenous people.

NATSILMH's was established in November 2013. While NATSILMH is an independent body, it is supported and funded by the Australian mental health commissions as an expression of their commitment to the 2010 *Wharerātā Declaration* and supporting Indigenous leadership in the mental health system. (For the *Wharerātā Declaration*, see: <http://natsilmh.org.au/sites/default/files/uploads/Wharerata%20Declaration-JILPS%202010.pdf>.)

Over the past 3.5 years, NATSILMH has built a considerable record of achievement with highlights as follows:

- Developing the *Gayaa Dhuwi (Proud Spirit) Declaration* as a domestic companion document to the *Wharerātā Declaration*. Launched in August 2015, the *Gayaa Dhuwi (Proud Spirit) Declaration* has been extensively promoted by NATSILMH such that it is currently included in the *National Mental Health and Suicide Prevention Plan* as a guide to reform in Indigenous mental health and related areas. For the *Gayaa Dhuwi (Proud Spirit) Declaration*, see [http://natsilmh.org.au/sites/default/files/gayaa\\_dhuwi\\_declaration\\_A4.pdf](http://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf).)

- Formally advising the National Mental Health Commission on the Indigenous elements of the national review of mental health services and programmes (February – December 2014).
- Advising on mental health policy development that includes the *National Mental Health and Suicide Prevention Plan*, the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan*, and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017 - 2023* (Social and Emotional Wellbeing and Mental Health Framework) that was endorsed by AHMAC in February 2017.

In relation to the last point, please note that NATSILMH in consultations for the current *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan* (NATSIHPIP) sought to ensure that the NATSIHPIP was drafted in such a way as to ensure that it would operate as a complementary document to the Social and Emotional Wellbeing and Mental Health Framework (then in development) and the 2013 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (NATSISPS). This means that:

- the latter two are acknowledged in the next NATSIHPIP as the primary documents for guiding Indigenous mental health and social and emotional wellbeing and suicide prevention policy; and
- every opportunity to implement the Social and Emotional Wellbeing and Mental Health Framework and the NATSISPS through the next NATSIHPIP is availed.

NATSILMH welcome any opportunity to help ensure these outcomes over the next year of NATSIHPIP development.

Yours sincerely



Professor Pat Dudgeon  
Chair  
NATSILMH

## National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) Submission on the Social and Cultural Determinants and Indigenous Mental Health and Suicide

The focus of policy makers in the past decade has been on the physical health of Aboriginal and Torres Strait Islander (hereon 'Indigenous') peoples rather than on their mental health. This has occurred largely because of a lack of appreciation of the impact of mental health and related area problems on Indigenous health and life expectancy overall.

NATSILMH welcome that this is beginning to change. In particular, the Australian Institute of Health and Welfare's 2016 *Australian Burden of Disease Study* identified mental health and substance use disorders (including anxiety and depressive disorders, alcohol use disorders, drug use disorders and autism spectrum disorders) as the single largest contributing disease group to the total Indigenous disease burden (measured in disability-adjusted life years) from 2003 - 2011.<sup>1</sup>

Indeed, the data suggests an entrenched, perhaps worsening, mental health crisis. For example:

- **Trauma:** Trauma is not a mental illness but refers to experiences and symptoms associated with particularly intense stressful life events (including natural disasters, injuries, child sexual abuse or violent assault) that overwhelm a person's ability to cope.<sup>26</sup> Responses can range from chronic dissociation to psychotic breakdown and post-traumatic stress that can be diagnosed as Post Traumatic Stress Disorder (PTSD).<sup>2</sup> A 2008 study of 419 Indigenous prisoners in Queensland reported 12.1 per cent of males and 32.3 per cent of females with PTSD.<sup>3</sup>
- **Mental Health Conditions:** Over the period July 2008 to June 2010, Indigenous males were hospitalised for mental health-related conditions at 2.2 times the rate of non-Indigenous males; and Indigenous females at 1.5 times the rate of non-Indigenous females.<sup>4</sup> Rates of psychiatric disability (including conditions like schizophrenia) are double that of non-Indigenous people.<sup>5</sup>
- **Suicide:** Among Indigenous peoples, suicide is a relatively recent phenomenon with few precedents prior to the 1960s.<sup>6</sup> Yet fifty years later, the Indigenous suicide rate is a least twice that of non-Indigenous people.<sup>7</sup> Suicide is the fifth leading cause of death for Indigenous peoples,<sup>8</sup> compared to the 14<sup>th</sup> among non-Indigenous people.<sup>9</sup> It is the leading cause of death from external causes.<sup>10</sup> The peak age of Indigenous suicide is 30-34 years for males and 20-24 years for females;<sup>11</sup> and this is three times the rate for non-Indigenous people of the same ages.<sup>12</sup>
- **Self-harm** can be a way of coping with stress and akin to a 'cry for help',<sup>13</sup> but data collections do not distinguish between self-harm for this purpose and attempted suicide. In 2014-2015, Indigenous peoples were hospitalised for self-harm at 2.6 times the rate of non-Indigenous Australians.<sup>14</sup> Reported rates have increased by 55.6 per cent since 2004-2005.<sup>15</sup>
- **Alcohol use.** In the ABS *Australian Aboriginal and Torres Strait Islander Health Survey 2012 -13* (AATSIHS) 16 per cent of men and 12 per cent of women reported problems related to alcohol<sup>16</sup> - 14 per cent of Indigenous men were drinking an average of over five standard drinks per day; <sup>17</sup> 8.1 per cent were drinking more than seven standard drinks per day.<sup>18</sup> Indigenous peoples were admitted to hospital for acute intoxication at around 12.1 times the rate for the non-Indigenous population – with the highest rates in remote and very remote areas.<sup>19</sup>

In practice, trauma, mental health problems, suicide and alcohol and other drug use and many so called 'wicked problems' in some Indigenous communities are inter-related indicators of distress cannot be meaningfully discussed in isolation:

- Researchers estimate that people with major depression are at a 20 times increased risk of suicide.<sup>20</sup> In the AATSIHS, 12 per cent of respondents reported feeling depressed or having depression as a long-term condition compared 9.6 per cent in the general population.<sup>21</sup> Over 2008 – 2013, depression was the most frequently reported mental health related problem managed by GPs among Indigenous clients, followed by anxiety, and then use of tobacco, alcohol and other drugs.<sup>22</sup>
- Researchers estimate that men with alcohol dependence and who drink at levels of risk are at 6 times increased risk of suicide, with an increased risk for women.<sup>23</sup> Among Indigenous Australians, Chikritzhs *et al* (2007) found suicide to be the most common cause of alcohol-related deaths among Indigenous males and the fourth most common cause among females.<sup>24</sup>
- Violence among Indigenous peoples is often connected to alcohol use, and they are often victims of alcohol-related violence.<sup>23,24</sup> Violence is the most common offence resulting in the imprisonment of Indigenous peoples. In 2014, 35 per cent of Indigenous prisoners were charged or convicted with acts intended to cause injury compared with 16 per cent of non-Indigenous prisoners: double the rate.<sup>3</sup>
- High rates of mental health disorders are reported among Indigenous prisoners. In the previously discussed 2008 Queensland study cohort, mental health disorders were detected in 73 per cent of Indigenous male prisoners and 86 per cent of Indigenous female prisoners. Substance use disorders were the most common disorder: detected in 66 per cent of the male and 69 per cent of female prisoners. These were often co-morbid with other mental health disorders.<sup>27</sup> Conditions detected included anxiety disorders (20 per cent male prisoners; 51 per cent female prisoners of the cohort); depressive disorders (11 per cent; 29 per cent); and psychotic disorders (8 per cent; 23 per cent).<sup>27</sup>

Without a substantial complementary focus on mental health and related area then, any gains made in relation to Indigenous health overall and life expectancy are likely to be unsustainable.

Further, improving mental health should be a foundation response to Indigenous disadvantage and achieving the Indigenous Affairs priorities for Australian governments. These include addressing school attendance, unemployment, and community safety,<sup>25</sup> as well as reducing the high levels of imprisonment of Indigenous peoples.

## 1. **Social determinants**

Critical to understanding the high rates of Indigenous mental health and suicide is understanding that colonisation traumatically disrupted cultures, communities and families, with ensuing intergenerational mental health impacts. All these effects are exacerbated by the negative impact of social determinants today.

### *Colonisation as context*

The present day mental health of Indigenous peoples cannot be considered apart from colonisation and its traumatic impacts. The first wave of colonisation (characterised by frontier violence and dispossession) is relatively recent, occurring within only three to eight generations of Indigenous people living today. The last officially sanctioned massacre is recorded at Coniston, Northern Territory in 1928.<sup>26</sup>

A second wave of colonisation (late 1800s – 1950s) involved the further dispossession of people onto reserves and missions, or their confinement to camps outside of towns. Indigenous people were subject to legislation that controlled all aspects of their lives.<sup>27</sup> Against this background, and until the early 1970s in some cases, the forcible removal of thousands of Indigenous children to be assimilated occurred.<sup>28</sup> In the Australian Bureau of Statistics (ABS) 2008 *National Aboriginal and Torres Strait Islander Social Survey*, 12 per cent of respondents aged 45 years and over (i.e. born before 1933) had personally experienced separation from their family.<sup>29</sup>

The trauma that eventuated has been passed down between generations.<sup>30</sup> The mechanisms by which trauma is transmitted are the subject of ongoing research. Recent research also suggests the possibility of epigenetic transmission.<sup>31</sup> Milroy proposes a variety of mechanisms to understanding transgenerational trauma, including:

- the impact of attachment relationship with care givers;
- the impact on parenting and family functioning;
- the association with parental physical and mental illness; and
- disconnection and alienation from the extended family, culture and society.<sup>32</sup>

When considering suicide, it is the decades in which ‘decolonisation’ began in Australia (a process that is not viewed as complete by NATSILMH) that are associated with the increasingly high rates of Indigenous suicide. This can be dated in Australia with ‘deregulation’ in the 1950s and 1960s: the closing of reserves, and the end of formal legally encoded racial discrimination. However, this in practice did little to improve the desperate conditions in many Indigenous communities, while, on the other hand, enabling Indigenous peoples to access both welfare and alcohol without restriction.

Hunter and Milroy contend this scenario led to widespread dysfunction in Indigenous communities. This period preceded the rapid increase in suicide rates of Indigenous people in the 1980s who were born into a state of what they describe as ‘normative instability’, where alcohol abuse and dysfunction were layered upon trauma and distress in a broader context of deep poverty and social, economic and political exclusion.<sup>33</sup>

This situation persists into the twenty-first century where ‘deep and persistent disadvantage’ still characterises the lives of a disproportionate number of Indigenous peoples.

#### *Deep and persistent disadvantage, stress and trauma*

In 2013, the Productivity Commission classified Australian population groups using the the Social Exclusion Monitor. This comprises 29 indicators across seven key life domains including material resources, employment, education and skills, health and disability, social connection, community and personal safety, to assess what the commission terms their ‘deep and persistent disadvantage.’ A sum-score approach is used, with responses for each domain assumed to be of equal importance. Using this populated with HILDA data, it found that in 2010, 9.1 per cent of Indigenous peoples were estimated to suffer deep and persistent social exclusion in Australia,<sup>34</sup> compared to approximately 5 per cent in the general population.<sup>35</sup>

Social exclusion and associated negative social determinants have significant health and mental health impacts. In a 2014 study, the Australian Institute of Health and Welfare estimated that negative social determinants accounted for almost one-third of the Indigenous health gap.<sup>36</sup> Lower household income, lower levels of school attainment, and higher levels of unemployment were estimated to have the largest health impacts.<sup>37</sup>

Behavioural factors further contributed to the Indigenous health gap.<sup>38</sup> They included smoking, poor diet leading to obesity, and binge drinking.<sup>39</sup> But many of these behaviours are themselves responses to negative social determinants. In fact, the AIHW estimated that interactions between social determinants and behaviours risk factors added an additional 15 per cent to the health gap.<sup>40</sup>

Social exclusion and negative social determinants have significant mental health impacts on Indigenous peoples. In 2012–13, 30 per cent of AATSIHS respondents over 18 years of age were assessed with having high or very high psychological distress levels in the four weeks before the survey. That is, using the K-5,<sup>41</sup> a modified version of the K-10 assessment for psychological distress.<sup>42</sup> The assessed rate was nearly three times the non-Indigenous rate from comparable surveys.<sup>43</sup>

The underlying reason appears to be the much higher rates of exposure Indigenous peoples have to stressful (and traumatic) life events associated with poverty and disadvantage.

In the AATSIHS, 73 per cent of respondents aged 15 years and over reported that they, their family or friends had experienced one or more stressful life events (that is, events with mental health impacts) in the previous year.<sup>44</sup> That rate is 1.4 times that reported by non-Indigenous people.<sup>45</sup> The most frequently reported stressful life events by Indigenous peoples were: death of a family member or friend (reported by 37 per cent of respondents); serious illness (23 per cent); inability to get a job (23 per cent).<sup>46</sup>

Researchers report that 1.9 – 2.6 overlapping stressful life events are associated with mild or moderate psychological distress, with between 2.6 and 3.2 events associated with high or very high psychological distress.<sup>47</sup>

High and very high psychological distress is also:

- A risk factor for suicide. A 2009 study reported that those with high and very high psychological distress measured by the Kessler K-10 scale were 21 and 77 times more likely, respectively, to be experiencing suicide ideation<sup>48</sup>.
- Associated with at risk drinking and its flow on effects. In the NATSISS 2008, adults with high/very high levels of psychological distress were also more likely to drink at chronic risky/high risk levels (21 per cent compared with 16 per cent with low/ moderate levels of psychological distress) and to have used illicit substances in the previous 12 months to the survey (27 per cent compared with 18 per cent).<sup>49</sup> Substance abuse is a community safety issue and is associated with violence, child maltreatment, high rates of imprisonment, and other challenges facing communities.

A 2012 study of 271 WA Indigenous community residents found that almost all (97.3per cent) participants had been exposed to traumatic events. The same group of participants also had a lifetime prevalence of 55.2per cent for PTSD; 20per cent for depression; and 73.8per cent of participants met diagnostic criteria for alcohol abuse or dependence.<sup>50</sup>

It is important to highlight that trauma can have neurological and developmental impacts. In children, as discussed further below, cognitive, neurological and psychological development can be disrupted by the exposure to traumatic incidents resulting in wide-ranging impairments in arousal, cognitive, emotional and social functioning.<sup>51</sup>

When considering particular individual factors associated with suicide, a 2011 Queensland study is particularly useful. This reported that two-thirds of the entire sample (both Indigenous and non-Indigenous cases) had records of being exposed to at least one recent stressful life event prior to suicide, with no significant differences observed across age or gender. It reported the most common stressful life events found to precede an Indigenous suicide are:

- Conflict with partners (relationship conflict) and family members (familial conflict) or other persons (interpersonal conflict);
- Pending legal matters and criminal history; and
- Loss of significant persons (bereavement), with a particular focus on exposure to suicide in the social network.<sup>52</sup>

### *Racism*

A 2015 systematic review and meta-analysis of 293 international studies on the health impacts of racism found that racism was: strongly associated with poorer mental health, including (in decreasing order of association): depression, self-esteem impacts, and psychological stress; and less strongly associated with poorer physical health: overweight-related outcomes being the most commonly identified.<sup>53</sup> The studies were conducted predominately in the United States among its racial minority populations.

Among Australia's Indigenous peoples, too, racism is associated with mental health impacts and mental health-risk taking behaviours. The above is demonstrated in surveys and research papers including:

- The LEAD Experiences of Racism survey (2011). This involved 755 Indigenous people in four State of Victoria localities, all 18 years and over. Of these, 97 per cent had experienced racism in the previous 12 months. Over 70 per cent experienced eight or more racist incidents. People who experienced the most racism also had the most severe psychological distress scores. Two-thirds of those who experienced 12 or more incidents of racism reported high or very high psychological distress scores.<sup>54</sup>
- The 2003-2004 Western Australian Aboriginal Child Health Survey involved 5,289 WA Indigenous children aged 4 - 17 years across the State. Of these, 21.5 per cent reported experiencing racism in the previous six months. Of those, almost 19 per cent were at high risk of clinically significant emotional or behavioural difficulties, compared to 9 per cent who had not. Racism appeared to have a disproportionate impact on young women: Of females experiencing racism, 27.9 per cent were at high risk of clinically significant emotional or behavioural difficulties compared with 9.8 per cent of females who had not.<sup>55</sup> Smoking cigarettes, frequent marijuana use and drinking alcohol to excess were all significantly associated with report of experiencing racism.<sup>56</sup>

### *Adverse Childhood Experiences (ACEs)*

ACEs are stressful and traumatic life events for children. They can include a death in the family; injury; household alcohol or drug problems; child abuse or neglect; living in out-of-home care; and being bullied at school.<sup>57</sup> Indigenous families have a much higher recorded prevalence of childhood adversities that can impact on mental health in later life when compared to non-Indigenous families.<sup>58 59</sup>

Nationally in 2014-15, the most common reason for substantiation for Indigenous children aged 0–17 years was neglect (38.3 per cent) followed by emotional abuse (37.7 per cent).<sup>60</sup> While all forms of abuse significantly increase the risk of suicidal ideation and suicide attempts for young people, research suggests that the link is strongest in cases of sexual abuse.<sup>61</sup>

Important here is the impact of developmental trauma and impacts on neurological functioning. Young Indigenous people with developmental trauma can come to the attention of child protection and family services, mental health services, and the police and the juvenile justice system.

#### *Lack of access to primary mental health care*

Because of lack of access to/ or use of primary mental health care according to need, Indigenous peoples with mental health problems are overrepresented in other parts of the health and mental health system. For community based mental health clinics, about 9 per cent of contacts were provided to Indigenous peoples in 2013-14: 3.3 times the non-Indigenous rate.<sup>62</sup> In 2012-13, Indigenous people accounted for a disproportionate 9 per cent of mental health-related ED occasions of service. They accounted for 4.9 per cent mental health-related hospitalisations including specialised psychiatric care in 2012-2013; and 4.1 per cent of all episodes of residential mental health care in 2013-2014.<sup>63</sup>

#### *Institutional racism*

Institutional racism includes actions by institutions that are not overtly racist or believe themselves to be racist but amount to ‘the observance and administration of policies, rules and procedures that purport to treat everybody equally, but are unfairly or inequitably administered or applied in dealings with people belonging to a particular racial, ethnic, religious or cultural group’.<sup>64</sup>

Whether evidence of institutional racism or not, the NATSISS 2014–15 reported that nine per cent of respondents agreed that their own doctor could not be trusted, 35 per cent that hospitals could not be trusted.<sup>65</sup> The 2012-13 ABS *National Aboriginal and Torres Strait Islander Health Survey* (NATSIHS), reported that 35 per cent of those who reported being treated badly because they were Aboriginal and/or Torres Strait Islander usually responded by subsequently avoiding the person or situation. Such is backed up by other research.<sup>66</sup> About seven per cent of NATSIHS respondents reported that they had avoided seeking health care because they had been treated unfairly.<sup>67</sup>

Critical to addressing institutional racism and improving access to health and mental health services is the development of Aboriginal Community Controlled Health Services (ACCHSs) and other dedicated (if not community controlled health) services aimed at Indigenous peoples.

Studies have found that for Indigenous people ‘access to service is critical and, where ACCHSs exist, the community prefers to and does use them.’<sup>68</sup> With appropriate resources, an ACCHS is able to implement a culturally competent and comprehensive primary health care model based on the culturally shaped, holistic concepts of health understood by the communities they serve.<sup>69</sup> However, in the 2015 Service Reports, of the 203 Australian Government funded Indigenous Primary Health Care Organisations, including ACCHSs, 55 per cent reported service gaps for mental health and social and emotional wellbeing; and 47 per cent - alcohol, tobacco and drug service gaps.<sup>70</sup>

Where such services do not exist, Indigenous people are obliged to rely on general population health and mental health services. As such, it is critical that such services are culturally safe and that its staff, and indeed the organisation itself, is culturally competent to work with Indigenous peoples. [These concepts are assumed knowledge in the reader.]

**Recommendation 1: That the social determinants of the high rates of trauma, mental health problems, suicide and related problems among the Indigenous population are addressed as a foundation preventative response to these issues. This includes by supporting the implementation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017 – 2023* through the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan 2018 – 2023*.**

## 2. Cultural determinants

Health is not a universal concept, rather it is a culturally informed concept, conceived of by Indigenous peoples as ‘social and emotional wellbeing’ (SEWB) – connecting the health of an Indigenous individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry.<sup>71</sup> It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine. The diagram below illustrates the SEWB concept and the influence of historical and social determinants on SEWB that were discussed in the previous section.

Determinants of Social and Emotional Wellbeing



Gee, Dudgeon, Schultz, Hart and Kelly, 2013

SEWB includes a strong sense of self and cultural identity that can provide meaning and resilience in times of adversity.<sup>72</sup> Identifying, participating in and engaging with culture are essential to the development of strong and resilient Indigenous children and young people.<sup>73</sup> A positive cultural identity has been found to assist Indigenous children and young people to navigate being a minority group in their own country.<sup>74</sup> Indigenous cultures contain natural protective and wellbeing factors such as kinship networks; and language, culture and cultural identity that have been found to be key protective factors that predict resilience in children.<sup>75</sup>

SEWB works to reduce psychological distress because it is a source of resilience that provides a ‘buffer’ against the worst impacts of stressful life events.<sup>76</sup> This is important because, as discussed, Indigenous peoples experience stressful life events at higher rates than other Australians.<sup>77</sup> Without SEWB/resilience, exposure to such events can leave individuals, families and communities vulnerable to psychological distress and trauma.

A summary of the evidence base demonstrating the link between cultural practice/ SEWB and resilience is set out below:

- A ten year study in Central Australia found that connectedness to culture, family and land are

contributors to significantly better health (lower morbidity and mortality) in outstation communities.<sup>18</sup> The study found that residents of communities where traditional languages and cultural practices are valued and maintained are less likely to be obese, less likely to have diabetes and less prone to cardiovascular disease than Indigenous peoples across the rest of the Northern Territory.<sup>78</sup>

- A qualitative health study found that Indigenous ceremonies (kanyirninpa/holding) prevent self-harm and suicide in desert communities in the southeast Kimberley region of Western Australia. This cultural practice results in increased cultural and community/social connectedness. The ceremonies embed participants in multiple supporting relationships across and within generations, preventing or ending social isolation.<sup>79</sup> Such cohesion building practices potentially support community development and community safety.
- An evaluation of the Indigenous festivals including the Croc Fest, the Dreaming Festival and Garma, found that benefits for participants included increased empowerment, capacity building, social capital, exposure to positive role models, cultural security, cultural confidence, local leadership, economic opportunities and pride in Indigenous identity.<sup>80</sup>

In addition to strengthening individuals, strengthening SEWB means strengthening families, and communities. This is important because:

- Families and individuals make up communities and communities provide support for families and individuals.
- Good family functioning is generally associated with better outcomes for both adults and children. Children, in particular, can benefit from having positive role models for building relationships and an environment that fosters the development of high self-esteem. Families are also pivotal to the wellbeing of Indigenous communities and their culture and survival. They help define identity and build a sense of connectedness to kinship and culture.

SEWB promotion then is proactively supporting and building the health and wellbeing of individuals, and the health and cohesion of families and communities. It means supporting, reclaiming and promoting culture as a source of family and community cohesion outside of health service contexts. It means promoting strong Aboriginal identities in contemporary Australia. It means supporting Indigenous peoples to access their lands and waters to, in turn, support their contemporary cultural identities and practices.

Inherent in the SEWB promotion is engaging Indigenous communities in decision-making over matters that affect them. In contrast, imposing solutions undermines SEWB by disempowering individuals, families and communities. Imposed solutions can also be culturally inappropriate and even harmful.

For this reason, any attempt to strengthen SEWB and work with the cultural determinants of health requires Indigenous leadership, and family and community engagement to be effective. This is not only by virtue of any responses needing to address cultural and 'lived experience' elements, but also because of Indigenous peoples' right to be involved in service design and delivery as mental health consumers. Further, their right as Indigenous peoples to self-determination (or self-governance) in matters that impact upon them, including matters related to mental health and suicide prevention, must also be respected.

Related to this, Chandler and Lalonde's research across Canadian Indigenous communities should be considered. The researchers examined cases of suicide among young First Nations people of British Columbia and the protective effects of 'cultural continuity' against suicide. In their first study (1987–92) cultural continuity could be seen as defined according to six indicators of self-determination and cultural maintenance/reclamation:

- Measures of self-government;
- Have litigated for Aboriginal title to traditional lands;
- A measure of local control over health;
- A measure of local control over education;
- A measure of local control over policing services; and
- Community facilities for the preservation of culture.<sup>81</sup>

Chandler and Lalonde mapped suicides in 197 communities or bands in British Columbia and found that those that had all six markers above had no or little cases of suicide among their younger people. Conversely, in communities where there were none or fewer of these markers, youth suicide rates were many times higher than the national average.<sup>82</sup>

A second study (1993–2000) identified two other markers and found similar results to those of the first study. The additional markers were:

- A measure of local control over child welfare services; and
- Band councils that included equal numbers of women.<sup>83</sup>

If thematic elements can be drawn from this work, the first is the importance of self-determination and community empowerment; and the second is cultural continuity, maintenance and renewal and the association of these with lower suicide rates in Canadian Indigenous communities. More broadly, the studies indicate that primordial prevention that incorporates these two themes has an important place in suicide prevention in Australian Indigenous communities.<sup>84</sup>

Cultural continuity is an important concept in Indigenous suicide prevention in part because inherent in the concept is that young people have a sense of their past and their cultures and draw pride and identity from them. By extension, young people also conceive of themselves as having a future (as bearers of that culture).<sup>85</sup>

While the implications of cultural continuity as a concept are yet to be fully explored, including their application in Indigenous settings, and in urban settings, support for cultural continuity is a highly productive line of policy development in relation to suicide prevention (and more broadly, Indigenous peoples' mental health and SEWB) based on cultural maintenance and, where necessary, reclamation.

**Recommendation 2: That the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan 2018 – 2023* helps to implement the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017 – 2023* and supports strengthening social and emotional wellbeing and cultural continuity**

**(including cultural maintenance and, where necessary, reclamation) as important health, mental health and suicide preventative activity.**

- <sup>1</sup> Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6. Cat. no. BOD 7. Canberra: AIHW.
- <sup>2</sup> Heffernan E, Andersen K, McEntyre E, Kinner S, 'Mental Disorder and Cognitive Disability in the Criminal Justice System', Chapter 10, In Dudgeon, Milroy and Walker (eds.) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Edition*, Commonwealth of Australia, Canberra, 2013, p.170.
- <sup>3</sup> Heffernan E, Andersen K, Dev A, et al., *Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons*. Med J Aust 2012; 197 (1): 37-41.
- <sup>4</sup> Based on combined data from New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory. Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework 2012: detailed analyses*, Cat. no. IHW 94. Canberra, 2013, p.639.
- <sup>5</sup> Australian Institute of Health and Welfare, 'Psychiatric Disability Support Services', Mental Health Services in Australia, May 2014, <http://mhsa.aihw.gov.au/services/disability-support/> [Verified 14/8/14].
- <sup>6</sup> Hunter E, Milroy H (2006). Aboriginal and Torres Strait Islander Suicide in Context, Archives in Suicide Research; 2006, 10(2): 141-157.
- <sup>7</sup> Steering Committee for the Review of Government Service Provision (2016). *Overcoming Indigenous Disadvantage: Key Indicators 2016*, Productivity Commission, Canberra, p.8.42.
- <sup>8</sup> Australian Bureau of Statistics (2015), 'External Causes', in *Causes of Death, Australia, 2013*, ABS Cat. No. 3303.0, published online <[www.abs.gov.au/ausstats/abs@.nsf/Lookup/byper cent20Subject/3303.0~2013~Mainper cent20Features~Externalper cent20Causesper cent20\(V01-Y98\)~10021](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/byper cent20Subject/3303.0~2013~Mainper cent20Features~Externalper cent20Causesper cent20(V01-Y98)~10021)> [Verified 6 April 2016].
- <sup>9</sup> Australian Bureau of Statistics (2015), 'Key characteristics', in *Causes of Death, Australia, 2013*, ABS Cat. No. 3303.0, published online <<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/byper cent20Subject/3303.0~2013~Mainper cent20Features~Keyper cent20Characteristics~10009>> [Verified 6 April 2016].
- <sup>10</sup> Australian Health Ministers' Advisory Council (2015), *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, AHMAC: Canberra.
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