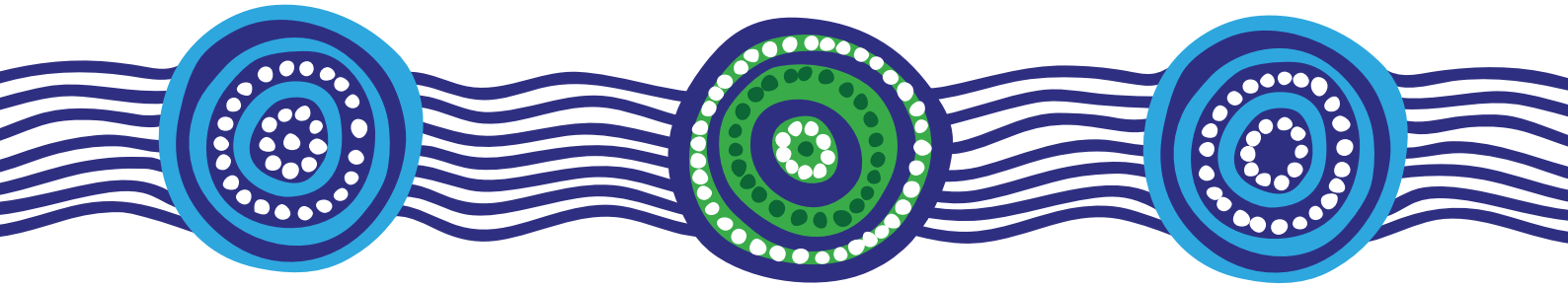


Stories from community

How suicide rates fell in two Indigenous communities

HealingFoundation
Strong Spirit • Strong Culture • Strong People

November 2018

Authors

This paper was written by Dr John Prince with the assistance of Nancy Jeffrey, Uncle Lesley Baird, Senimelia Kingsburra and Bernard Tipiloura. Professor Pat Dudgeon edited the paper and provided welcome guidance and support in its development.

Acknowledgements

We acknowledge the many community members in Wurrumiyanga on the Tiwi Islands and Yarrabah in North Queensland who shared their stories in this report.

Their courage, wisdom and dedication to creating healing environments for their communities is an inspiration.

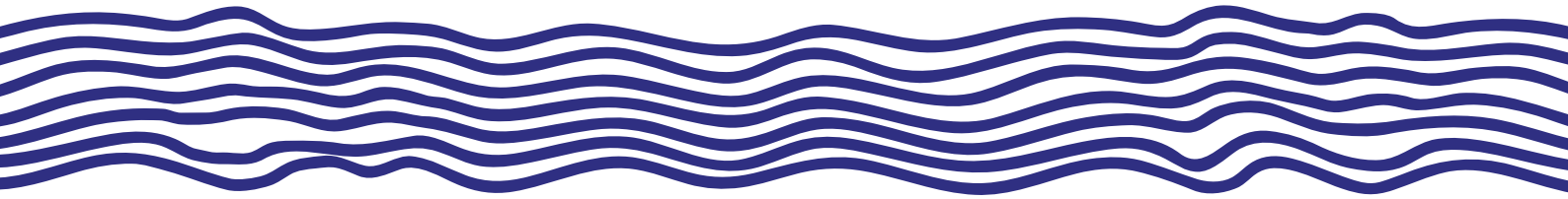
We thank the leadership of Gurriny Yeamlucka Health Service for their assistance and willingness to share their many learnings in the development of this work.

Abstract

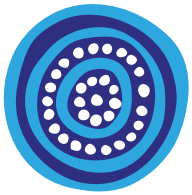
This is the story of suicide prevention in two remote Indigenous communities. The suicide prevention story from the Tiwi Islands (Northern Territory) and Yarrabah (Queensland) presented here is told by the communities themselves. It is a story of community empowerment in each place and as such supports the existing work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP).

ISBN: 978-0-9941578-8-1

Contents



Introduction



> Empowerment is the capacity by which individuals, organisations and communities gain control over their lives to improve health and wellbeing. Empowerment is recognised as a process, an outcome and an immediate step to longterm health and social status. **Wallenstein 2006**

Indigenous suicide is a significant population health challenge for Australia. Suicide has emerged in the past half century as a major cause of Indigenous premature mortality and is a contributor to the overall Indigenous health and life expectancy gap. In 2014, it was the fifth leading cause of death among Indigenous people, and the age-standardised suicide rate was around twice as high as the non-Indigenous rate.

Indigenous children and young people are particularly vulnerable, comprising 30 per cent of the suicide deaths among those under 18 years of age. In addition, Indigenous 15–24 year olds are more than five times as likely to suicide as their non-Indigenous peers. As males represent the significant majority of completed Indigenous suicides, gender can also be understood as a risk factor.

Hunter and Harvey (2002) offer two compounding explanations for the preponderance of suicide in young Indigenous males—first, they are overrepresented as vulnerable to suicide risk factors (e.g. alcohol abuse and traumatic exposure) and second, they are the product of wider disadvantage and carry deeper issues of loss of cultural identity and cultural continuity (which would otherwise be a protective factor against suicide). However, while there is preponderance of suicide in young males, the increasing number of suicides and self-harm among young Indigenous females is an ongoing concern.

This might be understood as the result of Intergenerational Trauma—a form of historical trauma that is transmitted across generations. It is the trauma that is transferred from the first generation of survivors who directly experienced or witnessed traumatic events to the second and further generations. Atkinson et al (2010, p. 138) define Intergenerational Trauma as 'the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes'. Other researchers have suggested that historical trauma can become normalised within a culture because it becomes embedded in the collective, cultural memory of a people and is passed through the generations through the same mechanisms by which culture is generally transmitted (Duran and Duran 1995). Without the necessary skills, many children grow into young people and adults who struggle with self-destructive, pain-based behaviours including aggression and violence, substance misuse, criminal acts, suicide, sexual promiscuity and inactive lifestyles (Atkinson et al 2010; van der Kolk 2007).

The Aboriginal and Torres Strait Islander Suicide Prevention Strategy (ATSISPEP) Literature Review (2016) notes the phenomenon of 'suicide clusters' in remote Indigenous communities. The term refers to a series of suicide completions and/or self-harming acts that occur within a single community or locale over a period of weeks or months. What is driving such events is believed to be 'copycat' phenomena where a single suicide 'inspires' peers to model the same behaviour. Hanssens' investigation into suicide clusters in the Northern Territory from 1996–2006 identified contagion as a strong predictor of Indigenous suicide in Indigenous communities. Hanssens urged for intervention to address the potential for suicide clusters in communities and recognised it as an important aspect of any overall response to Indigenous suicide (Hanssens 2007).

The 2010 *Hidden Toll* report of the Senate Community Affairs References Committee into Suicide in Australia recommended the 'timely distribution of suicide data from coroners' offices regarding suicides to allow early notification of emerging suicide clusters to public health authorities and community organisations'. The *Hidden Toll* report also referred to the need to implement post-vention services to Indigenous communities following a suicide to reduce the risk of further suicides occurring.

There is surprisingly little evidence about what works in general population suicide prevention, let alone in Indigenous-specific prevention. In 2013 following an extensive literature review, the National Mental Health Commission (NMHC) noted in its *National Report Card on Mental Health Services and Suicide Prevention* that, 'in terms of what works for suicide prevention, we are only just starting to scratch the surface.' This is further magnified in an Indigenous context. The 2013 Close the Gap Clearinghouse's *Strategies to Minimise the Incidence of Suicide and Suicidal Behaviour*, which focused on Indigenous suicide prevention programs, showed that few programs had been suitably evaluated. The publication concluded that there was a need for significant further research into Indigenous suicide prevention and for service and program evaluation.

The ATSISPEP is an important Australian Government response to the above, aimed to identify the success factors that underpin successful Indigenous suicide prevention activity. The final report, *Solutions That Work: What the Evidence and Our People Tell Us*, summarises the work of ATSISPEP in expanding the evidence base for what works in Indigenous community-led suicide prevention and sets out a potential set of success factors from a meta-evaluation of evaluated, community-led, Indigenous suicide prevention programs. A prevention framework is also included in the final report with associated tools. The concluding section of this document draws on the work of the ATSISPEP and the implications of the findings from this work for the conclusions and tools contained in the ATSISPEP report.

One of the most important publications into suicide prevention in remote Indigenous communities is the *The Elders' Report into Preventing Indigenous Self-harm and Youth Suicide* (2016). This brings together—for the first time—the voices of Elders and community leaders from across affected communities, who wished to speak publicly about the causes and solutions needed to address this issue.

Mick Gooda notes in the foreword to the report that it is solution-based and holds the experience of Elders from communities from Cape York to the Kimberley on what needs to be done to address this crisis. The report contains the words of Elders who have witnessed firsthand the grief and despair that youth suicide inflicts on families and communities. Indeed, what makes the report different from other mainstream investigations into these issues is that the solutions come from the people. They have not been watered down, marginalised or interpreted by outside 'experts' or governments.

What is most striking is that from one side of the country to the other, the speakers in this project share the same views about what is causing the rise in youth suicide and the solutions needed to halt the loss of young lives in response to two questions:

1. Why is self-harm and suicide happening?

2. What is the solution?

Interviews with 31 Elders and community representatives suggested that a loss of cultural identity and cross-cultural confusion is one of the main reasons for rising Indigenous youth

suicide rates and despite good intentions, government programs have failed to stop the problem. Bernard Tipiloura of the Tiwi Islands suggested 'suicide occurs when young people find themselves in no-man's land'. Dean Gooda, of Fitzroy Crossing in Western Australia, was dismissive of bureaucratic intervention: 'we end up with ideas on suicide prevention that come from Canberra and bear no semblance to what is needed in the community and on the ground'. The report highlights that Elders are seeking meaningful community-based solutions to the challenges associated with suicide:

> What we know from decades of experience is that bringing in outsiders does not lead to longterm solutions—these can only come from within communities, who need to own and control the healing process. Themes such as community empowerment, the strengthening of cultural identity, maintenance of Indigenous languages, culturally appropriate employment, bi-cultural education and returning to country—these human rights are what our people have been advocating for decades…many institutions…have a vital role to play in making this vision a reality, however they have to respond differently than in the past.

In the past two decades the communities of Yarrabah (Queensland) and the Tiwi Islands (Northern Territory) have both seen suicide rates fall dramatically from the very high rates experienced in the 1990s. While understanding suicide in remote communities has been challenging, these two communities have a story that, when told from the community's perspective, might provide evidence of how trauma and healing impact suicide rates and how community-based solutions lead to success.

Accordingly, in early 2017 ATSISPEP provided funding to the Healing Foundation to work alongside each community so that their story could be told and shared with others. After a number of visits to each community and working with Elders, community leaders, community organisations and families, the following stories emerged.

It is important to note that while the story of each community presented here allows for learning and sharing of knowledge, these stories belong to the community. Each community has offered their story to be shared in the hope that other communities can learn from the things they did and continue to do. Each community, however, knows that the journey of healing is long and at times fragile. Neither community believes they are fully incubated against further suicides:

> Yes we could still be visited by suicides and go back to those times. We have to be careful, watch out for our young people, keep the ganja and ICE out, keep them safe. It can still happen. **Elder – Tiwi Islands**

In fact, while capturing the story of each community, both communities were challenged again by suicide—small in number but reaching deep into each community. And once again the community is responding—but this time with a clear framework of what to do to take care of each other and respond from a place of strength.

Somewhere between

A story from the Tiwi Islands

The first suicide anyone encountered on the Tiwi Islands was in 1989, at a time when there was no word for the act in Tiwi language. By 2006, the community, just a 20 minute flight from Darwin, had one of the highest suicide rates in the world—mostly by hanging or electrocution after climbing the electricity poles. Today, a spiked collar is strapped around every electricity pole to prevent climbers reaching the cables. They are a reminder of a time past and also a prevention for a present threat.

The wave of suicides that triggered a community response began in June 2005 and within weeks there were more than 50 copycat attempts for reasons that run deeper than feeling 'lonely', 'relationship breakdown' or 'refusal of requests for money, cigarettes or ganja from family' – which were reasons some interviewees suggested.

Like most Aboriginal people and communities, the Tiwi Islands suffered disconnection from culture, land, language and self through the colonisation process. As Chandler and Lalonde (2008) might argue, 'cultural continuity' was broken. In 1911, the islands came under the control of the Commonwealth of Australia with land leased to a priest from Sacred Heart Mission. Shortly after, police and soldiers enforced new laws and all Tiwis were declared wards of the state with numerous prohibitions installed. Over time, everything the Elders had once passed down was forgotten as the mission assumed the role Elders had once held:

> The mission made us lose control and confidence and we lost our role as men, teachers and Elders…everything started to be forgotten and we lost control of everything. I reckon we felt shame…I started to drink and felt angry. **Tiwi Elder**

In this process, the community's ability to 'govern' its own affairs was lost, as was control over traditional lands, health, education and the passing on and preservation of culture. As Chandler and Lalonde (2008) found in their study in British Columbia (Canada), where these markers are still in place or have been re-established cases of suicide for First Nations people are less likely.

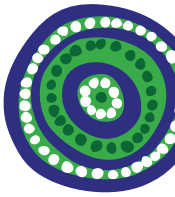
In developing this case study, more than 80 community members were listened to. Interviews also included local staff currently employed within the Tiwi Islands and also former health professionals who worked on the Tiwi Islands from 2004-2008.

About that time

In spending time with community members as they reflected on the time leading into and out of 2006, care was taken not to focus on the details of individuals and families. This part of the story remains with people in their grief and memory. No one was untouched by the loss of family during this time and as one community member reflected 'there were so many deaths the cultural rituals could not keep up with them'.

The focus of reflection for this report was much more on the community context at the time, and in maintaining this focus a number of themes emerged. Importantly, the community suggested it was easier to identify these themes now rather than at the time of the suicides:

> At the time I was a Tiwi health worker and the community was asking why… we were learning and grieving for months and months…mostly young people but we could not come up with the answers…just kept asking why…why…why? **Community member**



> At the time we didn't know what was happening. There seemed to be no explanation except people seemed to be copying each other every day and nothing could be done to stop it…we didn't know what to do. **Community member**

> No one knew what to do and the government didn't know what to do. We thought the ganja and the alcohol caused it and our young people caught between two worlds but it felt like there was a spiritual aspect. But there was no framework to work with and no communication. **Mental health worker**

> Ganja was the big one…it made them sleep and then they had bad dreams…and then they would go out and climb the poles. **Elder**

There is no doubt that the reflections on this time from 2004-2006 attribute the influence of drugs and alcohol as a primary reason for suicide ideation and attempts. Alcohol had been present in the Tiwi communities for many years but there were new addictions entering the community. Many community members reflect on the impact then and now of the 'three Gs'—gambling, ganja and grog.

A key theme throughout all the interviews was that engaging with these addictions was also the result of disengagement and disconnection from traditional life and culture:

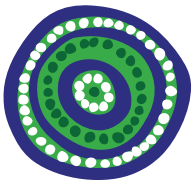
> I think it's important to identify. For our young people to know and practice what skin they belong to, what dance they belong to and what country they belong to. If they know these things, they will stay strong within. This will also set a good example to friends, cousins and family. We want to take the young people to their country, to show them their land and their boundaries. **Elder**

> Everything got lost over time…people lost their identities and no longer knew their skin groups, language, country…our young people have been disconnected from their identity and our old people from their roles…then we lost our jobs and there were no jobs. I can see now so much had been lost. **Elder**

In reflecting on and understanding this time, the 'sista girls' story is a critical part[1]. Their voice into this story became important and much more than inclusion of a diverse group of young women within the community. Their challenges at the time of the suicides were profound and with added complexity. The story told by the sista girls emphasizes the time when acceptance within the community was low as many sista girls were 'coming out'. As a community within a community their loss to suicide was substantial as they struggled for acceptance within their families and community:

> It was hard back then and we lost some six girls at that time. The suicides brought some change and acceptance as we were able to talk more with our families about it…but then we lost everything…culture, families and community…for some it was too much. **Sista girl**

1 The sista girls are Tiwi Islanders that were born male but who identity as female.



The inclusion of the sista girls voice continues to be important and while acceptance is higher now there are still challenges. Notably, some sista girls attended the Sydney Mardi Gras in 2017 and received wide-ranging publicity. There were many Elders, family and community members who noted how proud they were of the girls and their community. The sista girls talked about an increased sense of empowerment and control over their lives by going to the Mardi Gras.

While not specifically turning to themes such as disempowerment and loss of control, Elders, community members and health workers reflected back and often used such terms when describing what was happening at the community level before and during this time of high numbers of suicides:

> There was a lot happening then when I think back. The Tiwi Health Board had gone into administration and staff were let go or not paid and when the NT Government came in at the point the Board collapsed things changed. It was still a primary health clinic but medical models were brought in that required highly qualified people so our people lost their jobs and the professional came in. Some were great like [names a non-Indigenous mental health worker] but most came and went…we lost the community-based therapeutic models of care.
> **Community member**

> Before the NT Government came in and then the Intervention, programs were more run by the community for the community. Staff were not necessarily qualified but they cared for the community. The Clinic back then was a healing place and a welcoming environment for everyone…there was more involvement in educating families, working with families…but somehow over time this was all lost.
> **Community member**

> By the time the suicides were really bad, we had lost control of our own communities. We were back to be being managed like we could not take care of ourselves…maybe after all that we had gone through we felt like we couldn't but in the end we had too. **Former community mental health worker**

> There was no control…control was external and everyone was feeling hopeless.
> **Community Member**

> Looking back, the suicides should never have got to the stage they did but I believe it happened because we took control away from the community…and maybe we see that more clearly now because things changed when the community took control back. **Former NT mental health worker (non-Indigenous)**

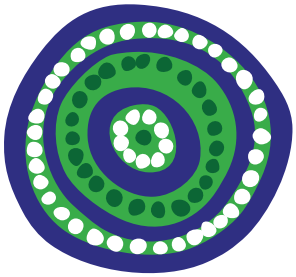
It is hard to measure the level of control that had been taken by aggressive government policies at the Territory and Commonwealth level and/or control ceded to others through poor governance at the local level. Certainly, community reflections are consistent with the literature that increasingly identifies the processes of colonisation as the major factor leading to trauma in Indigenous communities, which in turn leads to increased levels of AOD use and misuse and higher rates of self-harm and suicide. Loss of culture, connection to land, and control over the community's own affairs (including health, education and employment) are prevalent themes within the local context:

> Our men had lost their role, Elders had lost respect, young people didn't care for those traditional ways, they were lost and we could not get them to reconnect to things. Role models were gone and so [many] people were lost in a community that was changing…had changed…there was nothing from the past to connect with and the future seemed uncertain and maybe scared people. So they turn to the alternatives. **Community member**

Finally, within the suicide cluster described and examined here, many community members talked about copycat suicides. Community members talked about copycat behaviour being 'normalised'. The notion of copycat behaviour, the definition of copycat and the normalising of the behaviour may not sit well with researchers and readers alike: can a person really be 'inspired' to take their own life by another and can this become normalised in a community? One community member reflected:

> There are some deep psychological contexts that need to be considered, beyond the monkey-see monkey-do definition of 'copycat'. In my experience, personally and across all communities I've known intimately, the central driving factor in mental illness leading to suicidal ideation is desperation. Desperation to be seen, to be honoured, and to be—for once in a lifetime—revered and held in high regard. For many Tiwi people, particularly younger people coming to terms with their identity as a hated and unwanted nuisance, the future looks really terrible. There may be no possible way of imagining ever having a good life, or one that isn't a daily stagger through morose and trauma. So, having seen others end their pain and be rewarded with a funeral which delivers more recognition and love than any moment in memory or future imagination, many choose to 'copy' and take this path of honour and celebration…. The role of spirituality is a crucial one. An Aboriginal person with a deep understanding of themselves will make stronger decisions. They may still end their own life, or feel as though they are close to it, but the strength of their spirituality will determine the validity of the decision.

As people reflected on this time, there was much pain shared and the collective trauma prior to 2004 and then during the following years has become collective memory. However, amidst it all, there is a new dawn and in a moment the community turned to collective intervention and collective healing. This is a moment and time for 'us to take control…it was becoming too much to bear'.



Time for change

There are eight different homelands and 16 clans on the Tiwi Islands. Tiwi Islanders speak one traditional language and there are four skin groups: Takaringuwi (Mullet), Miyartuwi (Pandanus), Lorrula (Stone), and Warntarringuwi (Sun).

The recognition of these skin groups is a critical factor in the story being told by the community with regard to suicide prevention on the Tiwi Islands.

In 2006, many dimensions of a crisis were coming together in what one community member described as the 'perfect storm'. These dimensions can be identified in the many conversations as community members reflected on the 'moment that everything changed and we said that's it…that's enough'.

It is clear from listening to the community that while all community members were affected by the suicides, there appears to be a moment when the community collectively recognised the urgency of the problem and that there needed to be new actions taken. This was a consistent theme and supports the work of ATSISPEP and the tool developed for assessing Indigenous suicide prevention activity. That is, a strong, urgent and unmet need for suicide prevention emerged and the community appeared to reach consensus about this:

> Whatever was happening wasn't working and there were some young people that suicided and it was so unexpected…like out of character and it was like if they could do it anyone could. We just saw that it was so bad and everyone knew it. **Community member**

> It was time for families and friends and the community to come together. We had to come together because the Elders were no longer running out to save them 'cos they were so tired. If we didn't come together there might not have been a community left. **Elder**

> Meeting every week at the old presbytery with everyone and different families on different nights, there were so many funerals people would say they were going and did not feel anything…. There were other problems but ganja was masking things. **Community member**

As much as the sheer numbers of loss of life and family members influenced community action, the publicity the Tiwi Islands was receiving over the high number of suicides was mentioned a number of times as an influencing factor:

> There was this story 'The Land of the Dead'[2] that was in the newspaper. It was terrible and lots of our people, Elders, and those that had suicided were named. It was there for everyone to see and I think a lot of us felt shamed…shamed by what was there and we felt tricked into telling our story. I remember thinking we need to have a different story…here we are 10 years later telling it. **Community member**

---

2 'The Land Of The Dead' appeared in *The Guardian* newspaper on Saturday 24 June 2006. Journalists Cathy Scott Clark and Adrian Levy stayed on the Tiwi Islands to investigate in their own words 'how did two tiny islands off Australia's north coast come to have the highest suicide rate in the world?'

> That story [the newspaper article] sort of helped us, the community realised this is going too far and it didn't look good for the community. **Community leader**

Many community members reflected on the moment the community decided to take control of the crisis:

> We took control…empowerment and control were key concepts early and we decided what we wanted to achieve and we talked about the issues. The community and skin groups were meeting all the time and we started to do something…every day there were skin group meetings. **Community member**

The coming together of the community and the skin groups has been well remembered, and addressing such a significant issue through skin groups—that is, traditional, cultural ways—has meant more recent community challenges are again being addressed through skins group meetings and consultations:

> Skin groups are not interested in politics and they form the basis of the cultural model and taking a cultural approach. Empowering skin groups to take control means empowering communities to take control and this means in the end communities have the final say…it became a process of self-determination. **Elder**

> [Name deleted] said let's run skin group meetings, and we did. We ran a heavy schedule of skin group meeting…it brought everyone together and it demonstrated to everyone that we cared and people were cared for and people are cared for… the families and the skin groups saved them in the end. **Community member**

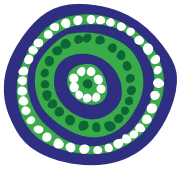
> I'll tell you what changed! Tiwi people…the four skin groups come together and strong people talked about it…strong men and strong women in each skin group talked about it. **Elder**

> It was good talk…talk about what is right and who we Tiwi people are…what it means to be Tiwi strong and as we talked we began to heal too. Those meetings were a healing time. **Elder**

> The community changed itself and we were surprised by that…one of the things that changed things was the community recognised there was a problem and everyday there were skin group meetings…like a community meeting**.** **Community member**

As one community member suggested, 'community issues…they want to deal with them as families with support from skin groups'.

It is clear that during the many meetings that took place, there was a need for both intervention and prevention work. There was the need to address the urgent issues of daily suicide attempts. Longer term strategies that could bring sustained change to families and communities were needed.



It is not clear as the story of this time emerged what the role of the NT or Commonwealth governments were. As the community talked about taking control and empowerment, there was little reflection about the government. That is, government was largely absent from the conversation—though the NT Intervention that soon followed these meetings sent new shockwaves through the community. One Elder suggested that:

> The Intervention scared everyone…we thought we were losing control of what we had just gained…we thought it might bring back the suicides…the Government didn't care and never thought to consult us.

Another suggested that the 'Intervention was good as it brought the community together… we were like united against the government and what they had done and what they were doing.' While the meetings were times for discussion and healing, they were action focused and a number of initiatives were put in place, but as one community member suggested:

> We did not know what to do but we knew doing it through our cultural way rather than whitefella way…we knew we had a chance for change.

Time for action

Emerging out of the community and skin group meeting it was clear that 'everyone was burn out'. There were five local mental health workers who were great liaisons but had no suicide expertise or training. Nonetheless, there was consensus, 'people were on the same wavelength', that the community had to take the lead. From these actions and over the next two years the number of suicides (attempts and completions) began to decline to a point of no attempts and no self-harm.

Notably, at the time there were 28 different services in the community but there was, according to the health workers at the time, no framework, communication or coordination. There was a focus on grassroots responses 'Kevin Doolan and the boys [Youth Diversion] just got out and talked people down and back'.

> Youth diversion had night patrols and we did have the resources and vehicles to deal with it. We used the 'bush telegraph' and Youth Diversion very quickly got to them with the right skin group. They found nine out of ten [people] and bring them back and privately talk to them…find them and calm them and talk polite and then go to family and have a process of care to follow up and show care… follow up with love. **Elder**

> Youth Diversion ran the intervention program…mostly young people in a vehicle and they would hear someone had gone to bush or was climbing a pole and they would find them within half an hour with the right skin group to talk to them and then they follow up with the family and provide a safety mechanism.
> **Community member**

There was also a focus on systems and processes:

> We dealt with the families and nurtured the person back to health and at the time there was a changed attitude of police with a new guy who empowered the community to take control and good relationships [were formed]. **Indigenous mental health worker**

> We started by engaging families and friends and Youth Diversion started engaging families. We were lucky we had a Youth Diversion [team] and who worked on young people and open their minds to something good. These were community people that knew the individuals and the families…no one else could do what they did to intervene and then protect and prevent further suicides. **Elder**

Additional to what might be called community-based, grassroots responses there were additional programs such as Tiwi4Life introduced. Further:

> There was a campaign in the community to get rid of the rope or anything that could be used as rope. The spike went up on the poles. Everyone was thinking and talking about suicide. We workers were stressed but strong men and strong women pulled them through and we said all the time 'suicide is not a part of our culture.'

> We did counselling and talking to their families and helping. We had suicide prevention seminars and training workshops in the community as part of saying let's stop this and do something. We began to see that we can't go back and some strong leaders came through in the family. Then we had some young people who didn't want this thing to happen again…and healing has happened and we do a lot of healing keeping our family, spirit, culture strong.

Further, local band B2M (Bathurst to Melville) became part of the story. The high profile saltwater band focused their music on engaging families and started doing musical therapy:

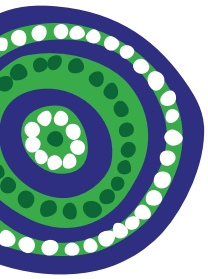
> Music reached into people's consciousness…B2M were good but it's about integrity and honesty and truth and we needed to be leaders and demonstrate leadership and encourage young ones to step up, talk more about introducing music in the school and encourage young people. **Community member**

Music and sport became (and remain) key mechanisms for engaging young people in stronger lifestyles and choices. The Tiwi Bombers[3] became a big part of the community and still are. Both created places and spaces for cultural knowledge to be shared and where culture could work:

> We pushed and pushed the message that there is a better life ahead and you need to find the right way forward. There is music, sport and culture and we took people to the bush and showed them the way and then brought them back. We were gentle with each other and put in good words…show them common sense and common knowledge that suicide is not normal.

3 The Tiwi Bombers Football Club is an Australian Rules Football club, currently competing in the Northern Territory Football League. The club is notable as being the first all-Aboriginal team to play in a major competition.

A slower process of change, but change nonetheless has occurred for the sista girls:



> The sista girls were the highest suiciding and not accepted by the community and culture or the church…no one cared or wanted to show love to them and no one understood why. But in this time we got educated and through the process there was two way learning.
>
> At that time we struggled to have a voice because there was not acceptance but now we have a voice and that voice is as member of a skin group first and a sista girl second.
>
> This is a safer place now and other sista girls come here because it can be safer for them. But this is complex and there are still things that are difficult for us. But now we come here [Tiwi Design] and soon want to open a café near the pottery and the community is happy about that.

Indeed, there is some level of community pride for the sista girls and certainly less shame. Their celebration at the Mardi Gras, the celebration of their art (acknowledging the significant support they receive through Tiwi Design) and the increased acceptance are clearly protective factors. Further, the conversations with Elders about involvement/dance in ceremony and the complexities brought into a gendered tradition for those born as men but identifying as women are beginning to take place. There is a journey still to be travelled for the sista girls to feel and have complete safety and acceptance but the community is 'more loving now, but not completely.'

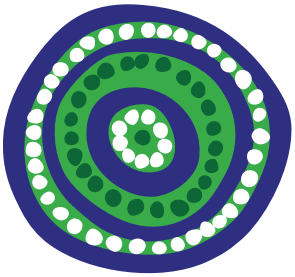
Across the community, when asked about the factors that were important at the time of the suicides and that ensured success and change took place, the following were noted most often:

- Tiwi people fixing Tiwi problems with Tiwi wisdom
- community working together and reaching consensus
- working through the skin groups the Tiwi way and using cultural knowledge and cultural ways
- focussing on three priorities being you (individual), family and community
- having to have a right person facilitating with the key knowledge and understanding of the individual and their challenges
- supporting families and engaging families with strong women and strong men.

As one female community member noted:

> As mothers and aunts, we were so sad and we saw the memory that was being created…we needed to change things and make good memories…change our story and tell the story to young people to keep them on the straight line.

Memory as a protective factor is not mentioned in suicide research—neither in an Indigenous or mainstream context. However, this report notes that it emerges as a theme in both the case studies in this report. That is, both Tiwi and Yarrabah created, through community empowerment, a new narrative and have consciously sought to embed this narrative in the community as a means to protecting those still challenged with suicide ideation not to further contemplate, plan or act on such ideation.



And now…

As stories were listened to, the present context emerged. The most salient theme was the possibility of further suicides, a fear which does not leave the community. The lessons from the past continue to inform the present.

Yarning circles with the women in the community highlighted best what is happening from a strength-based approach in the community, and again the women referenced the importance of the skin groups:

> Strong men's and women's group [consisting of skin groups] are here to sort problems out…with skin groups…also support structures in place. After skin group meeting then family are called together to assist person in trouble.
>
> Young ones don't understand the need for healing groups…for young ones and the women, Relationships Australia has done a healing forum here…CatholicCare[4] have a men's healing group on Monday and women's group on Tuesday and there is an action group for family mediation (consisting of skin groups).
>
> Take young ones hunting and back to country, bush camps every year and families show they care and love more.

The group of female Elders described the present this way:

> Skin groups sort out problems and then CatholicCare came after skin groups were formed.
>
> Football on White Ribbon Day[5] has helped because all the young ones girls and boys have to do the rules or they don't play.
>
> Elders want to move forward and take the good things not the bad…families are strong and support each other through the skin groups.
>
> The young ones learning too much American culture and still don't respect us, they don't care about our language and that makes us sad so we have to change that… crèche is helping our children with good beginning.
>
> We still have some things…why are our children still being removed…government don't understand our way only white man's way and Elders feel disrespected when the white people don't attend sorry business…we have a lot of mental health issues and overcrowding in houses…incarceration so we need more support when they come back to community.

One story told from an Elder was how she was a big drinker and was sorted through the skin group system. She was grateful and has maintained sobriety or 'I would have died'.

---

4 CatholicCare NT is a not-for-profit organisation, providing counselling services and programs to individuals, couples, families, children groups, schools and agencies across the Northern Territory and have offices and programs on the Tiwi Islands.

5 Globally, White Ribbon is the world's largest male-led movement to end men's violence against women. The White Ribbon Day campaign works through primary prevention initiatives involving awareness raising and education, and programs with youth, schools, workplaces and across the broader community.

At the time of collecting the community story, a new round of skin group meetings was being initiated as a form of community planning:

> Skin group meetings is the way to go and means change comes through the community and that planning is place-base. The cultural model is the key and to engage in the cultural model and by doing that we become empowered… the cultural model is so important to use that and drive change from within the community. We are going to look for ourselves and look after each other and take responsibility.

There are programs that are in place and investments into young people and their education remain a priority. The Personal Help and Mentors (PHAMS) program and a focus on school attendance (through the Yellow Shirts) aims to build young role models:

> If they [young people] play up it gets sorted out through the skin groups and the kids will have a different solution than being suspended…done our way not the whitefella way…not the government way but they don't know our way, don't believe in it.

This case study acknowledges this is not the first time some people in the Tiwi Islands have been asked about the time of the suicides. The following (selected) words from Tiwi Elders were published in *The Elders Report*. They keep the thread of the Tiwi Island story going with a vision for the future and point the reader in the direction of three interconnected key protective factors should suicide visit the community again—something no community member dismisses as out of the question. These are cultural connection, skin groups and healing:

> I strongly believe that if our young people today join culture with western style, they will be ok…I like to teach them to identify themselves. For example, I follow my mother's skin tribe and I'm small red ochre bird, that's my skin. I also follow my father's dancing. My father would dance the brolga. I can also dance my own cultural dreaming—the coloured reed fish. I want to educate these young people to identify in themselves what tribe they belong to and how they tick as Tiwi people because if you don't have those things it's very difficult to be proud of yourself…. All these things we Elders enjoy teaching our young people and it is important to keep doing this until I say goodbye to this nice world…I believe that the only way out for our young people is through connecting with their culture so they become proud of their country and holding knowledge. If we can win some of our young people back, we have a good chance of holding our culture and building a strong community that is physically healthy and in good mind. **Bernard Tipiloura**

> We are trying to generate income for our people through what we have here on the islands, especially our young people. We are creating jobs and more activities on the ground here for our young people. We are trying to break the cycle. It's important for our young ones to step up. Culture is the most important thing that we have. We are trying to keep our young ones connected. It's important to keep it continuing on…. The suicide rate has dropped. We have some youth programs and we have representatives from each clan group and tribe. They meet with our young people and take them out bush for two weeks to teach them culture. Slowly we are trying to get our young ones involved in culture. **Francis Xavier**

> We've got a place out at Four Mile Beach. A place for healing. It's for both young men and women. You can even camp there. It's a place to teach them culture and dance. Dance identifies who they are, what country (homeland) they belong to, what dance they belong to—crocodile, shark, boat dance or buffalo dance. We do all those different dances in these two islands. They hold their culture through us, the Elders. **Noel Puantulura**

And finally, while culture holds and binds the community together so too does the reality of a loving and respectful community. While never spoken of in a strategic way or as a concept, 'love' was spoken of very often as the story was collected. People spoke of ensuring people challenged by suicide 'need to know they are loved', 'that their family loves them', and 'that they need to show love'. When further explored, community members referenced Tiwi words to explain the imprecise translation of the meaning of words that also hold the community:

- tayamangamiya – Tiwi for respect for self, noting self-harm being contrary to this strong cultural principle
- ngarwurrayamangamiyi – Tiwi for a collective cultural principle of respect for the group/community, noting any form of self-harm is a breach of the principle
- ngarwurrayamangajirra – Tiwi for a foundational respect within culture and a respect that binds community together. Self-harm causes a rupture within the collective community.

Collectively, these three words are cultural expressions that can hold people during a crisis. They aim to create bonds that cannot or should not be broken, and while the core is respect, community members used these terms as expressions of love:

> I go on Facebook and see what people are saying. If I see something bad for someone or they are thinking about bad things I tell them they are loved and love is a bond not to be broken…I ask then [post] not to break that bond of love.

The cultural expressions of tayamangamiya, ngarwurrayamangamiyi and ngarwurrayamangajirra maintain individual and community respect and were deemed to be protective factors against suicide ideation since, when understood, they provide obligation and responsibility to community. When practiced, they create inclusivity and a sense of belonging.

Summary

The story from the Tiwi Islands lends support for some of the research undertaken by ATSISPEP. It is the story of a time that saw trauma as the genesis and outcome of high rates of suicide. It is the time when the community came together and recognised a strong and urgent need for prevention and intervention within a community setting.

From here, the community determined it needed to take control of processes, systems and services, which they recognised at the time were out of their control, to address an issue and its associated causes and effects, which they also felt were out of their control.

The response from the community was to initiate and lead the development of a range of responses and, in the process of doing so, became empowered—as empowerment is the capacity of individuals, organisations and communities to gain control over their lives to improve health and wellbeing.

Over time, the emphasis on intervention shifted to prevention but in both cases responses were driven by cultural knowledge and systems. Reconnection to self, culture, ceremony, language, skin groups and land remained a priority.

The people of the Tiwi Islands know that the islands are not incubated or immune from future suicides. But they also know (as do the non-Indigenous people who work in services on the islands) that the solutions are held by them in their cultural knowledge and traditions, 'what has served us best for thousands of years remains the best response to whatever we face in the years to come'.

Community empowerment

A story from Yarrabah

The story from Yarrabah took some time to complete. Initial community consultations took place in May 2017 but were suspended when it emerged that at the time the community was facing a significant challenge with regard to suicide ideation and a number of completions. Correspondence with Gurriny Yealamucka (31 May 2017) noted:

> At this point in time there have been many deaths in the community, including two through suicide (in the past three months). The Social and Emotional Wellbeing team is currently working with a large number of clients experiencing grief-related distress, including suicidal ideation among some of this cohort.

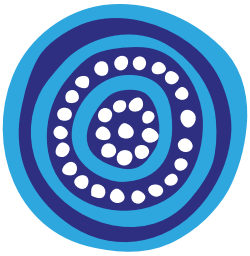
The consultations with the community and the Social and Emotional Wellbeing team at Gurriny Yealamucka were completed in December 2017. This story is therefore not only focused on previous times when suicide was a significant challenge within the community, it also focusses on how localised, culturally-informed, community responses that had previously been developed, continue to act as important supports when individuals, families and the broader community are affected by suicide.

About that time

In 1995 the community of Yarrabah had very high suicide rates that—given the population size of the community—was overwhelming and gave rise to comment such as 'these were some of the highest rates of suicide in world'. This time is known in the community as the 'third wave' of suicides.

Located in North Queensland, Yarrabah is a rural Aboriginal community with approximately 3,000 residents. The Gunggandji people lived in the area long before Yarrabah was set up as an Anglican mission in 1892. The church administered the settlement for the next 70 years and during this time different Aboriginal groups, including children of mixed descent removed from other areas of Queensland, were settled in Yarrabah (Tsey et al 2002). Local community members suggest that 80 per cent of the Yarrabah community have connections with the Stolen Generations and that loss of family connections is largely prevalent across the community.

In 1960, the Queensland Department of Native Affairs assumed direct control of the community and there followed some infrastructure developments, including a paved road connecting Yarrabah to Cairns in 1972. Over the next few years, the departmental administrators and staff gradually left and in 1986 Yarrabah was gazetted as a 'Deed of Grant in Trust' (DOGIT) community with the Yarrabah Aboriginal Council being established (Tsey et al 2002).



The first of the three waves of suicide occurred between 1983 and 1986, prior to the establishment of the Yarrabah Aboriginal Council. In 1988, following this first wave of suicides, the community conducted a health needs assessment. Some of the key health issues identified in the assessment were:

- the poor health status in the community
- the lack of a local doctor
- fragmented health services
- no local control over health services.

The second wave of suicides occurred in the early 1990s and then a third wave in 1995. This third wave saw suicide rates soar to some of the highest (per head of population) in the world:

> I lived in the upstairs house and heard a mother screaming…she found her son… he died…and across the road a young fella and he died…I felt it was all around me…and an older man…in the same place. **Community member**

> There were about 95 suicide attempts over time and mainly male. The youngest was a 12 year old boy…it affected many families and there were many causes. People had different points of view but alcohol, drugs, family violence and community violence were all thought to be problems that were leading [to suicides]. We didn't know for sure though. **Community member**

Despite the previous two waves the suicides of 1995 caused great confusion and even fear amongst the community and, reflecting back, community members and Social and Emotional Wellbeing (SEWB) workers believed there was a fight between culture and spirit:

> We believed then and we believe now that there was a spiritual aspect to what was happening. It was seen by many people as a spiritual attack on the community and our spiritual resilience was low. **Community member**

> We didn't know what was happening and it was too much to take in…but it felt like a fight between culture and spirit. We could not comprehend and it came from nowhere and affected everyone. **SEWB worker**

The difference of the third wave of suicides from the previous two was, according to the community, that everyone in the community was affected:

> It impacted the whole community and became a community issue so we knew we had to come together as a community and we tried to work together as a community. See the problem our way and address the problem our way.
> **SEWB worker**

The crisis within the community-led to what is known now as the 'community suicide crisis meeting'. However, before this there was a series of meetings that included community Elders and service providers. From here a committee was set up and it was under this leadership that the community meeting was set up:

> The community meeting came after one big whack of suicides. Everyone was at the meeting as it was everyone's business and everyone had their say and they wanted a solution…we learnt even from that, that when there is a suicide the community has to come together and put a plan in place. By community we mean people, families and services. **SEWB worker**

The community suicide crisis meeting is well remembered by community members and it is acknowledged and commemorated with a mural at Gurriny Yealamucka Health Aboriginal Corporation:

> Everyone remembers that meeting. We all came together, 400 people, and we met and talked. There are people here that were not even born when the meeting took place but we have made sure we have never forgotten…even though it is a long time ago now. **Community member**

> The community meeting was a major turning point in Yarrabah's history. It was held in the community hall and we looked at problems and solutions. Four hundred people came to the meeting and it was very emotional. There were a lot of agencies there to support the people as they shared their story under deep emotional pressure and there was a mix of young people and old people. **Community member**

The community meeting reached some consensus regarding the focus and priorities for the community. There was agreement that the individual (at risk of suicide) exists within a family and community structure. There was agreement that the processes of colonisation and the historical determinants of the current context were loss of land, loss of culture, confusion, wounding of the spirit, oppression, racism, negative impact of government policies and Intergenerational Trauma. The effects of this led to individual AOD use/misuse, abuse, violence and mental illness, all of which takes place within the family and community setting.

The community meeting acknowledged the need for a time of change.

Time for change

At the time of third wave of suicides, and resulting from the 1995 community meeting, a number of solutions were identified. They included:

- the establishment of the Crisis Intervention Group
- closure of the alcohol canteen
- application for funds from the Queensland Health Department to establish a Family Life Promotion Program
- commissioning of a primary health care service feasibility study. This was due to the fact that the community saw suicide as the tip of the iceberg of other complex health problems.

In 1997, Queensland Health provided funds for the *Yarrabah Multi-Purpose Primary Health Care Feasibility Study*. A decade after the first health needs assessment, many of the findings of the feasibility study replicated those of the earlier needs assessment:

- the health status of the community remained poor
- many services were provided from outside of the community
- Yarrabah had no control over the services provided by external agencies
- service coordination was poor
- most community health needs were not being met.

Importantly, the feasibility study—noting the findings were based on extensive community consultations—identified some key underlying issues relating to health and wellbeing. These included:

- the loss of spirit and the need for reclaiming of spirit
- the need to respond to the experience of hopelessness
- the need to respond to the loss of land, loss of culture
- Intergenerational Trauma and unresolved grief, from both past and present circumstances.

Indeed, the feasibility study prioritised social, emotional and spiritual health.

As a result of the feasibility study, a community-controlled Primary Health Care Service model was proposed as the preferred way to address health service developments and to improve the health status of the people of Yarrabah.

Momentum for the implementation of the feasibility study was built through a significant grant of $500,000 provided by GlaxoSmithKline. This aimed to assist Yarrabah with capacity building to plan and manage health services. Three specific community-based strategies were developed to address health priorities identified in the feasibility study. These were:

- *Family and Child Health Strategy*
- *Alcohol and Drug Strategy*
- *Socio-Emotional and Spiritual Well-Being Centre of Excellence.*

Each strategy had an associated implementation plan developed. Further, and most importantly, the feasibility study led to three important outcomes:

1. the establishment of Gurriny Yealamucka Health Service in 1998—the first community controlled health service established within a DOGIT in Queensland
2. the Family Wellbeing Project Partnership with the University of Queensland and James Cook University
3. the establishment of the Yaba Bimbie Men's Group (Yaba Bimbie) formed in 1997 and auspiced by Gurriny Yealamucka.

Each outcome emerged specifically from community concern about suicide and acted as both intervention and prevention strategies. This marked the beginning of the community purposefully pursuing and exploring the concepts of empowerment and control, which are acknowledged as critical social determinants of health and wellbeing, and suicide prevention.

The establishment of the Family Life Promotion Program in the community saw the employment of Family Life Promotion officers (rather than Suicide Prevention officers):

> At the meeting people said they wanted their own workers and Family Life Promotion was workshopped as a positive definition. We were the first to come up with the idea and we got our workers and called them Life Promotion officers. **SEWB worker**

> It was the beginning of community control and empowerment. Queensland Mental Health were here prior to 1995 but we realised their solutions would not work and, in the end, they had no idea on what they can do and could not understand Indigenous people. We hear the voices of the spirits and Queensland Mental Health could not understand and assessed them with white tools. A full understanding of Indigenous people was not there and we had no control…it was external control and that led to a feeling of hopelessness. **Community member**

There has been much written about the influence of the establishment of Gurriny Yealamucka, Yaba Bimbie (father/son) and the Family Wellbeing Empowerment Program (FWB) in Yarrabah as a means for addressing the high number of suicides in the mid-1990s.

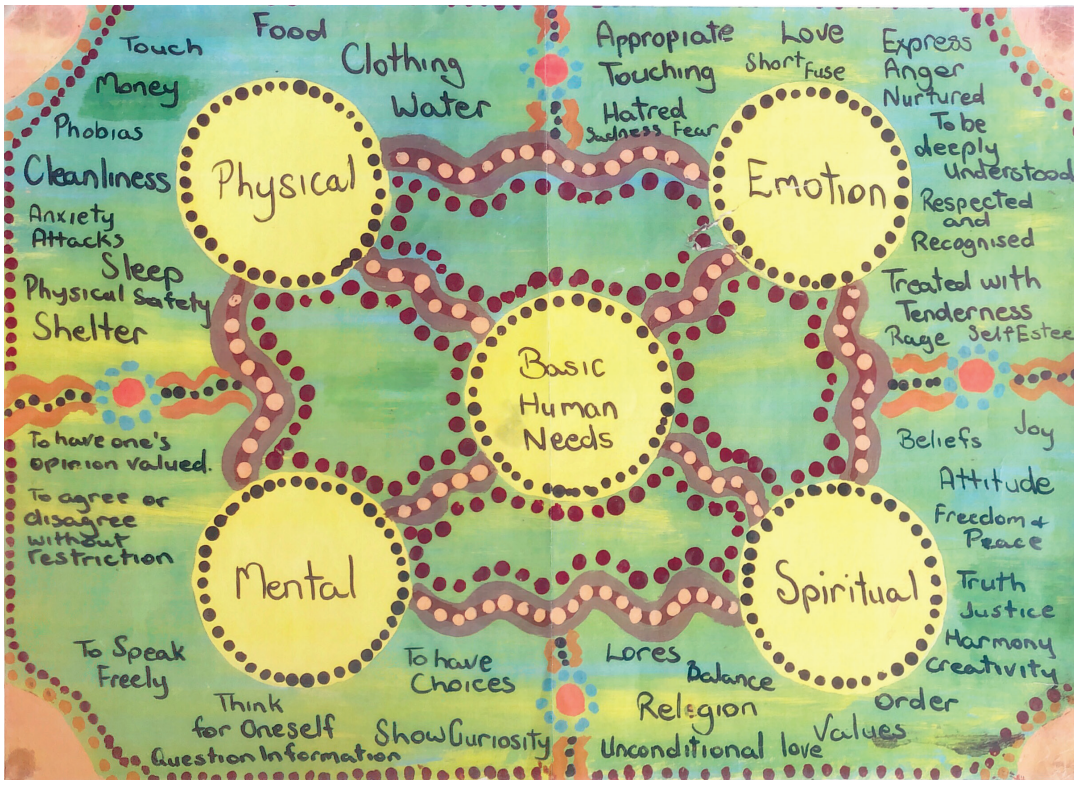
Family Wellbeing (FWB) is a personal development course conducted in five stages, with each workshop delivered by two facilitators. Completion of all five stages provides participants with a nationally accredited qualification in counselling.

The program builds communication, problem solving, conflict resolution and other life skills that enable an individual to take greater control of their life choices. It is based on the principle that all humans have basic physical, emotional, mental and spiritual needs and that the denial of such needs (e.g. through the processes of colonisation) will result in behavioural and emotional difficulties:

> Family Wellbeing was important. It felt like it was the right program and it gave ordinary people the skills to deal with everyday issues. **SEWB worker**

Importantly, unlike most programs that rely on adjustment or modification from mainstream programs to an Indigenous context, FWB was developed by Indigenous people conducting their own inquiry into their personal experiences, needs and solutions and then looking out

Diagram 1: Yarrabah version of family wellbeing program domains



to enrich this cultural knowledge with what was deemed useful from mainstream responses. That is, FWB has, at its base, Indigenous cultural knowledge and frameworks, while incorporating mainstream knowledge and frameworks.

However, while FWB has cultural knowledge and frameworks, there has been a localising of the program to meet the specific cultural practices of the Yarrabah community:

> We took the key elements and domains of the Family Wellbeing Program and did them our way. The book [training manual] meant nothing to me but when Aunty Kayleen drew the program Yarrabah way then family wellbeing made sense to me. Aunty Kayleen designed and adapted the FWB program to our local context.
> **SEWB worker**

In 2001, Yaba Bimbie was introduced to FWB and several men went on to complete the program and become program facilitators. The 20-year existence of Yaba Bimbie is viewed as a key determinant of change in behaviour and the reduction in the high rates of suicide. Over the years, this men's group has achieved a number of important outcomes, including:

- acknowledgement of a key challenge for men in Yarrabah being the loss of cultural identity, spirituality and breakdown of family values
- restoring men's rightful place in the community and the obligations that go with that
- restoring relationships of respect with women, families, Traditional Owners and community leaders

- a code of acceptable conduct that includes being loving, kind, compassionate, forgiving, respectful, honest and truthful
- strategies to support personal development, leadership, parenting, employment, education and training, tradition and culture
- reclaiming and redefining Indigenous culture as well as an identified need for a men's place to give men space and to implement objectives
- recurrent Commonwealth Government funding for two men's group workers and two women's group workers from 2007 onwards
- sharing strategies and learnings with other communities.

The establishment of Gurriny Yealamucka, the FWB program and Yaba Bimbie had at their core the concepts of empowerment and control. Each was focused on community control as a means for creating effective services and hope for those who were experiencing no hope and little control over their lives and choices. As noted in the FBW fact sheet *Promoting Aboriginal Health: The Family Wellbeing Empowerment Approach*:

> …empowerment is the capacity by which individuals, organisations and communities gain control over their lives to improve health and wellbeing. Empowerment is recognised as a process, an outcome and an immediate step to long-term social status.

Disempowerment and chronic stress are linked to alcoholism, depression, eating disorders, heart disease, cancer and other chronic diseases. Disempowerment also underpins, both as a cause and effect, violence, crime, alcohol and drug abuse and suicide (Tsey 2008). FWB is premised on the practice of empowerment, which starts with personal development and capacity enhancement. It considers individuals' personal blocks and barriers to change and provides opportunities for group interaction and development of supportive networks. Within these networks people can collectively organise for community or other system-level change.

The evaluation of the FWB program and related empowerment-based activities form the basis for the exploration of the relationship between control factors, empowerment and Indigenous health. This was used to support Gurriny Yealamucka's service delivery and community projects. This has demonstrated how empowerment principles and practice can be integrated into community based health programs and identifying mechanisms to optimise program sustainability.

Through the partnership between, and participatory research methods employed by, James Cook University, the University of Queensland and Gurriny Yealamucka community priorities were identified. Through these relationships, the evaluation methods were able to identify the following outcomes for Yaba Bimbie and other FWB participants:

- increased reflective skills, hope and confidence
- personal healing and improved ability to control destructive behaviours and emotions
- prevention and management of domestic conflict and more positive family relationships
- safe environments to voice pain enhance the ability to explore feelings and attitudes

- reduced levels of alcohol consumption and conflict
- interest in sharing experiences in dealing with suicide with other communities.

While the FWB program is no longer formally being funded and run in the community, the key elements of the program remain at the core of the prevention and intervention strategies to suicide in Yarrabah and they guide suicide responses:

> [Name of SEWB worker] is the only person with the full qualification now but we all have her diagram and we try to continue the line and do the elements of the FWB program…it gave us back control and the confidence to do what we knew we had to do. **SEWB worker**

Gurriny Yealamucka, the FWB program and Yaba Bimbie are the three cornerstones of the responses developed in 1995 and all remain key strategies that guide the community as they maintain vigilance and build education and awareness around suicide prevention and intervention. Finally, developed in 1995, and updated every year thereafter, is the suicide crisis list—a list of people, programs and organisations with contact numbers for people to access if they are thinking about suicide.

The Yarrabah community flow chart – suicide crisis list

The Yarrabah Community Flow Chart

A guide for individuals working with people at risk of self harm and suicide

Questions to use to assess level of risk and to help decide where to refer

- *Is everything alright in your life?*
- *Is despair/hopelessness being expressed by the person?*
- *Is the person receiving treatment for mental illness/emotional problem?*
- *Is there abuse of drugs or alcohol?*
- *Is there a family history of suicide?*
- *Have there been past suicide attempts?*
- *Are they thinking about suicide?*
- *Have they a suicide plan?*
- *Do they have access to means (e.g. gun)?*
- *What protective factors do they have?*

Medium to High Risk

- Multiple risk factors present *(consider answers to the above questions)*
- Active suicidal thoughts present

Low Risk

Low Risk DOES NOT MEAN No Risk

Agreeable to a referral at next possible time

Acute Care Team (ACT) 24/7
4226 3100
After hours, number will be forwared to Cairns Hospital who will contact the ACT.

Child and Youth Mental Health (under 18)
Weekdays:
8.00am-4.30pm
4226 3400
Other times as per ACT

In an emergency

Emergency – Ambulance/Fire/Police.....000
Police link.....131 444
Ambulance – Non-emergency.....131 233
Gurriny Healthcare Service.....4226 4100
Mobile phones with no coverage.....112
Suicide Helpline Call Back Service.....1300 659 467

PEOPLE RARELY SUICIDE IN COMPANY – ORGANISE SUPPORT & SERVICES

Other options for referral & assistance

Cairns Integrated Mental Health Service.....4226 3100
Cairns Regional DV Service.....4033 6100
Centacare, Cairns.....4044 0130
Community Health Centres - Cairns.....4226 4333
Edmonton.....4226 4900
Dads in Distress.....1300 853 437
DV Connect Mensline.....1800 600 636
Elder Abuse Helpline.....1300 651 192
Gay & Lesbian Counselling.....1800 184 527
Headspace (Cairns).....4041 3780
Mental Health Carers Supportline
Qld (landlines only).....1800 351 881
Parent Line.....1300 301 300
PHAMS.....4056 9444
Pregnancy Counselling Link.....1800 777 690
Qld Aids Council.....1800 177 434
Relationships Australia.....1300 364 277
Yarrabah Primary School.....4056 0666
Yarrabah Secondary Department.....4056 0333
Sexual Assault Helpline.....1800 010 120
Yarrabah Women's Resource Centre.....4056 9481
Wuchopperen Health Service.....4080 1000
YETI.....4051 4927
YouthLink.....4031 6179

24 hour referral services:

13Health.....1343 2584
Alcohol & Drug Information Service.....1800 177 833
Bereaved by Suicide.....1300 467 354
beyondblue Supportline.....1300 224 636
Child Safety Services.....1800 177 135
Family Drug Support.....1300 368 186
Kids Helpline.....1800 551 800
Life Bereavement Support Service.....0439 722 266
Lifeline Australia.....131 114
Mens Line Australia.....1300 789 978
Poisons Information Centre.....131 126
StandBy.....0459 299 147
Suicide Callback Service.....1300 659 467
Veterans Counselling Service.....1800 011 046
Victims Counselling & Support.....1300 139 703
Women's DV Helpline.....1800 811 811

Flowchart developed by Dr Edward Koch Foundation, the FNQ Suicide Prevention Taskforce & Gurriny Yealamucka
Enquiries - (07) 4053 6757

Below is a list of people who are willing to talk and listen to you when you need help. If for some reason you cannot talk to someone on this list, please seek help from someone else who you can trust and can talk to.

Community

Allenby & Vanessa Ambrym...0487 807 573 (M)
Amy Neil - Sexton.....(Judulu)
Andrew & Vera Wilson.....0497 804 206 (M)
.....0448 805 583 (M)
Jayleen Miller.....0450 087 479 (M)
Fr Michael & Valma Connolly.....4056 9586 (H)
.....0497 087 003 (M)
Pamela Mundraby.....0497 729 823 (M)
Pastors Paul & Natasha Munn.....4056 9083 (H)
.....0457 186 095 (M)
Paul Neal Jnr
Wayne & Gwen Costello.....0447 714 266 (M)

Djenghi

David & Linda Baird.....4056 9365 (H)
.....0414 569 372 (M)
Josephine Murgha.....4056 9481 (W)
.....0484 389 679 (M)
Leslie Baird.....0478 648 279 (M)
Mary Kyle.....4226 4151 (W)
.....0423 928 411 (M)

Gindaja (Drop-In Centre)

Lyndell Thomas.....4056 9156 (W)

Gindaja (Rehab)

Thelma Yeatman.....4056 9156(W)
.....4056 9282 (H)

Mourigan/Back Beach

Fr Edward Murgha....0411 108 116 (M)

Oombunghi

Ainsley Dangar.....4056 9372 (H)

Reeves Creek

Melanie Walsh.....0448 618 469 (M)
Merton Bulmer.....0499 442 594 (M)

Life Promotion Officer
0400 063 990

When making a referral, the following should be said:

"Hello, I'm ..... from ..... I have a person with me who is at HIGH RISK OF SUICIDE."

September 2017

© Dr Edward Koch Foundation #12

And now…

As noted previously, at the time of the consultations, suicide ideation had once again returned to Yarrabah and community members have been lost to suicide. Some community members reflected on the possible reasons for the recent challenges:

> It feels like some people have again lost connection to culture and cultural ways. If people are suiciding or thinking about it then there are people here feeling they have lost control and are feeling unsupported…some people might not be feeling loved. We have to show people we love them…people have to feel loved. **Community member**

In May 2017, this current context had left Life Promotion Officers, the Gurriny Yealamucka Social and Emotional Wellbeing team and some community members 'on edge and really worried about the next phone call and our community and if we are returning to a dark time'. Many of the initiatives described in previous sections continue on—for example, the continued growth and effective service delivery of Gurriny Yealamucka as a community-controlled health service, a men's group that supports change and healing journeys and a network of support for those experiencing suicide ideation.

There was some confidence these initiatives could support the current challenges and trauma in the community, since these were effective responses previously. By December 2017, the Gurriny Yealamucka SEWB team were reflective and increasingly assured in the work they were undertaking—though less confident about funding and their ongoing tenure:

> We can't be done with suicide until we are all healed from the past and current trauma. We have Intergenerational Trauma so we can't expect people won't still think about suicide. **Community member**

> The Stolen Generations have meant the next generation have not learnt about family connection…when the children were taken away love was taken away… they stole love out of a traditional family structure and connections were broken and then no one knew how to do that family stuff. **Community member**

> Identity is not easy to find in Yarrabah and every generation has to work it out… they try to keep the traditional culture and don't understand the new one and sometimes we don't fit into our own community. **Community member**

In the same way there was a focus on trauma and healing in 1995, there remains a focus on the importance of healing as a suicide-prevention strategy:

> We know the stories but we are still waiting for the answer…It takes a lot of healing when family traditions and ways are broken. We are storytellers but the story gets broken when one is taken out of the story. **Community member**

> We try to see people healed but we still need a place for people to tell their story because there are unresolved issues and we need to draw them out.

> We do that when there has been an incident but we need to do that before they start to think about suicide. **SEWB worker**

> When we are a community healed we will see less suicide…it is a battle between culture and spirit but it's the effects of colonisation and trauma that ultimately causes suicide and until we heal the generations we won't see the end of it [suicide].
> **SEWB worker**

Yaba Bimbie continues to maintain a focus on men's healing and restoring cultural pride, connection and responsibility within the context of the men's group. Further, education and awareness are also important prevention strategies that are driven by the Gurriny Yealamucka SEWB team:

> We continue to promote life and have a focus on awareness every month. We have to be careful that in talking about suicide we do provide further triggers for people…We thought about a plaque to honour those in the community we had lost to suicide but we did not want people to see it and then want to have their name on it. **SEWB worker**

> Talking about suicide can be a trigger for suicide and promoting awareness of suicide needs to start with connection to culture and we need to tell the story of life and promote life and how to take care of ourselves and each other.
> **SEWB worker**

> During this time [heading into Christmas] we have a couple of things like 'All I want for Christmas' with a promotion of good health and then the 'Twelve Signs of Christmas' like the Twelve Days of Christmas…which are twelve signs to look for in others to make sure they are alright and then let people know what they should do if they see a problem…if we put up a solution we like to put up a solution. **SEWB worker**

Finally, when asked about what other communities can learn from Yarrabah's experience some key factors were commonly identified. These were:

- the whole community needs to come together and recognize the problem as a community problem and time needs to be taken to reach consensus/agreement/commitment
- there needs to be respect of Elders and cultural ways for addressing the problem, there needs to be healing leadership/leaders and family leaders need to be known and identified
- communities need to do it their way – 'Yarrabah worked because we did it Yarrabie way'
- communities need to take control and communities need to be the solution
- organisations and services do not come first – the community comes first
- solutions need to come from the ground up and services need to fit through the cultural frameworks and not the other way round.

In the words of one SEWB team member:

> You have to know as a community you can deal with the problem…when we met for the big community meeting we did not fully understand why or how but we knew we could deal with the problem because we had strong leaders and the presence and wisdom of the Elders. We had strong cultural protocols and without honoring these protocols we have failure. Then you need to know who else can help.

The case study highlights how increased community empowerment and control can be an effective response to suicides in remote Indigenous communities. While different in practice to the Tiwi Islands, there is profound consistency with the Tiwi Islands. In both communities:

> It will never be people up there in ivory towers or outside our communities that make the change, it is us – people, families and leaders in the community, people on the ground [that] make the difference…we know what to do now.
> **Community member**

Summary

The story of suicide prevention in Yarrabah is not a closed subject. In the same way the Tiwi Island communities worry and guard against future suicides, so too does the community of Yarrabah. Unfortunately, as the story was being told, listened to and written, suicide again visited the community in deeply traumatic ways for community members and service providers alike.

However, this is still a story of success where successive waves of suicides brought the community to a consensus about an urgent need and the necessity for the community itself to respond to such need. While in retrospect, Tiwis reflect on seizing back power and control and being empowered, in Yarrabah there was a deliberate focus on the concepts of empowerment and control and what the processes might be for operationalising them from the very start.

Success is deemed to be due to the community taking control of health and wellbeing and primarily through the establishment of Gurriny Yealamucka and the FWB program. Each empowered the community by increasing the capacity of individuals, organisations and communities to gain control over their lives to improve health and wellbeing.

It seems everyone remembers the story and those not born at the time of the community meeting can retell the story of the meeting as though they were there. There are physical reminders and acknowledgement of the meeting around the community and the suicide narrative is now dominated by the beginning of healing and change, rather than loss and grief – though no one who has passed is forgotten.

It is not clear what has led to the emergence of recent suicides and increased suicide ideation. The time will come for this kind of question to be explored. Right now, responses to the current sadness are those that were established in an earlier time, developed since that time and within the context of the services provided by Gurriny Yealamucka, have become more formal and structured. It is the community that has control of current intervention and prevention, but as previously, there will likely need to be culturally sensitive support from external agencies, that bolster the culturally-driven responses from within the community.

Common themes

The stories of suicide prevention from the Tiwi Islands and Yarrabah have much in common. More than 2,500km apart and with differing processes of colonisation, both communities found a way to address suicide that share much in common.

Colonisation and decolonisation

The case studies strongly suggest the level of suicide in each location was a long-term outcome of the colonisation process which is critical to addressing suicide in the two communities. The traumatic disruption of colonisation on communities, cultures and families is known to be the primary factor and is the source of poor social and emotional wellbeing in communities.

The communities in the Tiwi Islands and Yarrabah also recognise that the processes of decolonisation, that included the closure of reserves and the end of formal legally encoded racial discrimination, also enabled Indigenous people to access welfare and alcohol without restriction. Hunter and Milroy (2006) suggest this combination led to widespread community dysfunction and preceded the rapid increase in suicide rates for Indigenous people born into a state of what the authors describe as 'normative instability', where alcohol and dysfunction are layered onto trauma and distress. This occurs in a broader context of deep poverty and social, economic and political exclusion as well as the loss of cultural traditions, roles and identities. The communities of Tiwi and Yarrabah put this theorising in plain language for this report.

Intergenerational Trauma

The stories demonstrate how the communities are grappling with the emergence and understanding of Intergenerational Trauma. Young people in both communities are experiencing and remembering events in the life of the community. Trauma has become embedded in the collective, cultural memory of the community and is passing through the generations using the same mechanisms by which culture is generally transmitted (Duran and Duran 1995).

There is evidence within the stories community members told that they are making sense of this through not only focusing on family but also community and rebuilding their connectedness to each other and their cultural wisdom. Young people are also experiencing and remembering the positive events in the life of the community—particularly the community meetings and the consensus that communities held in order to take control of their own challenges.

Healing and cultural reconnection

These case studies are stories of the beginning of a healing process from colonisation and past and present government policy. They are stories where communities themselves address the effects of Intergenerational Trauma.

Each community talked in detail about the loss of connection to culture, land, language and even self. Social determinants of health and wellbeing, reconnection to culture and traditions and the need to reduce alcohol and drug use in response to the suicides were dominant themes. Indeed, both communities were, at the time of the suicides, and have been since, focused on upstream approaches that aim to address detrimental social determinants as a response to suicides.

The FWB program in Yarrabah is a key example of such an approach, while in Tiwi the focus of reducing the three Gs—gunja, grog and gambling—as well as strengthening families through skin group meetings, provided a similar focus. Both suggested that strong families and strong communities are the best protection from suicide ideation and attempts.

Both communities have also acknowledged that building strong families and strong communities requires an understanding of the impact of colonisation and various pathways necessary for healing. Communities recognise this requires both cultural and contemporary understanding of social and emotional wellbeing. However, the dominant theme in each story was reconnection and transmission of cultural processes and traditions that had been lost. Men's and women's groups in each community were well established and played a pivotal role in this process as did Elders-driven on-country healing programs for young people to help them become stronger and think differently.

These two stories demonstrate the existence of healing leadership in each community, where cultural and contemporary understanding of social and emotional wellbeing and trauma-informed practice were present. Elders and leaders were present early in the responses and have remained respected advisors since that time to the present day. This leadership and knowledge is seen as important to bringing the community/communities together and providing the specific and local cultural knowledge, framework, understanding, safety and wisdom needed to build empowered community responses to past, existing and future crises.

Community empowerment and local responses

In understanding that colonisation has led to a loss of control and connection, both communities sought to take back control. Empowerment was recognised as an important element to the responses that aimed to address community challenges. This is empowerment that can counteract the pervasive disempowerment that followed colonisation, became an important step in addressing community challenges. Its potential in enabling multiple flow-on benefits that go beyond addressing a particular issue is also recognised.

The involvement of Elders in programs cannot be separated from community empowerment-based approaches, provision of cultural elements in programs, or cultural governance of programs within a cultural framework. Having become empowered, each community continues to feel empowered.

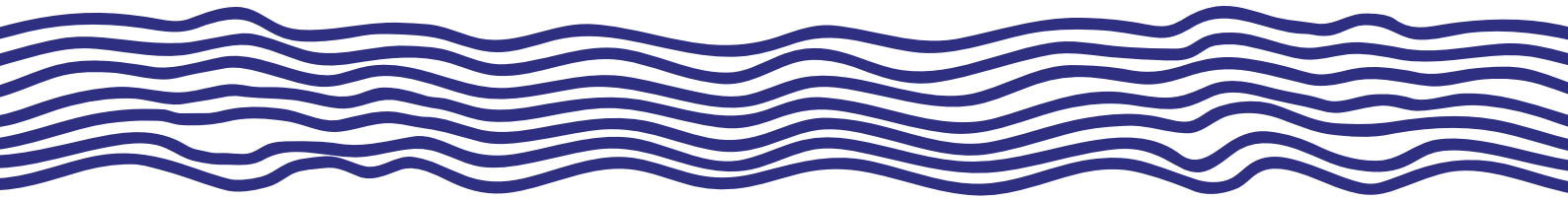
In both instances the community initiated and drove processes with empowerment occurring as each community created their own momentum, gained their own skills, and advocated for their own changes. Governments and service providers were expected to respond to/support the localised priorities, needs and strategies identified by the communities.

Both communities developed training where groups of people in the community had been educated/trained in how to identify and support individuals at high risk of suicide. Each community had formally and informally trained people that reported increased knowledge of suicidal behaviors and confidence and/or willingness to assist individuals at risk of suicide.

In the Tiwi Islands the Youth Diversion team were the first responders, while in Yarrabah the Life Promotion officers and the Gurriny Yealamucka Social and Emotional Wellbeing team took on the role. These are local community members with the cultural, family and kinship knowledge needed to make effective responses at the intervention, prevention and post-vention stages.

Clearly, in both communities there have been awareness-raising programs and a variety of means to do this. Multimedia has been one approach but the case studies provide evidence of sport, art (painting and dance), music and social media all being used to communicate strong messages around suicide awareness and education. These are local responses embedded in local culture, language and traditions.

Finally, peer-to-peer support and mentoring occurs through leveraging peer-to-peer cultural obligations and responsibilities of care and support. Suicide prevention activity is employing community members and providing them with training (and/or upskilling) as appropriate. In this way, suicide prevention activity addresses community unemployment rates and creates culturally relevant jobs and long-term employment for community members.



ATSISPEP suicide prevention success factors

Key success factors for Indigenous suicide prevention have been identified by ATSISPEP. These are summarised in the table on page 37. Many of these factors align with stories from Tiwi and Yarrabah. That is, the *practical efforts* of each community bear out the *theory* as outlined and developed by ATSISPEP.

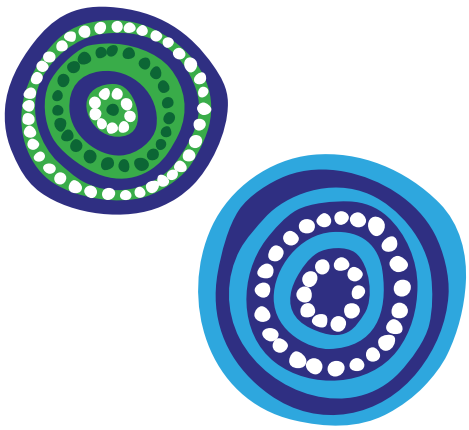
The case studies suggest the most critical response is that there is consensus that suicide prevention activity is required. This is central to success. Consensus opinion must be provided through cultural means and appropriate cultural authority secured. Alongside this success is driven by the fact that the community believes it is empowered to take control of the issue and activities.

The case studies demonstrate the power of community control when consensus is reached. They demonstrate how different communities can respond with, and through, a process of empowerment. They also demonstrate how healing can take place within and through trauma and grief. The case studies are stories of hope as each community remembers a time past that continues to inform the present and future should suicide visit again.

Further, the ATSISPEP project generated a number of tools and resources for use by Indigenous communities along with stakeholders, government, organisations and funding agencies to support Indigenous suicide prevention activity. These tools and resources respond to the importance of community leadership and recognise that responses cannot be standardised across differing communities but must instead reflect local needs.

The case studies presented here provide support for the utility value of the tools and resources. However, in light of the case study findings there may be a need to review the tools. The case studies highlight the complex and dynamic nature of suicide prevention and intervention at a local community level. Therefore, the somewhat linear approach of some of the tools may be limiting or seem complex to community members using them as, at times, they demand categorical answers to complex questions.

Finally, the case studies demonstrate how theory and practice can come together through empowered, local responses to the devastating events that took place in each community. Capturing these stories demonstrates that learnings are best documented and understood when communities have the opportunity to first create, and then second, tell their own story.



Key success factors for Indigenous suicide prevention

UNIVERSAL/ INDIGENOUS COMMUNITY-WIDE	**Primordial prevention**	• addressing community challenges, poverty, social determinants of health • cultural elements • alcohol/drug use reduction
	Primary prevention	• gatekeeper training – indigenous-specific • awareness-raising programs about suicide risk/use of dvds with no assumption of literacy • reducing access to lethal means of suicide • training of frontline staff/groups in detecting depression and suicide risk • e-health services/Internet/crisis call lines and chat services • responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	**School age**	• school-based peer support and mental health literacy programs • culture being taught in schools
	Young people	• peer-to-peer mentoring, and education and leadership on suicide prevention • programs to engage/divert, including sport • connecting to culture/country/elders • providing education and hope for the future – preparing for employment
INDICATED – AT RISK INDIVIDUALS	**Clinical elements**	• access to counsellors/mental health support • 24/7 availability • awareness of critical risk periods and responsiveness at those times • crisis response teams after a suicide/prevention • continuing care/assertive outreach post ED after a suicide attempt • clear referral pathways • time protocols • high-quality and culturally appropriate treatments • cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	**Community leadership/ cultural framework**	• community empowerment, development, ownership – community-specific responses • involvement of Elders • cultural framework
	Provider	• partnerships with community organisations and ACCHS • employment of community members/peer workforce • indicators for evaluation • cross-agency collaboration • data collections • dissemination of learnings

References

Atkinson, J., Nelson, J. and Atkinson, C. (2010), 'Trauma, transgenerational transfer and effects on community wellbeing', in N Purdie, P Dudgeon & R Walker (eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Practices and Principles*, Department of Health and Ageing, Canberra, pp. 135–144.

Close the Gap Clearinghouse (2013), *Strategies to Minimise the Incidence of Suicide and Suicidal Behaviour*, Australian Institute of Health and Welfare, Canberra.

Dudgeon. P., Milroy, J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos, G. and Holland, C. (2016), *Solutions That Work: What the Evidence and Our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project, University of Western Australia.

Duran, E. and Duran, B. (1995), *Native American Post-Colonial Psychology*, State University of New York Press, Albany, New York.

Hanssens, L. (2007), 'The Search to Identify Contagion Operating Within Suicide Clusters in Indigenous Communities, Northern Territory, Australia, *Aboriginal & Islander Health Worker Journal*, September/October, Vol.31, No. 3.

Hunter, E. and Harvey, D. (2002), 'Indigenous Suicide in Australia, New Zealand, Canada and the United States', *Emergency Medicine*, Volume 14, pp. 14–23.

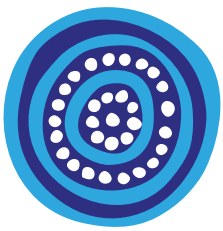
Hunter, E. and Milroy, H. (2006), Aboriginal and Torres Strait Islander Suicide in Context, *Archives of Suicide Research*, Volume 10, pp. 141–157.

National Mental Health Commission, (2013), *A Contributing Life: The 2013 National Report Card on Mental Health and Suicide Prevention*, p. 175.

Senate Community Affairs References Committee (2010), *The Hidden Toll – Suicide in Australia*, Commonwealth of Australia, Canberra.

The Elders' Report into Preventing Indigenous Self-harm and Youth Suicide (2014) People, Culture and Environment.

van der Kolk, B.A. (2007), 'The developmental impact of childhood trauma' in L. Kirmayer, R. Lemelson, and M. Barad (eds.), *Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives*, Cambridge University Press, New York, pp. 224–41.



Appendix 1 – Methodology

In early 2017 ATSISPEP provided funding (auspiced by the Aboriginal and Torres Strait Islander Healing Foundation) for Dr John Prince to work with the communities in the Tiwi Islands and Yarrabah.

The method for collecting data and story was developed with each community through initial visits in March 2017. During this first visit local community members who were willing to assist in the research as cultural brokers were identified. There were between two and four in each community and each was remunerated for their contribution.

From March 2017 to December 2017 three field trips took place to each community, noting that Nancy Jeffrey from The Healing Foundation joined the research team in the Tiwi Islands and worked closely with the women to capture their part of the story.

Over the course of the field trips more than 40 community members were interviewed in Yarrabah and more than 60 were interviewed in the Tiwi Islands. In the Tiwi islands interviews took place primarily in Wurrumiyanga (Bathurst Island). Interviews were a combination of face-to-face, focus groups and yarning circles. Interviews and yarning circles were mostly gender-specific and at times age-specific, and took place in people's homes, workplaces or in community gathering places.

Additional to interviews with community members, community organisations were also interviewed well as past and present primary and allied health workers. Some interviews took place via telephone as some health workers had left the community and were working in other parts of the country.

All interviews were semi-structured and ranged from 45-60 minutes. The majority of interviews were audio-recorded and later transcribed for analysis, while others were written in note form. All interview data is stored in password-protected files, that only the principal researcher can access.

Analysis included first managing the data to look for key themes and then reading and annotating to begin the process of data interpretation. This was an integrative process where various parts of the data were related to other parts. This part of the analysis involved integrating the data to previous understandings.

Categorising then identified the most salient themes and then linked data to explore relations that are internal or necessary and those which are external and contingent. Connecting categories then involved considering components of the data that tended to occur and/or recur together. Where two parts of the data conforms to this type of pattern, a conclusion can be made that there is a connection between them.

Importantly, once the data was analysed and the case studies written, each story was returned to the community to ensure those who had contributed to each story had the chance to approve the written story. In this way the researcher becomes the custodian of the community story for a short time but the story remains with the community, which has the final say on the written interpretation.

HealingFoundation

Strong Spirit • Strong Culture • Strong People

www.healingfoundation.org.au