An Analysis of Suicide in Indigenous Communities of North Queensland: The Historical, Cultural and Symbolic Landscape

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May 1999

ISBN 0642735352

Publication approval number: 2831

Report prepared in May 1999
Text revised in October 2000

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Publications Production Unit (Public Affairs, Parliamentary and Access Branch)
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Acknowledgements

This project on which this report is based was funded by the Commonwealth Department of Health and Aged Care, and John Murray of the Department provided logistical support during its transformation into a publication. It stems from an earlier and larger study under the directorship of Associate Professor Pierre Baume who was, at the time, the Director of the Australian Centre for Suicide Research and Prevention at Griffith University.

Subsequently, other Centre staff have provided information and support throughout the project including Phillipa McTaggart, Portia Hickey, Chris Cantor and Diego DeLeo. Mary Whiteside, Hans Spier, Desley Harvey and Jo Winterbottom at the University of Queensland helped with collation and analysis, and Louise Livingstone and Joanne Brown provided logistic support. Others due recognition include the Cairns Base Hospital Ethics Committee and workers for the Cairns, Townsville and Mount Isa Health Districts of Queensland Health.

However, this research would not have meaningfully progressed without the support and cooperation of the Indigenous communities on which this report focuses—Yarrabah, Mornington Island and Palm Island. The Aboriginal Coordinating Council provided a means by which we could responsibly collect information and particular thanks are due to Alf Lacey from Palm Island.

For helping with collecting information and providing other insights regarding Palm, Neil McLeod and Robert Blakeley are also due our thanks. Finally, but foremost in enabling this work to proceed is the community of Yarrabah. We offer our sincere appreciation to the Yarrabah Community Council, the Gurriny Yealamucka Health Council and to the Family Life Promotion Program (David Patterson).

Finally, we wish to acknowledge the past pain and the continuing memories of those Indigenous people from throughout the region who were swept away by the tragedy of suicide. We hope that our work will contribute to empowering Indigenous communities, not only in their responses to suicide, but also in their efforts to support social, emotional, cultural and spiritual wellbeing.

Contents

Figures

Tables

Graphics

Acronyms used in this report

ACC	Aboriginal Coordinating Council
ATSIC	Aboriginal and Torres Strait Islander Commission
AISRAP	Australian Institute for Suicide Research and Prevention
BAC	Blood alcohol concentration
CDEP	Community Development and Employment Program
DAIA	Department of Aboriginal and Islander Affairs (later Advancement)
DNA	Department of Native Affairs
DOGIT	Deed of Grant in Trust (community)
FLPO	Family Life Promotion Officer FLPP Family Life Promotion Plan
FNQ	Far North Queensland
JCU	James Cook University of North Queensland
OATSIH(S)	Office of Aboriginal and Torres Strait Islander Health (Services)
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
UQ	University of Queensland

Executive summary

This is the first systematic and comprehensive examination of suicides in Aboriginal communities in Queensland based on community records as well as available mortality figures. The data provides a picture which is notably different from that for suicide generally, in Queensland and across Australia. What particularly characterises and distinguishes this picture is the relatively recent emergence of suicide as a significant cause of mortality, its relation to initial clusters of suicide in custody in the 1980s, the unabated increase in aggregate suicide rates, the concentration of deaths among young adult males, the predominance of hanging as a means, and spatial and temporal clustering.

An adequate understanding of suicide in Aboriginal communities requires an appreciation of historical, cultural, and community contexts, as well as recognition of the distribution of these deaths across region, communities and time. The picture which emerges is that these suicides do not as a rule take place in custody, they are commonly young men, they are almost always associated with particular patterns of alcohol or substance use, are often preceded by interpersonal conflicts, and frequently occur in families in which there have been similar losses and where lifestyles of risk are common.

There are many human and social acts where the meaning of the act resides, ultimately, in the sense which is made of the act and its context and consequences. As indicated, suicide is an act invariably demanding a search for attribution, sense making and a social and societal explanation and accounting. What is critical from a preventive perspective is to appreciate that it is the sense making and constructions of others, i.e., the meaning and personal significance of the act for others that can create and constitute further risk. This underscores the critical importance of community and media accounts and explanations.

It is important to contextualise and qualify the explanation of cultural context and meaning that has constituted a significant part of our research. We have focused on a particular aspect of meaning and cultural communication, that relating to the representation and understanding of hanging suicide. We have done this, in part, by standing back and considering the nature and extent of such symbolically-laden representations and how they might be an integral part of the phenomenon of dramatically increasing hanging suicide rates in Aboriginal communities. We have not, however, explored or adequately addressed the larger cultural context and meaning of death, loss, emotional pain, relatedness, the changing self constructions of youth, the nature and mediating role of emotional meaning, expression and coping. These are clearly critical avenues for further inquiry and research in the Indigenous and multi-cultural context of Australia.

Finally, we have not explored or addressed, in this paper, the meaning of the suicide act for the individual involved. While this will reflect and incorporate, to some extent, larger cultural understandings and significances, it is entirely possible that for many individuals, the act is a spontaneous, unreflective institutionalised response to a particular set of circumstances and feelings, which have their own unfolding script and sequence. Furthermore, while the act may constitute a powerful statement to family, community and researchers, at an individual, experience level it may be a situation-provoked drunken gesture, or a simple attempt to cease emotional pain. Clearly the binge drinking which accompanies such acts is often in the service of coping with powerful feelings and there is considerable evidence that acts of self-injury can be analgesic and reinforcing with respect to emotional pain.

This research has necessitated our publicly presenting and discussing information about a salient but sensitive issue and social problem in Aboriginal communities. Suicide is also inextricably a part of other problems and concerns in many contemporary Aboriginal communities, such as

alcohol, incarceration, violence, and family breakdown. We are very aware of the balancing act that attends public discussion and examination of such 'social problems'. We have not publicly presented or discussed much of the information included in this report over the past decade because of expressed concerns relating to possible sensational media coverage, the distress to communities of public discussion of community matters and concerns, the potential for media coverage of our reports and conclusions to simply add to the ongoing social construction and stereotyping of the suicide issue. However, we feel strongly that this non-discussion of Indigenous suicide by professionals such as ourselves has itself become something of a risk factor in Australia, contributing to the non-addressing and non-resolution of what we believe should be a national priority. We feel that this report has been written with the strong support, involvement, and endorsement, of the Aboriginal communities with whom we have worked since the commencement of this research.

Given the importance and visibility of Indigenous suicide as a national concern spanning disciplinary and sectoral boundaries, various 'ways of seeing' are evident in the professional reporting and analysis. For example, in the year in which this report was completed (1999) similar initiatives from other areas of Australia have provided very different perspectives and understandings. Tatz (1999) utilised a political and sociological analysis of Aboriginal suicide in New South Wales, while Parker (1999) undertook a psychiatric analysis in his audit of coronial records in the Top End of the Northern Territory. In this report from North Queensland, the authors intentionally have drawn upon diverse professional backgrounds and, consequently, theoretical frameworks. All have long professional involvement in the area of Indigenous self-harm. The Indigenous member of the team also lives these issues, residing in a community which has, over the last decade, suffered losses and enduring pain. That community, which has struggled to find responses, initially from whatever source and, ultimately, from within, will be considered in detail. This report seeks to find resonances between these different professional and personal sources and, in so doing, provide insights into avenues for intervention. In doing this we have considered at some length the concept of 'risk'. We believe that to be useful in responding to Indigenous suicide there must be a shift from consideration of individual-level risk factors, to a conception of the 'risk condition' and the community at risk and, consequently, an emphasis on interventions at that level.

We conclude this report by reviewing the epidemiological, psychological and public health implications of our work. We consider these implications at various levels – individual, family, community and Indigenous society. The implications for intervention are framed within a mental health public health model – the mental health spectrum of interventions. Quite intentionally our suggestions span the range of this spectrum of activities and are in no way prioritised – we believe that effective responses should be planned, coordinated and comprehensive. They must also be informed by an engaged and evolving understanding of the issues at hand, and by information that is timely, relevant, reliable and available to those working in the community.

We believe that for initiatives to be effective they must necessarily have community support and in their implementation empower Indigenous individuals, communities and organisations. Planners must address sustainability as there is a very real potential for harm in projects that raise expectations only to disappear at the end of the funding cycle. Finally, initiatives should be considered in the light of State and Commonwealth strategies in the arena of self-harm as well as other related areas (such as crime prevention, substance misuse, and mental health promotion and prevention). We believe that to be effective, strategy in the area of Indigenous self-harm must include approaches across the following areas:

Health promotion and universal prevention—whole of community approaches

- support for community development initiatives, particularly those fostering family wellbeing and an optimal childhood developmental environment;
- culturally appropriate school-based and community organisation-based programs to foster the development of emotional coping skills;
- support for developing a robust evidence base for such interventions including the transfer of the requisite evaluation skills to Indigenous communities and organisations;
- fostering intersectoral cooperation and collaboration such that communities have access to best practice, evidence-based, multidisciplinary programs and expertise;
- support for community to community dialogue and exchange of experiences, knowledge and skills relating to community-level responses to Indigenous self-harm;
- support for appropriate and acceptable health promotion and prevention initiatives aimed at reducing population level alcohol consumption;
- avoidance of negative stereotypes of Indigenous peoples and of Indigenous suicide in the mainstream media; and
- empowering communities through access to information including:
  - collection of accurate, reliable and relevant material at a community level which is available in a timely fashion for service and community planning;
  - collection of accurate information relating to Indigenous suicide at National, State and regional levels, and mechanisms for making this available in a timely manner to health and social workers and researchers engaged in and with Indigenous communities;
  - development of Indigenous expertise at all levels to collect, analyse and utilise the above information with adequate resources and support to sustain these activities; and
  - development of social indicator systems relevant to the area of community risk.

Selective prevention—groups at elevated risk

- facilitating discussion and dissemination of information regarding the potential negative impact of particular constructions of Indigenous suicide through Indigenous organisations and to Aboriginal and Torres Strait Islander communities;
- development and implementation of strategies to influence media reporting and portrayals of violence and self-harm;
- development of a strategy to address and counter current beliefs and understandings which present suicide as a reasonable and normative response to experienced pressures and emotional pain, and understandings which promote the notion that an individual is being encouraged or compelled to take their own life by others who have died in this way;
- support for health promotion and prevention initiatives aimed at Indigenous drinkers to prevent or reduce binge drinking;
- family support programs for those families impacted by lifestyles of risk, particularly those with a cross-generational history of coping problems and high-risk behaviour patterns; and
- statutory and resource support for communities to develop local strategies to address alcohol misuse.

Indicated prevention and early intervention—individuals at elevated risk

- appropriate and adequately resourced community-based crisis response strategies capable of responding to instances of threatened or actual self-harm;
- adequate community-based capacity to respond to the immediate needs of individuals and families affected by a recent suicide (postvention);
- support for the development of appropriate approaches to counselling in communities;
- appropriate mainstream support for the above activities; and
- ensuring that primary care practitioners working with Indigenous patients are trained in the primary care management of alcohol-related problems and have the knowledge and skills necessary to manage self-harmful behaviours.

Standard treatments

- direct access for Indigenous Australians to the same range and quality of emergency and mental health services (adult and child) as is available to the wider Australian population;
- ensuring that these services are functionally accessible, that is, appropriately adapted to the cultural needs of Aboriginal and Torres Strait Islander people;
- developing appropriate programs for the effective management of Aboriginal and Torres Strait Islander people with dual diagnoses (coexisting mental health and substance misuse disorders); and
- support for the development of alternative treatment approaches, including appropriated therapies (such as narrative therapy) and Indigenous therapies (Hunter & Garvey, 1998).

Background of the project and methods

This study evolved from a larger project which sought to explore issues relating to suicide by violent means which was, itself, in response to a call from the Commonwealth Department of Health for a study into suicides by hanging. Initial discussions with Departmental representatives supported this wider scope and, within that part of the study dealing with Indigenous suicide (where hanging was recognised to be by far the most common means of suicide), a focus on the cultural and symbolic context of hanging. The original proposal (late 1997), was for an analysis of the database of suicides occurring in Queensland collected and held by the Australian Institute for Suicide Prevention and Research (Pierre Baume), with examination in depth of three subpopulations—children and young people with preexisting psychiatric disorders (Robert Kosky), children and young people in rural and remote communities (Joseph Reser), and Indigenous children and young people (Ernest Hunter). Ultimately, available funding did not allow the three subsidiary projects to proceed as initially envisaged and two smaller sub-projects emerged—children and young people with preexisting psychiatric disorders, and Indigenous suicide, with JR and EH cooperating on the latter. Subsequently, primarily due to the wishes of the communities and agencies who cooperated with the project that the resulting report stand independently rather than be edited and integrated within a larger document, permission was obtained from the Commonwealth (with the approval of the Australian Institute for Suicide Research and Prevention) to submit this report relating to Indigenous children and young people as a separate study.

The focus of this study of Indigenous suicide shifted in response to developments within the area of study—North Queensland. Ethics Committee approval was initially obtained through AISRAP and through the Cairns Base Hospital Ethics Committee. Consultation with representatives from communities and agencies proceeded slowly, with the focus of interest shifting to a consideration of changing patterns of suicide across the region and a more detailed understanding of the experiences of one community—Yarrabah. Indeed, it was not until mid-1998, after considerable discussions within the community and with the Yarrabah Community Council, that the third member of the research team, Mercy Baird, formally joined the project. The final member of the team, Paul Reser (who with Joseph Reser had been involved in research in Yarrabah a decade earlier), joined in late 1998. The team thus grew organically, its members bringing a range of experiences and perspectives to the task. The Indigenous member is finishing a degree in Primary Health Care and consequently brings a community development orientation to the analysis. The three non-Indigenous team members each represent different backgrounds—Psychiatry/Public Health (EH), Psychology (JR) and Sociology (PR). The report which follows clearly reflects, and has benefited, by this diversity of viewpoints.

The study shifted in response to practical and theoretical considerations (resulting in a resubmission for ethics approval through Griffiths University and the Cairns Base Hospital Ethics Committee in late 1998). In its final form the project sought to consider five related issues:

- patterns of Indigenous suicide in Far North Queensland at a community level;
- changing temporal patterns of suicide between identified communities;
- changing patterns of vulnerability over time within one community;
- the symbolic context and meanings of hanging as a method and its relation to Indigenous suicide; and,
- the nature of responses to suicide within a community and their changes over time.

In order to consider patterns of suicide within and between communities accurate information regarding deaths by suicide is obviously necessary. This entails all of the pitfalls associated with establishing the cause of death in studies of suicide generally, as well as the additional problem of identifying those individuals who were of Aboriginal or Torres Strait Islander descent (it is only within the last decade that Queensland has identified Aboriginal or Islander status on death certificates). In order to identify suicides which had occurred within the communities under consideration in this study two sources of information were sought. The first were the recollections of members of specific communities. The second is the Queensland Suicide Register, the collection of AISRAP in which all Queensland suicides since 1990 have been examined and analysed (Baum et al., 1998).

From the Queensland Suicide Register broad statistics were obtained regarding all those deaths in Queensland between 1990 and 1997 in which suicide was considered probable or beyond reasonable doubt (for clarification of AISRAP categorisation see Appendix 1 and Baum et al., 1998). Further information was obtained, including autopsy and other relevant reports, regarding all of those deaths in which the individual was identified as being of Indigenous descent and who was identified as living in North Queensland (from Mackay north) or where residence was unknown. Over a period of several months the autopsies were systematically reviewed and checked against the supplied aggregate statistics, with local sources being utilised in certain cases to obtain further corroboration. Although few, certain anomalies were discovered and corrected for the subsequent analyses. These included mis-identification of ethnicity, specifically of Indigenous persons who were not, in fact, Indigenous. This resulted in several reclassifications and raises issues regarding such research for which there are no easy solutions. For instance, there were several suicides of individuals from the Mackay region (and probably elsewhere) who were believed to be of Aboriginal or Torres Strait Islander descent but who may well have been of South Sea Islander descent. This approach did not reduce the possibility of misclassification of individuals who were Indigenous but who had been classified in the database as non-Indigenous. Within the discrete Aboriginal communities studied in detail in this report, however, no such instances were found (although this type of error is probably more likely to occur in urban settings).

In addition to the few misclassifications by race identified, there was also an instance of one death eliminated from our analysis that had been considered in the AISRAP analysis to be a ‘probable’ suicide. This death was classified as probable on the basis of a past history of suicide attempts and documented recent stressors, but had occurred as a direct result of inhalant (glue) sniffing. After discussion with AISRAP this death was reclassified. As with the previous issue, while this review identified deaths incorrectly identified as suicide which were not, it did not consider those not classified as suicide but which, in fact, were (such as certain motor vehicle accidents and deaths of individuals who were killed while lying on the road or railroad tracks). It should be noted that in terms of both of the above issues, remaining error in the state-wide information obtained from the AISRAP database is likely to be in the direction of underestimating actual Indigenous suicides. As noted above, the results of this review were subsequently compared with information obtained from informants from the three discrete Aboriginal communities examined in detail to see if community recollections and local information collections differed.

The final part of the field research was to document in detail the experience of one community, Yarrabah, which over the last decade has experienced several ‘waves’ of suicide. During that time various responses have been undertaken and, gradually, a coordinated broad response has emerged. Material for this section was provided by Mercy Baird and other workers in the Family Life Promotion Officer (FLPO) program, and obtained from correspondence, records, the minutes of relevant meetings and other written sources. Included in this information is data

collected in the late 1980s and early 1990s as part of research conducted into Indigenous suicide by James Cook University for the Aboriginal Coordinating Council. This data contains the results of a survey of young adults in Yarrabah in the course of which ‘risk status’ for self-harm was ascertained. After developing a means of establishing aggregate ‘outcome’ for this and a ‘control’ group (considered not at risk) without divulging named data outside the community, permission was obtained from the Yarrabah Council and the Cairns Base Hospital Ethics Board to include this follow-up component within the study.

This report thus contains information derived from several sources and approaches. Being based entirely on material from Far North Queensland is both a strength and a potential limitation. This is a region in which the communities in question, despite their unique features, have broadly similar post-settlement histories and contemporary social circumstances. Similarities and differences between communities in patterns of self-harm may be presumed to have occurred despite this common background and, consequently, provide greater support to inferences that isolate factors occurring at a local level. However, it cannot be presumed that the experiences and circumstances of Indigenous communities of Far North Queensland can be generalised to Aboriginal and Torres Strait Islander communities elsewhere. While the conclusions drawn from this analysis may well apply in other settings, that should not automatically be presumed. Generalising these findings to other settings requires a careful exploration of differences and, consequently, an informed understanding of local history and circumstances.

Rationale and structure of the report

As will be clear from the preceding section, the work informing this report proceeded in response to a range of opportunities and constraints. However, while the approach evolved through the life of the project, it was guided by certain common understandings born of the experience of all of the research team in this field, which, collectively, spans nearly a half-century. The report thus reflects evolving thinking, practice and insight in the area, both within this team and across other researchers and practitioners engaged in this work. It is structured to reflect and convey this process, guiding the reader both from general to specific information, and from data to practice. In order to accomplish this purpose the report contains information from other sources as well as the fieldwork of this study, and includes both quantitative and qualitative analyses. It draws on history and precedent to provide practitioners with an understanding of contemporary circumstances and, in doing so, it identifies precipitating and mediating factors. We believe that the understandings that follow from this analysis will allow for and inform more effective intervention at a community level.

While the initial brief for this study focused specifically on suicide by hanging, we have chosen to consider Indigenous self-harm more broadly. We have taken this approach for several reasons. First, suicide, regardless of means, is a violent act and, particularly in Indigenous contexts must necessarily be considered within the wider context of personal violence. Second, suicide has only emerged within the last two decades, and particularly the last decade, as a significant contributor to premature mortality in the Indigenous population. Third, of completed suicides by people of Aboriginal or Torres Strait Islander descent, the vast majority (particularly among males) are by hanging. Finally, it is the expressed opinion of the Indigenous collaborators to this work that it is inappropriate to focus solely on deaths by hanging. However, precisely because Indigenous suicide is a recent phenomenon and because the most frequent method of lethal self-harm is hanging, we have also sought to explore those social, psychological and symbolic factors that relate, in particular, to hanging as method. This reflects both a public health perspective and a culture context and meaning perspective, as these events are salient and consequential symbolic statements as well as acts with wide-ranging impacts and consequences in Indigenous communities.

The report begins with a review of existing literature relevant to Indigenous suicide in Australia, including material specific to Aboriginal and Torres Strait Islander populations and other material relating to indigenous populations elsewhere. The section that follows presents an analysis of Indigenous suicide in North Queensland demonstrating the disproportionate contribution of Indigenous suicides within this region to Indigenous suicides in Queensland and to suicides for the State as a whole. The concentration of suicides across time and space will be shown by exploring those deaths from three communities in that region. From this community level analysis it will become clear that over the last decade deaths from suicide have not been randomly distributed across the region. These deaths, and thus the risk of self-harm, have been concentrated in particular places at particular times. This section concludes by exploring the persistence of individual risk over time for a group of young men identified as being at ‘risk of self-harm’ in one community a decade earlier, at which time there had been a series of suicides.

This material suggests that while the regional and supra-regional patterns of suicide are not random, and while it is thus possible to identify communities in which risk is elevated, the identification of risk and vulnerability on an individual level is problematic. This is a reality obvious to practitioners working in such settings who are both alert to the imminence of self-harm but frustrated by their inability to predict what is usually an impulsive act of vulnerable individuals. The issue of risk is further explored in the second part of this study in a discussion of

Indigenous suicide generally and deaths from hanging in particular through an analysis of symbolic and communicative aspects of suicide by hanging in the Aboriginal population.

In the next section attention is drawn to the community level of analysis by documenting in some detail the experiences and responses of one community, Yarrabah, which has undergone dramatic changes in the prevalence of suicide and self-harmful behaviour over the last fifteen years. This community has been chosen for five reasons. First, suicide emerged earlier in this community than in others in Far North Queensland as an identifiable 'problem'. Second, as a consequence, Yarrabah had, earlier than most other communities, explored various ways of responding to events for which there was no clear local precedent. Third, there is considerable documentation that relates to the approaches undertaken by the community over this period, with all members of the research team having been involved at various times. Fourth, this chronology and analysis demonstrates a logical and consistent transformation in the way in which suicide within the community has been understood and integrated into the 'community narrative', and consequently, in the initiatives undertaken in response. Finally, in this community self-harming behaviour declined substantially through the late 1990s. Sadly, there were two further deaths attributed to suicide in mid-2000 during a time of significant change and stress for the community and, unfortunately, further tragic losses may well occur. Regardless, Yarrabah has experiences to convey and, wisely or not, the turn around of the late 1990s resulted in it held up by the media and others as a 'model', usually with a narrow focus on immediate activities that obscures important wider and longer term experiences and lessons. We believe that it is critical to carefully identify the specific and general considerations, the regional and local circumstances, the mediating and moderating factors, and to understand them within an Indigenous community context. We conclude this report by discussing issues emerging from this analysis with particular emphasis on what this material suggests in terms of the ways in which 'vulnerability' and 'risk' are framed and understood, and the implications for risk assessment, program evaluation, and for broader preventive programs and preventive interventions at a community level.

Literature review

An adequate understanding of the phenomenon of Aboriginal self-injury and suicide in Australia requires taking a broader, cross-cultural and historical perspective. The fairer and more informative touchstone for Aboriginal suicide is clearly indigenous suicide elsewhere, particularly in fourth world contexts, not majority culture statistics (eg; Gergen et al., 1996; Sloan & Motero, 1990). Suicide rates in many indigenous communities are extraordinarily high (Disley & Coggan, 1996; Duclos & Manson, 1994; Hezel, 1987; Hezel et al., 1985; Leenaars, 1997; May, 1990; Robillard & Marsella, 1987; Wyche & Rotheram-Borus, 1990), and areas range from Micronesia, to the Artic, to the American Southwest, to Lapland, to Brazil. Australian Aboriginal suicide and self-injury must also be seen and understood in the local historical and regional contexts in which it is occurring, and in the context of youth suicide generally, in Australia and internationally.

Youth suicide takes on a different character and complexity when considered from a cross-cultural perspective. Clearly cultural factors influence the nature and extent of family conflict and support systems, the challenge of moving from adolescence to adult life, acculturation and identity problems, the nature and magnitude of inter-generational discontinuities for particular cultural groups, the cultural construction and meanings of the act itself, the nature of self and emotional constructions, coping strategies for dealing with emotions, help-seeking behaviours, causal ontologies, etc. (Baumeister, 1986; Bee-Gates et al., 1996; Berry, 1990; Brady, 1992a; Condon, 1990; Eckersley, 1988; Huffine, 1989; Jessor, 1993; Kim & Berry, 1993; Kitayama & Markus, 1994; Kleinman, 1988; Lee, 1981; Lutz & White, 1986; Marsella & Dash-Scheuer, 1988; O'Neil, 1986; Radley, 1993; Schlegel & Barry, 1991; Stiffman & Davis, 1990; Shweder, 1991; Triandis, 1996). Cultural factors can also dramatically influence definitions, criteria, reporting biases and suicide statistics (Atkinson, 1978; Diekstra, 1996; Douglas, 1967; Reser, 1989a).

There are important touchstones to be found in the North American experience of indigenous suicide, where most research has been undertaken, and where experience with national and community-based prevention programs spans three decades (National Institute of Mental Health, 1973). Youth suicides have been an ubiquitous phenomenon in Native American communities for the past 40 years (Frederick, 1975; Leighton & Hughes, 1955; Levy, 1965; McIntosh & Santos, 1980; Shore, 1975; Webb & Willard, 1975) and continue to be an arena of considerable anguish and concern (Blum et al., 1992; Berlin, 1987; Duclos & Manson, 1994; Grossman et al., 1991; Kirmayer, 1994; Leenaars, 1997; Malchy et al., 1997; May & McClosky, 1997; Potthoff et al., 1998; Royal Commission on Aboriginal Peoples, 1995; Sigurdson et al., 1994; Strickland, 1996). This experience has included the phenomenon of suicide 'clusters' in small remote communities, a situation where a series of suicides and suicide attempts occurs over a period of weeks or months, mediated by suggestion, modelling, identification, and other factors, with devastating impact on a community. The many common denominators relating to suicide rates and circumstances among small, rural, indigenous communities in Australia and North America, for example, suggest both shared etiologies and noteworthy differences. Similarities include the preponderance of young male deaths, and, for this cohort, the role of binge drinking, the impulsiveness of the act, the use of guns and hanging, and the diverse regional patterns and frequent cluster character of proximate suicides. Differences include different histories and contexts, and different cultural assumptions, understandings, idioms of distress, situational triggers, and causal attribution's with respect to self-injury, and substance use and abuse.

Suicide is the second leading cause of death for America Indian adolescents, and suicide deaths among Indian and Alaskan Native youth are two to four times higher than the rates for other

groups of the same age in the United States and Canada, though these rates vary considerably by tribe and region (e.g., Kean et al., 1996; May & Van Winkle, 1994; Shore, 1994). Suicide attempt figures for Native American youth are thought to exceed 20 per cent. Reported age-adjusted suicide for Native American and Alaska Native youth vary dramatically with date, group and region. In a number of recent reports, rates for males 15 to 24 years have approached and exceeded 100 per 100,000 (Benetau, 1988; Cooper et al., 1992; Duclos & Manson, 1994; Kirmayer, 1994; Malchy et al., 1997; Westlake et al., 1993). The problem has proven to be a particularly challenging, devastating and cross-generational phenomenon.

Much of the recent research on suicide assessment and prevention in North America has been undertaken by Native American psychologists working with or at the American Indian and Alaska Native mental Health Research Centre in Denver, Colorado (e.g., Duclos & Manson, 1994; Fleming, 1994; LaFromboise, 1996; Trible, 1988). These recent efforts have focused on more accurately establishing the nature, location, and extent of the phenomenon, on longitudinal cohort studies of school-based youth, on developing, trialing and validating more applicable diagnostic and screening instruments, on the role and cultural context of substance abuse, and on the development and evaluation of intervention and prevention programs. There now exist a number of standardised and trialed risk assessment and preventive interventions that are widely used in Native American communities (Berlin, 1985; Indian Health Service, 1991; Keane et al., 1996; LaFromboise, 1996; LaFromboise & Howard Pitney, 1994; Levy & Kunitz, 1987; Manson, 1988; Manson et al., 1989; Norton & Manson, 1997), for example, the American Indian Life Skills Development Curriculum developed by LaFromboise and others.

Within Australia there now exist many discussions of Aboriginal self-injury and suicide in both popular media reports and in professional journals (Bolder, 1991; Brady, 1992; Clayer & Czechowicz, 1991; Hunter, 1988a; 1988b; 1993; 1995; Parker, 1999; Radford et al., 1990; Reser, 1989a; 1989b; 1991; Tatz, 1999; Robinson, 1990). There is a broad consensus that the problem is acute and the product of a complex set of individual, situational and sociocultural factors.

Considerable case study material was brought together by the Royal Commission into Aboriginal Deaths in Custody (1991; Biles & McDonald, 1992) and in multiple government reports (e.g., d'Abbs et al., 1994; Dodson, 1995; National Aboriginal Health Strategy Working Party, 1989; Swan & Fagan, 1991; Swan & Raphael, 1995). Queensland has figured prominently in these discussions (e.g., Atkinson 1990a; 1990b; Cantor & Slater, 1992; Powder & Law, 1987; Reser, 1989a, 1989b, 1991, 1992; Barber et al., 1988; Martin, 1993; Smithson et al., 1991; Taylor et al., 1989) as a substantial number of alleged suicide deaths in police custody occurred in Queensland and a number of Queensland Aboriginal communities appeared to be characterised by suicide clusters similar to those reported in Native American and Inuit communities in North America (e.g., Bechtold, 1988; 1994; Berlin, 1987; Blum et al., 1992; Duclos & Manson, 1994; Grossman et al, 1991; Lester, 1996; Levy and Kunitz, 1987; May, 1990; May & Van Winkle, 1994; Harras, 1987) and the Pacific (e.g., Hezel et. al, 1985; Rubinstein, 1983). Recent events in North Queensland suggest that a number of communities are experiencing similar 'cluster' or 'contagion' phenomena while other communities appear to have successfully passed through such a phase.

The North Queensland context is of particular interest as events here were arguably largely responsible for the establishment of the Royal Commission into Aboriginal Deaths in Custody (Reser, 1989a), and because of the relatively high incidence of suicide and parasuicide behaviours in some communities since the early 1970s. There also has been a concerted effort on the part of North Queensland Aboriginal communities to address the problem of increasing youth suicide and access the help and assistance of other agencies and researchers in more adequately assessing and understanding the nature and magnitude of the problem (e.g., the 1997 CATSA Suicide Summit; the Yarrabah Life Promotion project; Smithson et al, 1991). A number of

suicide prevention initiatives have been implemented in North Queensland and their respective experiences are of considerable interest elsewhere in Australia and overseas.

Notwithstanding the frequency and saliency of discussions of Aboriginal suicide, there have been very few systematic research studies of the actual nature, extent and distribution of these behaviours across communities and time in a particular region. There are many reasons for this relating to the availability and accuracy of cause of death information, personal case history data or medical records, as well as the sensitivity of the issue. For a number of historical and other reasons, however, there exists a modest number of research papers and discussions relating to suicide and self-injury in specific North Queensland Aboriginal communities (Barber et al., 1988; Martin, 1993; Powder & Law, 1987; Reser, 1992, 1991, 1989a, 1989b; Reser et al., 1990; Smithson et al., 1991; Taylor et al., 1989).

A substantial research initiative which provided a number of these papers and reports was centred at James Cook University, and the nature and extent of suicide and self-injury was examined in five North Queensland Aboriginal communities. Because this research was undertaken at the request and on behalf of the Aboriginal Co-ordinating Council, the results were not widely disseminated and a summary report was lodged with the ACC.

The most recent and dramatic increase of suicide deaths in several North Queensland communities, and the continuing absence of a more systematic look at these experiences of particular communities, over time and with respect to the region as a whole, makes a compelling case for a current stocktake and examination of available epidemiological data and patterns.

As well, the nature of the suicide deaths and patterns of self-injury over the past ten years in this region, the prominence of hanging as a method, the particular vulnerability of young men, the role of substance use and abuse, the proximity in space and time of multiple deaths—all point to larger regional and community patterns and contexts which may well inform our understanding of the nature and causes of these deaths, as well as the relative efficacy of current intervention and prevention programs. There has been, for some years now, an urgent need to collate existing data and examine the broader, regional picture of indigenous suicide incidence over time and across communities in North Queensland. It is now clear that the phenomenon of Indigenous suicide is moving rapidly through traditionally-oriented communities in the Northern Territory (Parker, 1999) and appearing, intermittently, in other regions of Australia. A clearer understanding of the North Queensland situation would be invaluable, not only in terms of tailoring particular intervention and prevention strategies to specific community need, but with respect to the larger epidemiological prognosis for regional and remote Australia.

Patterns and correlates of suicide in Far North Queensland

Sources of information

This section is an analysis of data received from two sources. The database of the Australian Institute for Suicide Research and Prevention (AISRAP) is based on coronial inquests into completed suicides in Queensland from 1990-1997. From this data research has already revealed that, in the middle of decade (1996) approximately half of all suicide deaths of young people in Queensland resulted from hanging (Kosky & Dundas, 2000). Of 137 recorded deaths by hanging in 1995 and 1996 of individuals aged 25 years or less, 35 (26%) were identified in the coronial reports as being Indigenous. All Indigenous deaths were male and 10% of these deaths were of individuals less than sixteen years of age (Kosky & Dundas, 2000).

For this report the AISRAP data has been clarified and expanded by information from community based sources regarding three discrete communities. In two of these this extends the timeframe back to the 1970s. Conflicts between the information provided from these two sources (AISRAP and communities) have been mentioned and will be discussed further. For all statistical tests applied in analysing the data an alpha of .05 is utilised to assess statistical significance. The community data utilised in this report was obtained through several approaches which included consultation with key informants in specific communities and (in the case of Palm Island) examination of a community Deaths Register. This latter comparison identified several kinds of inconsistencies. The first relates to location as the AISRAP data base identifies the suicide with the place in which the death occurred, not where the person lived or originated; deaths in the AISRAP data listed as Charters Towers or Townsville may mean nothing in terms of community association. Thus the suicide of community members in prison, i.e. in Stuart Creek in Townsville or Lotus Glen near Mareeba, are attributed to Townsville and Mareeba respectively, and the community attribution lost, despite the fact that these people are still very much part of the community notwithstanding their physical absence. The second inconsistency is due to the different periods of time included. The span incorporated in the AISRAP data available for this report covers 1990 to 1997, with deaths later than October 1997 not listed. The data from the Palm Island Deaths Register has a longer span, covering the period from August of 1971 to February 1998. The third source of inconsistency relates to the date assigned to the death. There are instances of deaths recorded by these two means listed by each source by different but proximate dates.

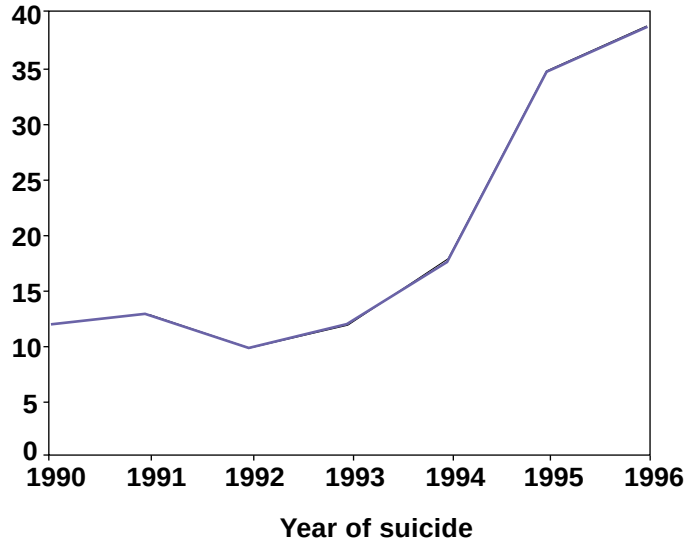
These sources of differences are relatively minor in that they do not bring into question the validity of either data set. However, of more concern, there is a number of cases that are *not* common to the two sets of data where their periods overlap. While one would expect that the AISRAP data, based mainly on coronial and police reports of suicide, would have the imprint of reliability due to its official sources, there are thirteen cases in the records from Palm Island categorised as (possible) suicides that are not listed by AISRAP. While some of the information in the Palm Island data are vague in detail and need further clarification, there are instances where specific means are listed that give some credence to the Palm Island data and attribution of cause. For example, two deaths in the early and mid-1990s by hanging were not listed by AISRAP. In addition there were four deaths that were listed by AISRAP as suicides from Palm Island which had no reference in the Palm Island register. These involved lethal methods of suicide (3 hangings and 1 shooting.) Two may have resulted from confusion over the recording of

the date of death, however the other two have no clear correlates in the community data. These discrepancies may have arisen from differences in attribution of place (as noted above) or name. Regardless, it raises obvious questions regarding the reliability of available data and its impact for considering this material at a community level.

Overview

Figure 1 shows the distribution of Indigenous suicide in Queensland over the period provided by the AISRAP data, with the information available for 1997 not complete. Interpreting the apparent increase should be tempered by awareness of potential confounding factors, such as changes in the identification and recording of Aboriginality or criteria for identifying deaths as by suicide. However, with the number of suicides for 1996 being some three times that for 1990, the magnitude of the change would argue against these factors being solely responsible. A chi square goodness-of-fit test for uniform distribution was applied to assess if the cases per year (for the period 1990 to 1996) were distributed equally. The resulting value of 42.6 had a probability of $p>.0001$ allowing the conclusion that there was not an equal distribution of cases across the years, though the size of the sample (n=139) dictates caution in the interpretation. It is also worth noting that this increase was primarily a male phenomenon, with little overall change in female suicides over the period (see Appendix 2). While the monthly pattern showed that April had the largest number of suicides (21), and May, August and November tied with the least number (7), these variations were not statistically significant. Considering climactic zones (north to south) as a factor made no apparent difference as to the month of completed suicide.

Figure 1: Recent trends in Aboriginal suicide—Queensland



For Aboriginal and Torres Strait Islander suicides in Queensland over the period, hanging predominated as a method of suicide. Of male suicides, 73% were by hanging, with firearms accounting for a further 14%. For females the 11 of 18 deaths from 1990 to 1997 by hanging represent 61% of female suicides. Table 1 presents actual counts of type of method for males and females.

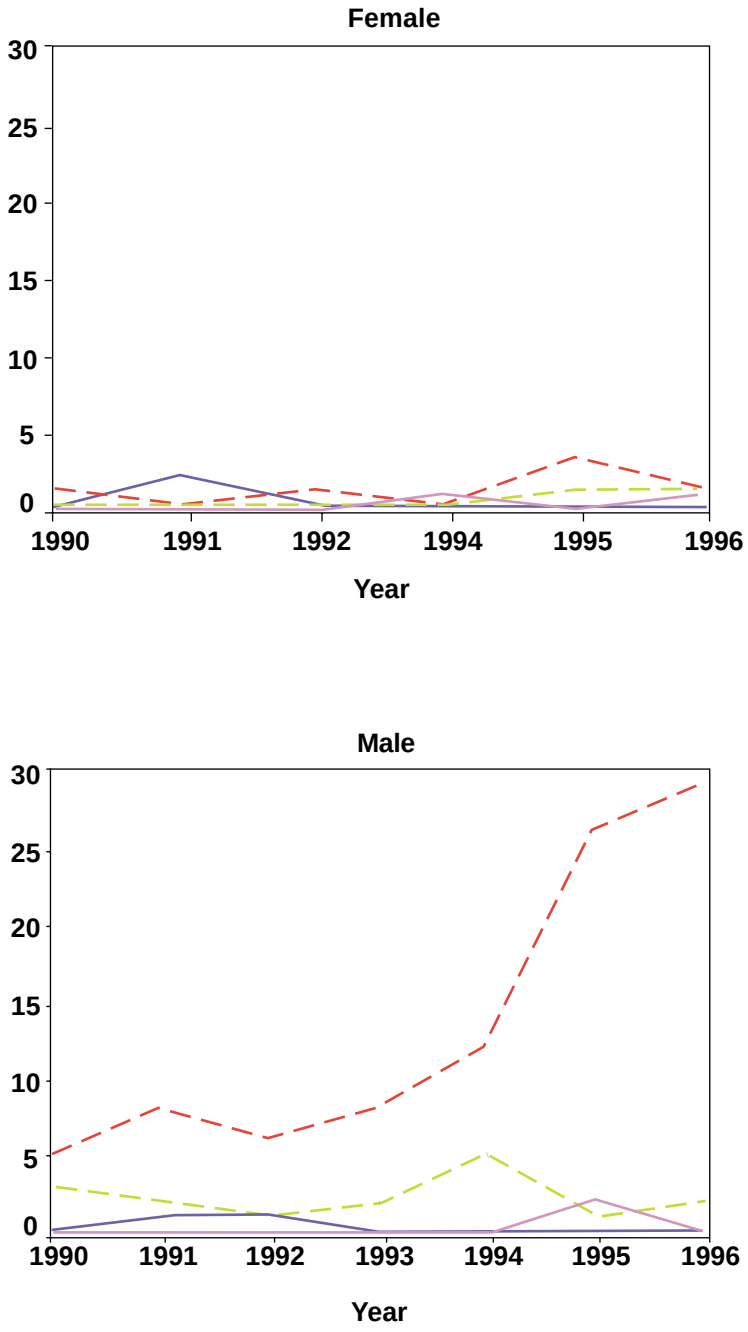
Table 1: Suicide by method from 1990 to 1997 (data for 1997 incomplete)

		Gender		
		Female	Male	Total
Method	Hanging	11	101	112
	Firearms	2	19	21
	Jumping	0	4	4
	Drowning	0	4	4
	Gas	2	2	4
	Train	1	3	4
	Poison	2	2	4
	Cutting/piercing	0	2	2
	Total	18	137	155

Plotting the most common methods of suicide by year (Figure 2) allows for comparison through time. Hanging as a means increased in both actual counts and relative proportion to other types of suicide for both males and females. The larger number of suicides for males clearly establish the pattern, as hanging as a method shows predominance not only over the period, but as a sharply increasing trend. By contrast the actual counts of suicides in the female Aboriginal population is so low that no clear pattern can be established. Other means of suicide have remained relatively stable over the period. This pattern contrasts to that reported for all suicides in Queensland for males, where both hanging and car exhaust is seen as increasing sharply in terms of methods used (Baum et al., 1998). It can be argued that it is precisely the predominance of hanging as a method in the ATSI population that is influencing the State trend. Removing the 70 Aboriginal and Islander hangings as a component of suicides by all methods from 1990 to 1995 (to make it congruent with Baum et al., 1998:16) alters the order of method so that hanging drops to third position behind drugs/poison for the Queensland population as a whole—despite the fact that the Aboriginal and Islander population of Queensland is but a small numerical minority.

Regardless of means, Indigenous suicides in Queensland over the period 1990 to 1997 contributed disproportionately to the suicide rate for the State as a whole. This is particularly so for young Aboriginal males—removing the 70 deaths of young Aboriginal males aged 15-24 years reduces the rate for Queensland males in this age group from 43.7 to 36.9 per 100,000. Though only 4.3% of the population in this age category, Indigenous males constituted 16% of the suicide deaths.

Figure 2: Method and trend by gender in Aboriginal suicide—Queensland



Community profiles

Aggregating data for Queensland as a whole provides a means by which to examine trends over time that are less consistent at a local level due to the small populations involved. This leads to great fluctuations over time in annual suicide rates calculated on a population denominator, usually, of 100,000 persons. However, disaggregating this suicide data by discrete Aboriginal communities brings to view regional and local patterns not observed at a State level. Depending on the source of data used (AISRAP versus community information, differences, as noted earlier, reflecting various factors including attribution of place, that is, of residence versus of death) between 30% and 39% of Indigenous suicides involved people from three communities in North Queensland—Yarrabah, Palm Island and Mornington Island. The population of these communities, which together number approximately 5000, constitutes only 5% of Aboriginal and Torres Strait Islander Queenslanders.

While this is clearly a disproportionate loss, the numbers involved in each community are relatively small. To overcome the temporal fluctuations of the data, moving averages for these three communities were calculated, utilising data obtained from AISRAP on Aboriginal suicide in Queensland. The span used for the average was three years, with the 1997 data (though incomplete) incorporated to calculate the moving average for 1996. For Yarrabah there has been an obvious fall with the last suicide occurring in 1996. By contrast, Mornington Island demonstrates an increasing trend, while Palm Island rates, while no longer rising, as of 1997 do not appear from the available data to be abating. There thus appears to be a periodicity in the incidence of suicide in these communities, with the "epidemic" receding first in Yarrabah which also showed the earliest onset (in recent times). Mornington Island seems to be experiencing a period of increasing incidence, while Palm Island may have peaked.

Figure 3: Three year moving averages of suicide in three Aboriginal communities (AISRAP data)

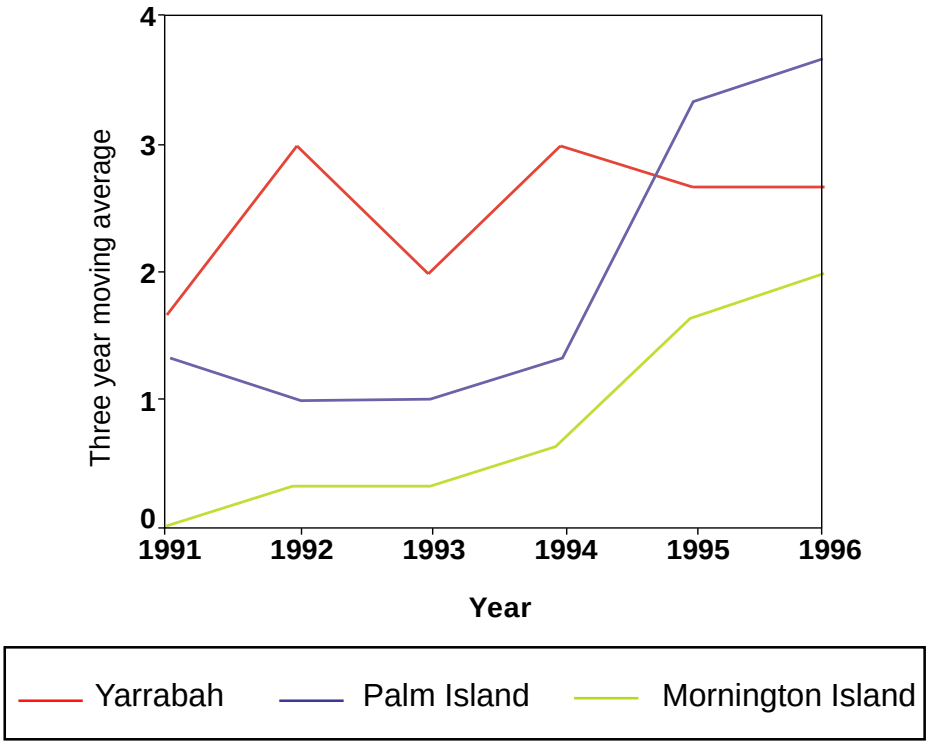


Table 2: Suicide in three Aboriginal communities from 1990 to 1997(AISRAP data)

Year	Yarrabah	Palm Island	Mornington Island	Yarrabah Moving Average	P.I. Moving Average	M.I. Moving Average
1990	0	1	0	–	–	–
1991	3	2	0	1.7	1.3	.0
1992	2	1	0	3.0	1.0	.3
1993	4	0	1	2.0	1.0	.3
1994	0	2	0	3.0	1.3	.7
1995	5	2	1	2.7	3.3	1.7
1996	3	6	4	2.7	3.7	2.0
1997	0	3	1	–	–	–

A slightly different picture emerges when the span of time over which suicide is tracked in these three communities is increased. Incorporating information from previous studies, community mental health programs, and health care providers (figure 4 and table 3) allows some contextualising of more recent patterns. It is of interest to note, for example, for the two communities where data is available for the past twenty years (Yarrabah and Palm Island) that more recent increases can be seen as part of a general increasing trend that dates back to the mid 1980s. It also appears, in both communities, to follow on from incidents some six or seven years previous. For Yarrabah specifically, this was an “index” case of dramatic nature and impact described later in the report. What must be of central interest is the decline noted in Yarrabah, the beginnings of an apparent decline in Palm Island, and possible explanations for these trends.

Figure 4: Three year moving averages of suicide in three communities (community data)

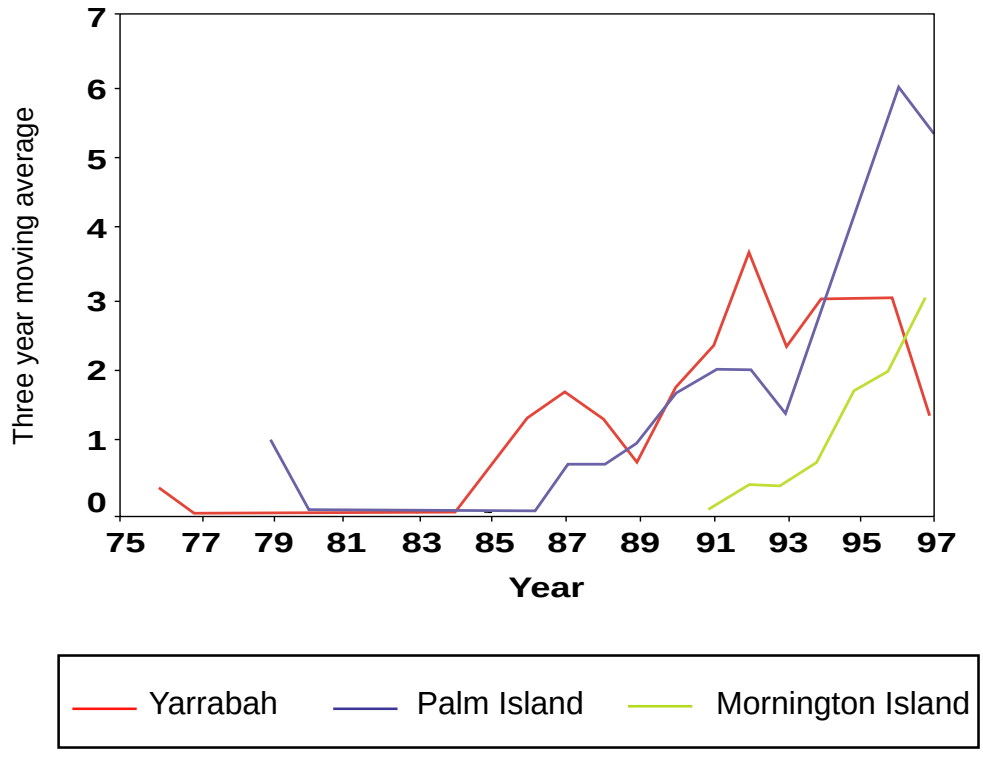


Table 3: Suicide in three Aboriginal communities from 1975 to 1997 (community data)

Year	Yarrabah	Palm Island	Mornington Island	Yarrabah Moving Average	P.I. Moving Average	M.I. Moving Average
1975	1	–	–	–	–	–
1976	0	–	–	.3	–	–
1977	0	–	–	.0	–	–
1978	0	3	–	.0	–	–
1979	0	0	–	.0	1.0	–
1980	0	0	–	.0	.0	–
1981	0	0	–	.0	.0	–
1982	0	0	–	.0	.0	–
1983	0	0	–	.0	.0	–
1984	0	0	–	.0	.0	–
1985	0	0	–	.7	.0	–
1986	2	0	–	1.3	.0	–
1987	2	0	–	1.7	.7	–
1988	1	2	–	1.3	.7	–
1989	1	0	–	.7	1.0	–
1990	0	1	0	1.7	1.7	–
1991	4	4	0	2.3	2.0	.0
1992	3	1	0	3.7	2.0	.3
1993	4	1	1	2.3	1.3	.3
1994	0	2	0	3.0	2.3	.7
1995	5	4	1	3.0	4.0	1.7
1996	4	6	4	3.0	6.0	2.0
1997	0	8	1	1.3	5.3	3.0
1998	0	2	4	–	–	–

Examining the distribution of suicide through time for Yarrabah specifically (Table 4), suggests some aggregation in this community, with gaps of several years between aggregates. A possible first spate occurred in 1986—1987, with three suicides in the span of as many months. A more significant and extensive aggregate seems to have begun in June of 1991, with an apparent clustering of some 17 suicides spanning 5.5 years before ending with the last reported suicide in this community during November of 1996. There is also some indication that December, January and February are the months of risk in terms of suicide in this community. Further analysis of this patterning of suicide through time is currently being undertaken to see if it fits conceptions of suicide clusters.

Table 4: Temporal distribution in suicides at Yarrabah, 1984 to 1998

Month	Total	74	..	86	87	88	89	90	91	92	93	94	95	96	97	98
Jan	3										1		1	1		
Feb	3				1						1		1			
Mar	0															
Apr	1									1						
May	0															
Jun	2								1					1		
July	2									1			1			
Aug	0															
Sep	1										1					
Oct	1								1							
Nov	2										1			1		
Dec	6	1		2					1				2			
Year Total		**1**	**..**	**2**	**1**	**0**	**0**	**0**	**3**	**2**	**4**	**0**	**5**	**3**	**0**	**0**

The involvement of alcohol

Exploring associations between alcohol consumption and suicide on the basis of postmortem blood alcohol concentration (BAC) requires caution. Earlier analysis by AISRAP demonstrated that, for Queensland as a whole: “suicides in which BAC was positive tended to be younger ..., male ... and of indigenous origin” (Indigenous v Caucasian—63% v 41%) (Baume et al., 1998, p. 75). However, for a significant number of the Indigenous suicides in the AISRAP database (39 of 156 or 25%) there is no record of blood alcohol concentration (BAC). While postmortems of possible suicide deaths as a matter of course include such measurements, there are circumstances where this is difficult (for instance, if the body is in a state of advanced decomposition). Furthermore, there appear to be other circumstances in which this information is either not obtained or not included in the coroner’s report.

To examine the role of alcohol in suicide, hanging suicide is compared with that for non-hanging deaths for which BAC information is available. One case was not cross-referenced between databases and therefore excluded. Five other deaths by hanging which occurred in prison were also removed (due to the restriction on access to alcohol in the prison system) giving a total of 78 hanging and 33 non-hanging deaths with BAC recorded. For the cases where alcohol consumption was measured, the categories used were Nil (none/zero); Yes (>0–0.02 ppm); Yes (0.02–0.05); Yes (0.02–0.05); Yes (0.1–0.15); Yes (0.15– 0.25); Yes (> 0.25 ppm).

Comparison across the remainder shows that alcohol was detected post mortem in over two-thirds of non-custodial hanging deaths (67.9%) and over three-quarters of non-hanging suicides (75.8%) showing a strong association between consumption and suicide. An increasing trend in number of suicides towards higher consumption levels is noted for the data to the 0.15-0.25 ppm category, then dropping off in number for the > 0.25 ppm category. While the categories are not equal in their interval and thus making the interpretation of any statistical analysis an exercise in caution, it is quite clear that the number of suicides in each of the above categories is not equally distributed ($X^2_{(6)} = 73.59$ p >.0000). The variation in amount of alcohol detected was however in essence no different when considering hanging versus non-hanging suicides. Furthermore no difference in the pattern between men and women was found. The small number of non-hanging suicides precludes further analysis of blood alcohol differences between these specific methods. For purposes of summation, categories of alcohol consumption have been further collapsed in the table opposite.

Table 5: Recorded blood alcohol concentrations for Queensland Indigenous suicides by hanging and firearms (AISRAP data)

BAC	% Non-hanging (n = 33)	% Non-custody hanging (n = 78)
Nil	24.2	32.1
< 0.15	18.2	20.5
0.15-0.25	39.4	29.5
> 0.25	18.2	17.9
Total	**100.0**	**100.0**

Case follow-up

In November and December of 1989, researchers from James Cook University were based in Yarrabah as part of a larger project looking at suicide and self-destructive behaviour in five of the discrete Aboriginal communities in North Queensland. This research was carried out at the request of the Aboriginal Coordinating Council, and involved fieldwork at the communities of Hopevale, Napranum, Pormpuraaw, Woorabinda and Yarrabah (Smithson et al., 1991). The process employed in Yarrabah to investigate the nature and extent of suicide and other deliberate self-harmful behaviour was similar to that utilised in the other communities. Both a list of people known to have engaged in self-destructive behaviour (cases) and a random sample of the community (controls) were generated. The list of cases was compiled through interviews with community elders, leaders, paraprofessionals and service providers. In the community of Yarrabah these cases constituted 26 people identified by these informants as having a history of deliberate self-harm. For the control group, 50 people were selected from a census of all residents undertaken in the initial weeks of the project. The sampling frame was all individuals between the ages of 15 and 65, numbering 827 out of a population of 1421, thus making this sample some 6% of the Yarrabah population between 15 and 65. Inclusion in the sample required a willingness to participate in the study, with no pattern discernible from among those who were unavailable or declined to participate. During the random sampling process used to generate the control group, one individual was noted as being identified as a “case” and so removed from the controls and placed with the cases for purposes of analysis. Interviews with the control group revealed five others who admitted to having engaged in deliberate self-harmful behaviour, but who were not known to sources in the community. These were retained as part of the control group.

In 1998, members of both case and control groups were followed up by two of the original researchers with the assistance of a community informant working in the area of self-harm (all members of this research team). For purposes of validity and confidentiality, it was not revealed to the community informant which of the individuals were from the random sample and which were from the group of deliberate self-harmers. Information was not available on five individuals (three cases, two controls) as they no longer resided in the community. Additional information, when available, was sourced from either hospital documentation (for the deceased), or Family Life Promotion Program personnel. The type of information collected focussed on any deaths that occurred and their nature, whether suicide or serious self-injury had taken place with the individuals or their families, and whether the individual regularly consumed alcohol.

Seven deaths had occurred among the 69 remaining in the study at the time of follow up. Four deaths occurred among the 21 cases, with one of these deaths by suicide. Of the remaining three, two were from liver disease (ages 23 and 32 at time of death) associated with alcohol consumption, while one was due to a chronic heart condition (aged 38). In the control group,

three deaths had occurred over the period, all from alcohol-related liver dysfunction (aged 46, 50 and 60 at time of death). One would expect a differential mortality disadvantaging the control group due to its greater age, as it was a drawn sample based on the population between 15 and 65 rather than formed on the basis of a behaviour found more commonly among the young. The opposite is actually the case in these two groups, with 15% of the cases experiencing mortality from non-suicidal causes over the period while only 6% of the control group had died. The causes in both instances reflect the high mortality associated with lifestyle factors in Aboriginal communities, in particular the negative impact of alcohol on health and, hence, resulting in premature mortality. Not surprisingly, a majority of both the random sample and identified self-injurers were reported as consuming alcohol. However, the proportion of abstainers in the control group (38%) was nearly twice that as for the cases (20%). As with other reports on drinking patterns among Indigenous peoples, more females were reported as abstainers than males in both the case and control groups (three of five in the former and 10 of 15 in the latter).

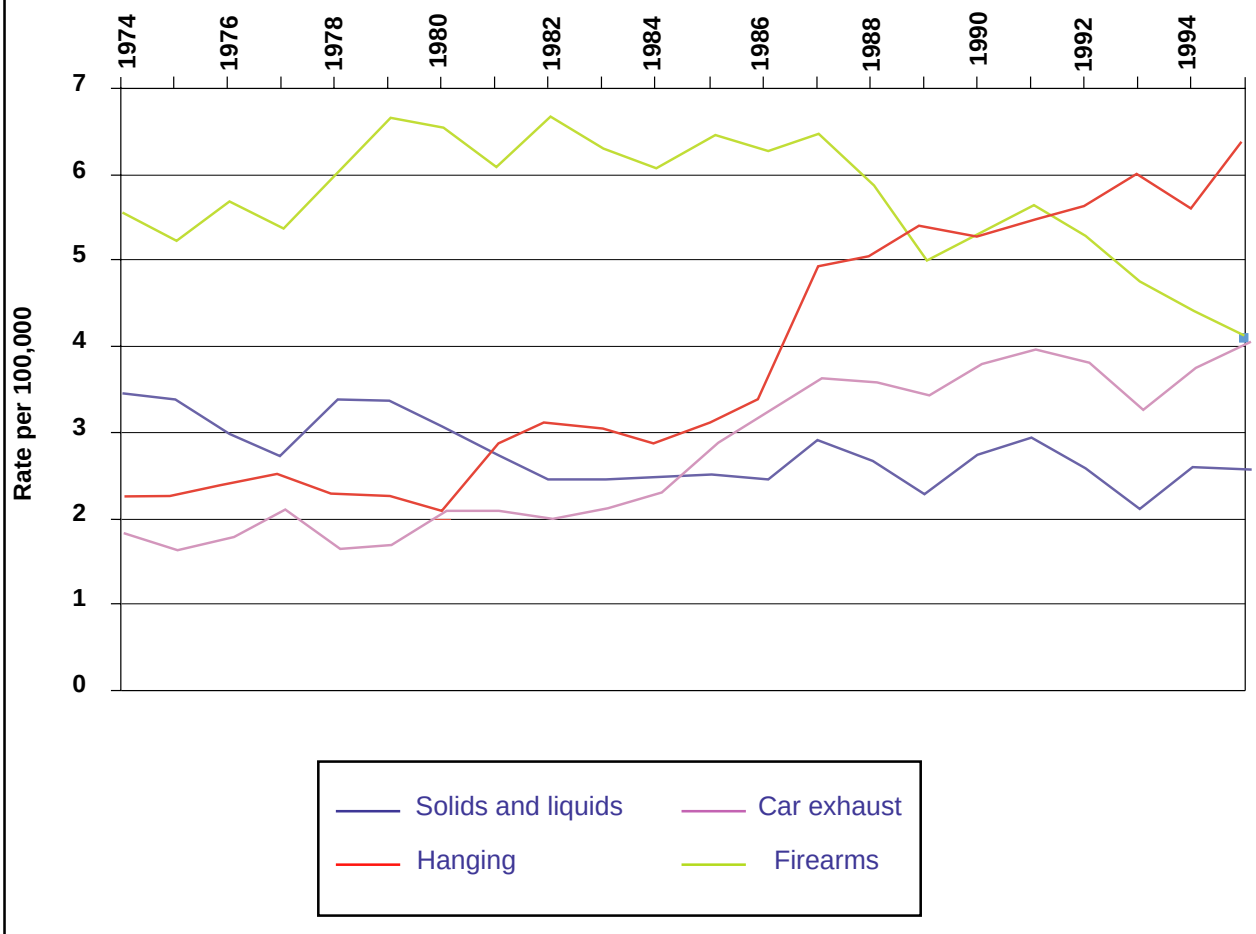
A continuing trend in the incidence of deliberate self-harm was also noted with differences observed in the control versus case groups. Among the five people who had identified themselves as engaging in self-destructive behaviour in the control group from the original sample, only one was identified as having further episodes of self-harmful behaviour during the 1990s. By comparison, of the 19 persons from among the cases identified in 1989 for whom information was available, episodes of threatened or actual self-harm were identified for 12 (63%), including two of the three who were reported as dying from causes other than suicide. The individual identified as a case in the original study and who subsequently died by suicide (hanging), was reported to have engaged in other incidents of deliberate self-harm preceding his death. The lower number of individuals from among the control group that persisted with self-harmful behaviour is not surprising considering the fact that the reported injuries were less severe both in their physical extent and in the duration of the behaviour when compared to those among the identified cases. This suggests that self-identification is a more sensitive measure than key informant observation. From the control group, two who had not initially indicated self-harmful behaviour were, in 1998, identified as having threatened suicide (a 33 year old man and a woman of 49 years), but with no report of actual physical self-harm.

The conclusions to be drawn from this longitudinal perspective point to several issues requiring further attention. The first is that the risk of self-harmful behaviour appears to persist through time, and may remain an appropriate target for intervention. However, such acts of deliberate self-harm are just one symptom of a broader condition of risk, as indicated by the detrimental effects of chronic alcohol abuse among both the cases and controls. The higher mortality among cases, and at a considerably younger age, does point to a constellation of hazard within particular high risk groups in the community. Neither alcohol consumption per se, nor deliberate self-harm are the primary problem; rather, they are indicative of broader social processes being expressed in a particularly vulnerable group. The persistence of deliberate self-harm and other deleterious outcomes suggest that, for this group, high risk remains as the cohort ages.

The symbolic meaning and cultural context of hanging as a method of suicide for Aboriginal youth

Nationally, hanging has emerged over the last decade as the leading cause of death by suicide, particularly for males (figure 5). However, the dramatic proportion of deaths by hanging for Aboriginal youth in Northern Australia requires particular consideration and discussion. It is clear that there are powerful symbolic undercurrents to hanging in Aboriginal communities and in Aboriginal popular culture. These reflect accretions of meaning from a cultural history of hanging deaths, from representations and understandings of 'deaths in custody', from multiple 'Aboriginal' films, posters, poetry and art which feature self-injurious behaviours and suicide death by hanging, from graphic and sensationalised media coverage, and from the first-hand experiences which many Aboriginal people have of hanging deaths and places where people have hung themselves. The stark reality of many small Aboriginal communities is that other lethal methods of suicide are often relatively unavailable to young people at a time of crisis (e.g., a firearm or drugs), and ropes and cords are an ever-present, available, familiar, and evocative household and lifestyle item which form a particularly poignant part of the message and statement of a suicide.

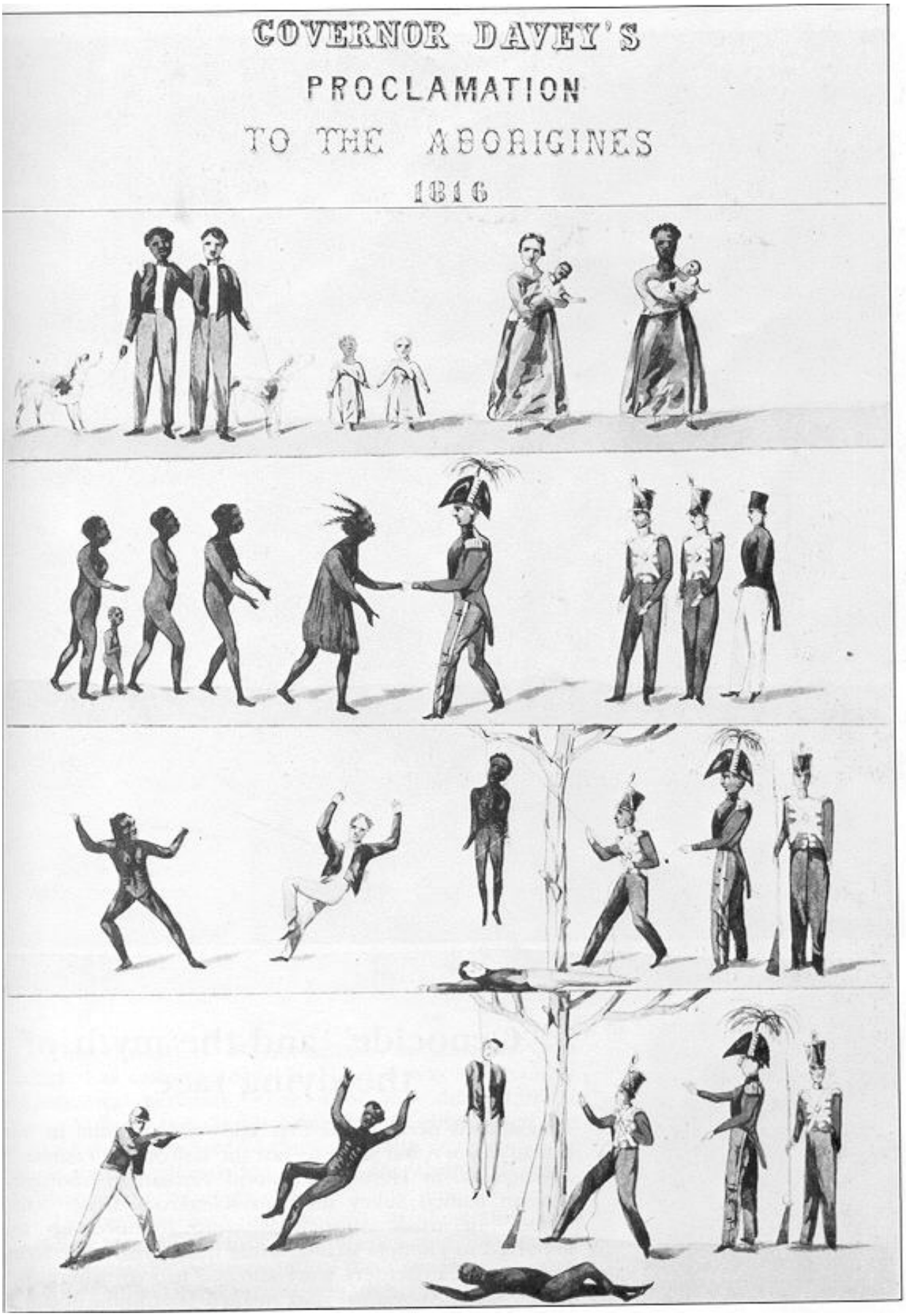
Figure 5: Suicide by method, Australian males, all ages, 1974-1995 (AISRAP data)



It is important at the outset to emphasise that suicide and attempted suicide are powerfully symbolic acts which are intended, in part, to make particular statements and express one's pain. Those who 'witness' such an act or outcome are visibly affected, shaken and impacted by the act. This symbolic statement can be very political as well as poignant. It is noteworthy that a number of the early recorded suicides on Palm Island in the 1960s and early 1970s were younger women who immolated themselves when their children were taken away, acts which clearly communicated their acute sense of injustice as well as pain. The method of suicide often says something about specific cultural meanings and associations, and some methods are far more effective as statements than others. Self-immolation, for example, is associated with political dissent and passive resistance, as in Tibet and southeast Asia generally. Hanging is very often associated with justice and injustice, as it was an ubiquitous form of capital punishment and a particularly confronting display of resistance, defiance, individual control and accusatory blame. It has been suggested that a particular photograph of the hanging of white settlers in colonial Australia, who were convicted of murdering Aboriginal people (Governor Daley's proclamation to the Aborigines, 1816), has played an important role in establishing the symbolic importance of hanging for Aboriginal people (Tatz, 1998). It is noteworthy that photographs of this proclamation (figure 6) routinely appear in books addressing Australia's contact history (e.g., Parbury, 1986; Hartley, 1992). Hanging was also and remains a stark symbol for the Royal Commission into Aboriginal Deaths in Custody, interweaving associations of the justice system, injustice, murder by the establishment, and defiance and martyrdom (e.g., Campbell, 1990; Griggs, 1990).

An exploration of the symbolic nature and currency of suicide representations, and the cultural context, experience of and meanings of self-injury and suicide provides an alternative and complementary perspective to epidemiological patterns and health statistics. It allows for an 'experience-near' understanding (e.g., Geertz, 1983) of factors which mediate and moderate suicide and which touch base with individual and community understandings and experiences. An explanation of the symbolic meaning of suicide also recognises the fundamental importance and power of symbolic meaning and expression in the everyday lives of peoples and cultures (e.g., Alvarez, 1974; Cassirer, 1927; Douglas, 1970; Langer, 1967; Lakoff, 1987).

Figure 6: Governor Davey's Proclamation to the Aborigines, 1816



The arguments

There a number of separate but interdependent arguments why hanging as a method of deliberate self-harm is a particularly salient, common, and meaning-laden method and expressive statement in Aboriginal communities.

1. Hanging as a method has a dramatic, powerful and confronting character quite different from other methods.
2. Hanging has, in addition, multiple culturally-specific meanings and associations for Australian Aboriginal people.
3. Instances of hanging have become an important and suggestive part of place meaning and residential location in many communities.
4. Hanging has become an institutionalised part of a pervasive cultural stereotype that Aboriginal people are exposed to and internalise.
5. Hanging has been the only method available for many Aboriginal people in custody, and is often the most readily available and efficient method in many communities and circumstances outside of custody. Such availability has become integrally linked with circumstance (e.g., incarceration) and other factors.
6. The 'Aboriginal deaths in custody' character of many Aboriginal suicide deaths by hanging has given this form of suicide a particular character, force, and symbolic meaning which relates both to the watchhouse and prison setting itself as well as the larger justice system.
7. Cultural assumptions and perceptions concerning personal control and agency, and cultural explanations and accounts of self-injury, death, and other life events tend to 'privilege' a method such as suicide.
8. Hanging as a method of suicide differs from other methods in that it allows for a number of interpersonal and culturally scripted dynamics to take place between statement of intent or threat and ultimate act, i.e., the procedure is more involved, public, dramatic, time-consuming, and open to intervention.
9. Hanging as a method is a particularly potent catalyst with respect to imitation or cluster suicide, as it presents a dramatic modelling sequence for a potential imitator (more so than other methods), and the 'incident' may well be viewed by many more observers. To the extent that a hanging suicide also carries other symbolic meanings, such as martyrdom, injustice, or pathos, this arguably enhances the salience of the method as well as the 'attractiveness' and identification character of the solution and strategy. The larger context here, is one where suggestion is a particularly strong phenomenon among young people generally and young people in Aboriginal communities in particular.

Developed argument and discussion

(1) The dramatic character of hanging is perhaps self-evident, but is worth discussing. A hanging body has a life in death. It is an asserting, disturbing, sculptural composite of space, place and human form (e.g., Grange, 1985). It is a rebuke and statement of uncaring relations, unmet needs, personal anguish, and emotional payback. An individual will often take their life at a location where estranged partners, or in-laws, or particular others will see the body hanging the next morning, or when they enter or exit a house or particular place. Such dramatic in-death statements are very typical of youth and cultures where kinship relationships are highly scripted, choreographed and interdependent (Hezel et al., 1985; Rubinstein, 1987; Lutz, 1988).

(2) Hanging, in an Aboriginal cultural context, has, arguably, multiple and culturally-specific meanings.

- Hanging of Aboriginals and criminals in Australia has various connotations of capital punishment, the legal system, injustice, and genocide. Aboriginal deaths in custody are epitomised and symbolised by the hanging deaths of Aboriginal youths.
- The deaths of Aboriginals and other indigenous people by suicide and in particular by hanging has featured in a surprising number of recent commercial films (e.g., *Dead Heart*, *Fringe Dwellers*, *Once Were Warriors*, *Smoke Signals*, *Thunderheart*) and in Aboriginal art, plays, posters, song lyrics and popular culture generally.
- Hanging as a method has particular meaning in rural and remote Aboriginal communities because rope, twine and cord are an ubiquitous part of life, often used in the binding and carrying of dead animals, and connote and convey an elemental, everyday, utilitarian quality. It is a low tech, subsistence, lifestyle-sympathetic method that is familiar and known. The complex, multireferential symbolic properties of rope, knots and binding in the Pacific also suggest that this is a cultural representation "profoundly embedded in the mundane and thus habituated space" of local cultural meaning systems (Kuchler, 1999, p. 145).
- Hanging as a method is also particularly suggestive and 'invitational' as so many Aboriginal individuals have taken their lives in this way. Hence there is the 'cue value' (e.g., Berkowitz, 1981) of rope and cord as an instrument of self-inflicted death, and in many instances it would be a method used by a relative or friend.
- Hanging also has particular connotations in many traditionally-oriented Aboriginal communities, as magical killing and sorcery is often accomplished by a 'pulling of one's strings', a cultural understanding whereby one's actions can be controlled, magically, by others.
- There appear to be many accounts in Aboriginal communities of dead relatives and friends appearing to an individual and saying nothing, but extending a rope fashioned into a noose. It is possible that hanging lends itself to such imagined experiences as a more concrete and immediate and culturally appropriate symbolic vehicle for suicide (e.g., Scott-Clark & Levy, 1998). There is also a solidarity in killing oneself in the same way as your friend or kin, and there is repeated reference to 'joining' those that have taken this route.

It is arguable that Aboriginal culture is characterised by a heightened body awareness and self consciousness which is reflected in body symbolism, self presentation, nonverbal communication, etc. There are many sources which document the symbolic associations relating to the body (e.g., Munn, 1996; Rose, 1993; Tamisari, 1998), but there are few discussions of how this somatic preoccupation and awareness might relate to self-injury and symbolic communication (e.g., Brady, 1992c; Reser, 1990a, 1990b, 1991; Robinson, 1990). It is possible that cutting and hanging are particularly salient, significant and symbolic acts in an Aboriginal context as they are acts which involve the body as actor, object and statement (e.g., Cranny-Francis, 1995; Foucault, 1977; Grosz, 1994; Tufnel & Crickmay, 1990).

There are many culture-specific factors which play a part in the social construction and scripting of the meaning and event in Aboriginal communities. There are striking parallels between this phenomenon in Australian Aboriginal communities and in indigenous communities in the Pacific and North America (e.g., Bechtold, 1994; Duclos & Manson, 1994; Hezel et al., 1985; Royal Commission on Aboriginal Peoples, 1994; Rubinstein, 1983). The role of media coverage of Aboriginal suicide in Australia, however, has overlaid cultural context with various narrative and thematic elements which are particularly lethal in terms of identification and imitation and which in many ways distort and mask more genuine and underlying cultural assumptions, meanings, and contexts.

> Few people will talk about the demon, fearing ridicule and the wrath of the thing that is haunting them. [John Smith], a member of Palm Island's ruling council, is an exception. [Brown], a former alcoholic, faced the Hairy Man one night in the summer of 1994. "I was round at a mate's house—we had been drinking and smoking dope for hours. It was really dark outside and I found myself walking down the road towards the hills. I saw a knife lying in the grass, and the blade shone out to me. I could hear voices, but couldn't make out what they were saying. I stopped at a place by the trees and started to make a fire. I took off my clothes and sat down with my eyes shut. Then I saw him—I thought for a minute that it must be God. But it was a terrible, dark face, a face that called out to me, and I could feel myself turning into something else. He was telling me that I had to do it, I had to kill myself. I tried to block out his voice and eventually he went away. I gave up drinking and smoking the next day but even telling you this story brings me right back down again".
>
> It is now [Craig], [John]'s 22-year-old brother, who hears the voices. An athletic, gentle giant, he has tried to kill himself eight times in the past two years. Three of [Craig]'s schoolfriends are already dead—all hanged.... (Scott-Clark & Levy, 1998, p. 19 [names changed from original])

It is important to appreciate that hanging has multiple and intersecting symbolic meanings and associations in Western European cultural contexts, e.g., the 'hanging man' in the Tarot deck, the wordgame of 'hangman', and as synonym and metaphor for suicide, despair, justice, retribution, and injustice, etc. The history, cultural context and meanings of hanging as capital punishment and public spectacle in Britain until 1868 provide a compelling, disturbing, and particularly apposite vantage point on the cultural context and symbolic history of hanging in Australia, where convicts and colonisation, capital punishment and frontier lynchings, generated their own national historical consciousness and symbolic associations and representations (Gatrell, 1996; Hughes, 1987). It is also not generally appreciated that hanging was routinely used as a form of capital punishment in Queensland, and that Aboriginal individuals were dramatically overrepresented in hanging deaths for particular crimes. Between 1859 and 1900, for example, a total of 16 men were hanged for rape in Queensland (Genever, 1996; Harris, 1982). Of these individuals, one was a European, three were Pacific Islanders and 12 were Aboriginals. Prevailing European sentiments of the time were particularly noteworthy in the context of hanging as deterrent and moral cautionary tale, and as an exemplar of symbolic racism. Thus, the telling comments of a Queensland legislator: "... for the Aborigines, I believe, hanging is the only thing that brings home to them the terror of the law" (Bramston to Legislative Assembly, during discussion on the crime of rape, QPD, 1865, in, Genever,1996, p. 394).

It is also possible that hanging in Aboriginal communities in Queensland has other symbolic meanings which have selectively diffused from other Pacific Island peoples and China over the past 200 years. Far North Queensland was home to many thousands of Pacific Island peoples and Chinese in the 1800s and early 1900s, and the current Pacific, Torres Strait, Papua New Guinea, and Maori population of Queensland is substantial. In each of these cultural contexts suicide by hanging had distinctive cultural roots and meanings. In Papua New Guinea, for example, suicide by hanging and a 'hanging tree' form part of certain groups' principal cosmological myth, providing a cultural path and option (Poole, 1985). In New Zealand, Maori suicide deaths by hanging have become a very salient social problem and concern, and an equally powerful cultural statement, as was poignantly communicated in the book and film *Once Were Warriors*. Indeed suicide and in particular hanging suicide by young men has reached epidemic proportions in a number of Pacific Island nations over the past twenty five years and it would be difficult to credit that this phenomenon has not had impacts in Indigenous communities in Australia, where many Pacific Islanders reside.

(3) An important consideration with respect to suicides in small rural communities, and in particular hanging suicides, is that of 'place meaning'. There is considerable research evidence and professional consensus that places and features acquire very powerful and determining meanings and associations deriving from important events, use and familiarity over time, individual and community emotional investment, cultural mythologies and narratives, etc. (Altman & Low, 1992; Chawla, 1994; Groat, 1995; Hirsch & O'Hanlon, 1995; Massey, 1994; Seamon & Mugerauer, 1985).

Places where an individual has committed suicide take on particularly strong meanings and associations, and can be a powerful reminder and trigger of the event for years afterwards. It must also be remembered that the places being discussed are small communities where particular places take on very powerful local meanings and associations. Houses, trees and other 'places' where known individuals and often relatives have taken their own lives are constant reminders of loss, pain and a bleak but beckoning option. Such 'place meaning' has been an underrecognised but very determining component of self construction and orientation, as well as experienced quality of life (e.g., Korpela, 1995; Proshansky et al., 1995). Hanging suicides are particularly tied to places in that the method subtly implicates the place and setting by providing the means, by way of a tree, or water tower, or watchhouse, or house beam. Such places can seemingly invite or 'beckon' an individual who is thinking about or preoccupied by intrusive thoughts of self-injury and suicide. The suggestive and invitation character of such places is intuitively recognised in many communities, and 'hanging trees' are cut down, and particular places avoided or physically modified where possible (e.g., Graham, 1989; Scott, 1996; Scott-Clark & Levy, 1998).

The reality of many rural, isolated, small communities is that such places often remain as salient and stark reminders of suicide and death. Again, it is noteworthy that hanging suicide is of particular symbolic currency here, and often takes place in one's home or residence. In this case, the house itself takes on particularly devastating and powerful symbolic connotations (e.g., Marcus, 1997). In Aboriginal communities, these reminders of dramatic death and human anguish are part of the furniture of the place, whether it be a watchhouse cell, an abandoned house, water tank, tree, or desolate strip of beach (e.g., Graham, 1989). Places cannot be easily whitewashed, cut down, or bulldozed out of memory. They enjoin a particular attentional captivity which can be both very positive and very oppressive. Places are like families—familiar, formative, script-ridden, and—at times—frightening. In Aboriginal communities "every story has a place, and virtually every place is a story" (Rose, 1993, p. 3).

(4) Following from both 2 and 3, but nonetheless distinctive, is the stereotypic character of Aboriginal hanging death. This stereotyping was and is very prevalent in North America where the stereotype is 'the drunken Indian', or 'the suicidal Indian', and there is a widespread belief and expectation that Indian people are particularly prone to helplessness, hopelessness, and suicide (e.g., Levy, 1992). It is clear, disturbingly so, that this is becoming a prevalent stereotype in Australia, and it is equally apparent that it is a belief that is being internalised by many Aboriginal people. This stereotypic quality is often captured and conveyed in art forms as well as popular culture beliefs. In Bradbury's documentary film, 'State of Shock', for example, the character in the play threatens to shoot himself and slash his wrists and Alwyn Peter speaks of "feeling like stringing myself up". Art imitates life imitates art. Recent and past media coverage has dramatically strengthened and consolidated this stereotype (e.g., Robson, 1987; Scott, 1996; Scott-Clark & Levy, 1998). Langton (1993) writes of this powerful, iconic image that is part cultural imagination and part racist stereotype of the 'other'.

(5) The fact that suicide is the only method available for many Aboriginal attempters in custody has artefactually increased the relative frequency of death by hanging. It is not widely known that half of all deaths in custody, worldwide, are by suicide. Almost all of these deaths are by hanging. If one also considers the disproportionate numbers of Aboriginal people in custody in Australia, it is easy to see that hanging deaths will be disproportionately high among Aboriginal individuals. This higher frequency, and the salience, suspicions, poignancy and symbolic impact of a hanging death by a young Aboriginal in custody (e.g., Reser, 1981a; White et al., 1977) all collectively ensure that Aboriginal deaths by hanging constitute a pervasive image, event, social representation, and suggestive model.

The relative availability of hanging as a method in non-custodial circumstances should not be discounted. It is often the case that a young person would have no access to a gun or a vehicle, or that there would be no cartridges for the gun, or petrol for the vehicle. What is always around is rope and trees, or other hanging points. Rope, in Aboriginal communities, may have come to have the same symbolic cue value that guns have in North American culture (Berkowitz, 1993; Anderson et al., 1996).

(6) It is difficult, but necessary, to separate Aboriginal suicide by hanging from 'Black Deaths in Custody' and the Royal Commission. At a popular culture and symbolic level, however, these phenomena are inter-related at multiple levels and reflect a shared and often traumatic experience which transcends generations and analytic catchments. It is important to appreciate, however, that the media coverage, film treatment, and artistic expression has focused principally on suicide deaths in custody. This has strongly emphasised associated meanings relating to injustice, defiance and martyrdom. The reality in Queensland is that a substantial proportion of suicide deaths in 1986 and 1987 were in custody, particularly in police watchhouse cells, notwithstanding many non-custody suicide deaths and countless attempts. These 'custody' deaths constituted all of the initial suicide cluster covering the period (e.g., Biles & McDonald, 1992).

It is noteworthy that twenty-two hangings occurred in policy custody in Australia in the calendar year 1987 as compared with one such death in 1997; six of the seven 1987 deaths which occurred in Queensland watchhouses were Aboriginal men (Dalton, 1998; Reser, 1989b). The year 1986-1987 also evidenced the highest ever number of Aboriginal deaths in custody from all causes (eighteen), with 1997-1998 being the next highest at sixteen deaths. The average annual number of Aboriginal deaths in custody over the past eighteen years is eleven (Dalton, 1998; Cuneen, 1998). What is remarkable about these figures with respect to hanging deaths in police custody is that numbers have gone from twenty-two hanging deaths in 1987 to one such death in 1997, at the same time that Aboriginal deaths in custody from all causes are almost at 1987 levels. This says something about the dramatic contrast in the number of Aboriginal suicide deaths by hanging in police custody in 1987 and 1997, and suggests that suicide deaths by hanging are now presenting as an Aboriginal community phenomenon, issue, and concern.

The symbolic context of the watchhouse in Aboriginal communities takes on a spectrum of different meanings and considerations (Reser, 1992). The fact that others had taken their own life in the same facility or cell is a matter of considerable concern and fear. Being locked up at night in a structure which cannot be sealed off from outside forces also dramatically increases anxiety and fear—from malevolent spirits, 'travelling men' (sorcerers), or spirits of the deceased. The phenomenon of a 'sensed presence' in the watchhouse is often very strong in Aboriginal community circumstances (e.g., Suedfeld & Mocellin, 1987). Of particular symbolic importance is the fact that such custodial settings can elicit powerful feelings of 'reactance', a strong urge to arrest a threatened loss of freedom (e.g., Brehm & Brehm, 1981; Reser, 1989c), particularly if quite obvious suicide-proofing has occurred, or the pointed removal of potential hanging instruments such as socks, belts, clothing, sheets (Reser, 1992). This 'reactance' is a particularly strong and salient feeling for Aboriginal detainees, as there is a perception that they are being denied control over their own bodies (e.g., Martin, 1987) in a context of self-fulfilling expectations about suicide. The circumstances of 'being locked up' in many small towns and communities also means being alone in a frightening place, while emotionally distressed, possibly ill, and probably intoxicated (Hunter, 1988b). All of these factors can dramatically heighten the suggestive, stress-inducing properties of the physical environment, in most instances an uncomfortable, oppressive and frightening cell (Reser, 1992).

In Yarrabah there were a number of circumstances that would suggest a particular set of beliefs and attributions were contributing to anxieties, sense making and suggestion. During 1987 and 1988 there was considerable discussion among young men at Yarrabah of 'ghosts' seen and heard

around the watchhouse where three men had hung themselves. There was also repeated reference to these ‘spirits’, and the ghosts of non-custody suicides, ‘calling out’ to young men to take their lives in this way and join them. This was in a larger cultural and community context of external attributions for violent deaths in terms of alcohol, sorcery, and contact history. The external attribution context, and accompanying metaphoric and popular culture understanding of hanging deaths in custody as system oppression and ‘murder’, also fit this larger sense making. These concerns about the spirits of the deceased and other malevolent ‘forces’ at the watchhouse at Yarrabah, and the specific reference to these concerns in the Powder-Law Report, led to the watchhouse being exorcised in 1989 and eventually replaced with a new watchhouse on a different site in 1990.

An examination of the local narratives at Yarrabah and Palm Island relating to ghosts and ‘the hairy man’, the repeated refrain of previous suicides calling out and urging suicide, the stated desire and inevitability of joining friends and relatives who had suicided—all suggest a certain felt compulsion and perceived absence of volitional control over the act of self-injury in instances of self-injury and hanging. This experienced absence of control appears to have been heightened by a state of intoxication, which itself is constructed and scripted in these northern communities as including one’s own behaviour being controlled by the alcohol, the actions of others, and intense feelings, including feeling suicidal (Reser, 1990b, 1991). Notably, alcohol involvement is almost invariably present in hanging suicide attempts by young men, and was implicated in all of the watchhouse deaths in these communities, deaths which took place within one or two hours of being locked up and while the individual was still intoxicated (Reser, 1989b). It should be noted that young people in contemporary remote Aboriginal communities are still very influenced by traditional beliefs. It is often a case of contemporary anxieties, but traditional labels, in a situation where there is much uncertainty about the nature and status of traditional entities and forces in a quickly changing bicultural world. The ubiquity of violent death and loss, and the attendant need for adequate explanatory accounts, also drives community-based, culturally congruent narrative accounts and constructions.

The symbolic importance of the hanging deaths ‘in custody’ also derives from larger metaphors and cultural frames for understanding ‘jailhouse hangings’. There is always a suggestion of ‘foul play’, police complicity, and injustice at the hands of the justice system in such attributions and sense making (e.g., Reser, 1989; White et al., 1977; Wilson, 1985). The very expression also suggests that the environment itself somehow caused the death. By extension, the Aboriginal collective experience of two hundred years of incarceration, capital punishment, and outback murders (e.g., Graham, 1989) makes all hanging deaths ‘custody’ deaths in that they relate to a bloody history of incarceration, institutionalisation, and eroded freedoms, and reflect relentless and oppressive circumstance rather than individual volition. This is a powerful symbolic matrix for young men whose own lives, and that of their fathers, brothers, uncles and friends are caught up in the justice system, and facilitates an easy identification with, as well as privileges, a particular kind of sense making.

(7) A characteristic of small communities is that particular and dramatic events initiate collective sense-making and ‘causal’ explanations. Suicides are particularly dramatic and distressing events which require explanation, accountability, and closure (Abraham, 1988; Anderson et al., 1996; Antaki, 1981; 1988). Explanations and sense-making are often of a narrative nature and are culturally informed with respect to content and causal attribution (e.g., Bohannan, 1960; Howard, 1981; Rubinstein, 1983). In Aboriginal communities, such ‘explanations’ are typically ‘external’, i.e., they make reference to external causes. Hence even a phenomenon such a suicide is not necessarily viewed as deliberate self-harm, but being the product of external factors over which one might have had no control. Hanging suicide is particularly sympathetic, ironically, to such external attributions in an Aboriginal context, as such

a death can be ‘reasonably’ attributed to others or other powers. In a custody context, it can be easily seen as ‘murder’, either figuratively or actually (Reser, 1989a).

In one community where many suicides have taken place, for example, attempters talk of hearing voices of friends who have suicided, inviting them to do the same, or seeing a human-like form which holds out a noose, beckoning the viewer to hang him or herself. In communities with a strong mission past, such narratives can involve a satanic presence that suggests and invites young people to suicide, and/or the notion that deceased relatives and friends have gone to a better place where presumably those left behind can join them. Such community and cultural narratives can provide a very useful window on how communities are making sense out of these events, but they also underscore the potentially lethal character of some explanations and accounts, and the highly symbolic and charged character of particular elements of the narrative, such as the noose, the aggrieved relation or friend, and evil forces. The role of the media in sensationalising and unintentionally validating such local sense making and narrative accounts is particularly powerful:

> The Hairy Man comes, unannounced, in the dead of night. He is a black, sinewy figure who stands before his sleeping victims like an ancestral hunter. One hand holds the spear by his side; the other holds a rope. There is a possum pelt around his waist and his eyes burn like the embers of a camp fire. Wordlessly, he hands over the rope... [Peter Gray] had experienced the dream many times. Always, he awoke from it sweating and terrified, not knowing where he was, fighting hard to control the compulsion to injure himself, sometimes, unsuccessfully.
>
> He was found at dawn, hanging from his mother’s gum tree; his friends cut him down, but [Peter], who had celebrated his 21st birthday the month before, was dead.
>
> Later, in the playground at St Michael’s Catholic school, where [Peter] and [Craig] had once shared a desk, the children were talking about [Peter] and playing the hanging game. As they grabbed the chains of the climbing frame and put them over each other’s heads, they said: “The Hairy Man’s coming, take the rope, put it on your head and then you’re dead.” (Scott-Clark & Levy, 1998, p. 16 [names changed from original])

The above *Sunday Times* article was copied and recopied and circulated widely in the Townsville, Palm Island, Cairns, and Yarrabah Aboriginal communities. Such is our contemporary global village.

(8) Hanging as a method of suicide involves a very different sequence of steps and possibly psychological states to bring this form of deliberate self-harm to conclusion. A number of preparations have to take place, with these becoming increasingly more elaborate in the absence of convenient hanging points or hanging material, such as a rope or cord or fabric. The investigations of the Royal Commission into Aboriginal Deaths in Custody provides a compelling argument for the high motivation and intentionality required in some instances for an individual to achieve success using this method in custody (e.g., Fleming et al., 1992). It is also a method which allows for a number of interpersonal and culturally scripted dynamics to take place between statement of intent or threat and ultimate act. There is a stage character to some suicide threats and acts in Aboriginal communities in North Queensland which includes the public, dramatic, performance quality of the event, its unfolding sequence over time which allows for the involvement and intervention of others, its escalating intensity of emotion and anger as the threat does not elicit desired or required responses from others, etc. Indeed the institutionalised character and everyday commonness of suicide threat in Aboriginal communities, and the repeated but ‘empty gesture’ character of such threats for particular individuals, conspire, along with alcohol use, to escalate a drunken conflict to the point where dramatic action is required to achieve a meaningful social response. There is often a developmental history for many individuals where the only way they, as a child, could stop or intervene in a domestic violence situation was to injure themselves, often with an axe or a knife. If individuals have not engaged in such behaviour themselves, they will very likely have witnessed such an event.

Another important aspect of this deliberate self-harm by hanging sequence is that drinking and 'getting drunk' is also a culturally scripted phenomenon in Aboriginal communities (Brady, 1992; Collman, 1988; O'Connor, 1989; Sanson, 1980), as in all cultures (Douglas, 1987; MacAndrew & Edgerton, 1969; Marshall, 1982), but in North Queensland Aboriginal communities this script includes elements such as experienced injustice and interpersonal rebuffs, anger, considerable expressed emotion, and feeling suicidal (Reser, 1990b, 1991). Finally, the character of remote Aboriginal communities is such that all of the elements of this tragic sequence are ever-present as stage, setting, props and cast, with the precipitating events playing out in the canteen, at someone's home, on the beach or in the riverbed, etc. These scripts and place meaning associations substantially reinforce the strong symbolic nature of hanging, as that which often happens when drunk, angry, upset, out of control, and 'at the end of one's rope'. The actual hanging epitomizes and dramatically communicates the sense of injustice and anger one is feeling in a situation of nonreciprocity or 'intolerable' treatment by a close relation. It is a violent act which becomes increasingly likely as highly charged arguments between close relations quickly escalate past the point of drunken comportment and threatened self-harm into actual and dramatic interpersonal violence or self-harm. Symbolic body language and self injury in indigenous communities carries a heightened meaning and significance relating to own emotional state, expressed and shared emotion, and the fact that actual body regions signify particular kinship relations and obligations, i.e., the body itself and the positioning of the body is a rich and inscribed communication medium (e.g., Gill, 1989; Lingis, 1984; Grosz, 1994).

What is also clear is that emotional expression, communication, and coping can have a very different dynamic and meaning context in northern Aboriginal communities (e.g., Martin, 1993; Myers, 1986; Reser, 1990b; 1991), with it being quite normative and expected that an individual would spontaneously express rather than attempt to control strong feelings and emotions in a charged interpersonal or group situation. Traditional cultural norms would ensure that others would help a distressed individual cope with how he or she was feeling. Such dramatic emotional expression and collective coping is, of course, very different from western norms of individual emotional coping and control (e.g., Kitayama & Marcus, 1994). It is particularly common for individuals to dramatically express and communicate their feelings when upset and intoxicated, and such emotional expression can escalate into violent conflicts and confrontations, particularly when expected emotional and social support is not available, or when a perceived slight or injustice, or an instance of shaming has occurred. Self-injury and attempted hanging is a common response to interpersonal conflict with close relations which 'allows for' a very dramatic statement in a context of already high expressed emotion, and, ideally, intervention. Tragically many young individuals in these communities do not have close connections in a cultural context where this is prerequisite to emotional equilibrium and well being, hence there is often little effective collective coping with individual distress, and attempted suicide by hanging is a particularly lethal method that at a certain point precludes intervention or change of mind.

(9) There is a strong connection between hanging as a method and the cluster character of many suicide deaths in Aboriginal communities in North Queensland which follows from the foregoing argument. Hanging suicide presents a dramatic modelling sequence which is typically fixated in one's memory. Many Aboriginal individuals in North Queensland have been eyewitnesses to a hanging incident, often when young. They have also seen and experienced the impact that such deaths have on a community, and know first hand its confronting power, shock value, and efficacy. The very fact that a hanging death often results in a person's body being suspended, on display, in public view, for a period of time exaggerates this observational learning, modelling character. What particularly characterises cluster suicide is its imitative, copy-cat quality, as well as contiguity in space and time (Reser, 1989b). That the clear majority of Aboriginal suicide deaths over the past 15 years in Queensland have been by hanging, almost

always by young, intoxicated men, tells us that there is an imitative, patterned phenomenon taking place. The clustering of these events over periods of 6 to 18 months in spates of similar and often identical circumstances strongly suggests that a hanging death is a particularly potent catalyst, in this cultural context, for subsequent, imitative suicide attempts by individuals of the same gender and similar age. The predominance of hanging suicide as an almost exclusive and strongly symbolic method used by young men and associated with cluster patterning has strong parallels in other indigenous culture contexts in the Pacific (particularly Micronesia, Fiji, and French Polynesia (Booth, 1995; Hezel, 1987, 1987; Hezel et al., 1985) and North America (Levy, 1972; Duclos & Manson, 1994; May & Van Winkle, 1994). It is also worth noting that other scripted, highly symbolic, methods of suicide exist in Aboriginal communities which have parallels with hanging suicide (e.g., d'Abbs, 1994; Reser, 1991). These include the dramatic shooting of oneself in the head on the sports field or oval of a community, typically when the community, as audience, is present for another event. This particular method, however, has not yet been associated with identified clusters, though multiple cases have occurred in the same and interconnected communities. In one north Queensland community a series of self shootings occurred in the mid 1990s, taking place in the public arena of the canteen.

The symbolic analysis provided has strong links with the processes of imitation and modelling which partly mediate suicide clusters. Symbolic thinking, associations and identifications with other are very important components of social learning (Bandura, 1977, 1986) and identification with the victim has been found to be a key factor in the susceptibility of adolescents to media coverage of suicide (e.g., Davidson et al., 1989; Hawton, 1986; Phillips & Carstensen, 1986; Strasburger, 1995). The evidence for the suggestive influence of media in youth suicide is now strong, consistent and noncontroversial (e.g., Gould et al., 1988a; Phillips & Carstensen, 1986; Phillips et al., 1989; Strasburger, 1995). The information dissemination and media impact reality in many remote Aboriginal communities, however, is that much communication and exchange is first-hand and social, and about people and in particular known others (e.g., Reser, 1979; White, 1977). The news of a suicide death in a southern capital city of a community member from North Queensland can have more dramatic community and symbolic impact than a hanging death near the water tower, because it is mediated and amplified through powerful social media as well as electronic media. It is arguable that young Aboriginal people are also much more susceptible to imitation, identification and modelling in the context of Aboriginal or Native American films, where identification is strong and suicide, substance abuse, and death are repeated themes, e.g., 'Thunderheart' (Michaels, 1987). The political content and message of these films is also very salient and symbolic (e.g., Brown, 1987; Cowlishaw, 1993; Vasta & Castles, 1996). As well, the repeated viewing of often violent videos by young people in these communities, while drinking, is a common and ubiquitous part of everyday life (e.g., Reser, 1989b; Tatz, 1994).

If one examines the circumstances of a particular North Queensland community, for example, it is clear that the salience and symbolic character of hanging has played a particularly important role. This community has seen at least twenty-six suicide deaths since the mid 1970s, with the majority these deaths taking place within a five and one-half year period. Ninety percent of these deaths overall (18) were by hanging and eighty-five percent (17) were young men. A number of other aspects of these deaths are worth noting. These include the ubiquitous role of alcohol, the fact that all of these hanging deaths were in or very close to the house of the victim, the close connection of these individuals to others who had suicided, etc. Indeed, two of the individuals who hanged themselves in the Yarrabah watchhouse in 1986 and 1987 had brothers who had taken their own lives in noncustody circumstances. One individual had two brothers who attempted within months of the watchhouse suicide and both of whom subsequently suicided in noncustody circumstances, with one of these deaths taking place on Palm Island. Two of the watchhouse suicides were next door neighbors in Yarrabah. All of these factors suggest that hanging was a particularly salient, powerful, modelled option for these young men.

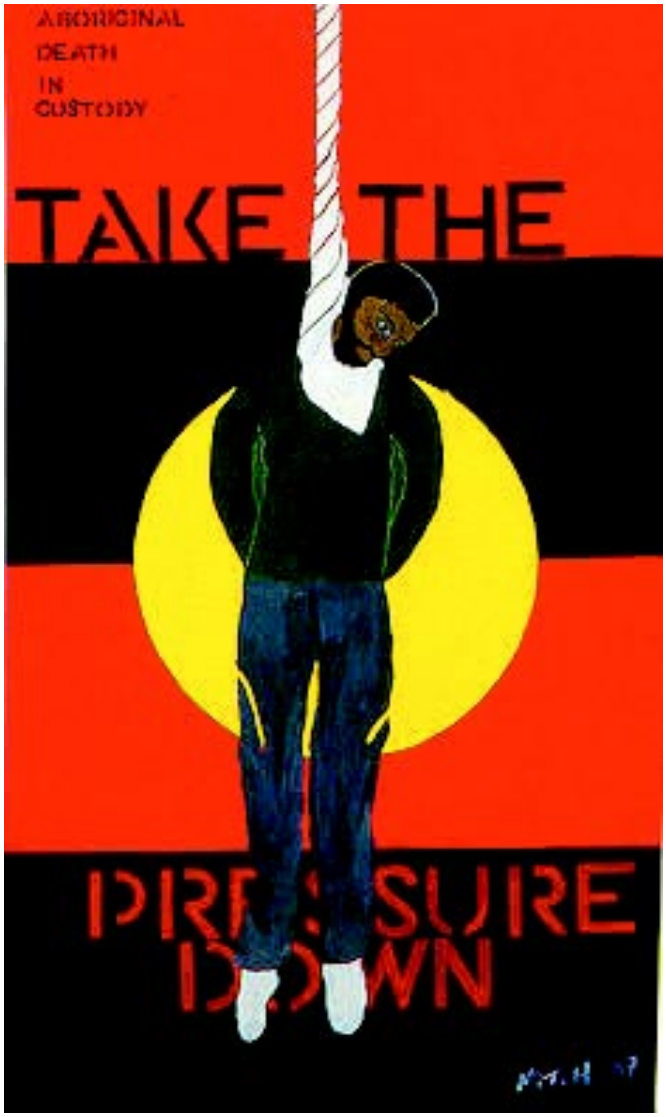
The death of Paul Pryor on 11 January 1988 in Melbourne, documented in the *Weekend Australian* (Rintoul, 1988), provides a compelling case study of non-obvious connections, communications and contexts. Paul grew up in Townsville and Yarrabah, the seventh of eleven children. His father was a deacon in the Catholic Church in Townsville. While he ran away from school at the age of twelve, his clear talent and motivation led him to win admission to the Victoria College of the Arts. He played acting roles in a number of television productions, including Women of the Sun, Sword of Honour, and Cyclone Tracey, as well as a Keneally play which was being run in the United States. He was, in the eyes of young people in Townsville and Yarrabah, a success, a role model, a mate who had made it. The sequence of events leading up to the suicide included being held and allegedly humiliated and beaten in the Yarrabah police station in July 1986, being arrested in Melbourne in July 1987, and being arrested in January 1988 in Melbourne on charges of motor vehicle theft. His family and friends indicated that it was in fear of being sent back to Yarrabah because of unpaid fines and a breach of a community service order that led to his death by hanging at his brother's house in Melbourne. His death, however, was not considered a 'death in custody'.

It should be noted that Paul was arrested and locked up in Yarrabah within six months of the initial two hanging deaths in custody there, on 4th and 18th December 1986, and another hanging took place on 19th February 1987, followed by a hanging death in Stuart Creek Prison in Townsville on 8th November 1987. This was a period when self-injury and suicide was escalating dramatically in Aboriginal communities in North Queensland. 'Black deaths in custody' was also becoming a media preoccupation, and the triggering events and deaths were taking place in Yarrabah and Townsville. Both of these communities had a long history of association with suicide and self injury on Palm Island and at Stuart Creek. If one were to consider Paul as a Yarrabah person, and certainly his extended family and friends did, then his death was the fourth custody-related death in Yarrabah in a period of twenty-two months, and the sixth suicide 'in the community'. It was also the case that Paul had an older brother who had suicided several years earlier outside of custody in Townsville. The fact that two suicide deaths also took place on Palm Island in 1988 must also be factored in. In brief, Paul Pryor was a well-known local celebrity, successful actor and musician, whose own life was shadowed by the multiple deaths of those around him and his own traumatic confrontations with the legal system and the paradoxes of being a 'successful' and highly visible Aboriginal. His hanging death was both a product and a causal link in the chain of Aboriginal suicide deaths taking place in and out of custody in the late 1980s.

Examples of symbolic representations

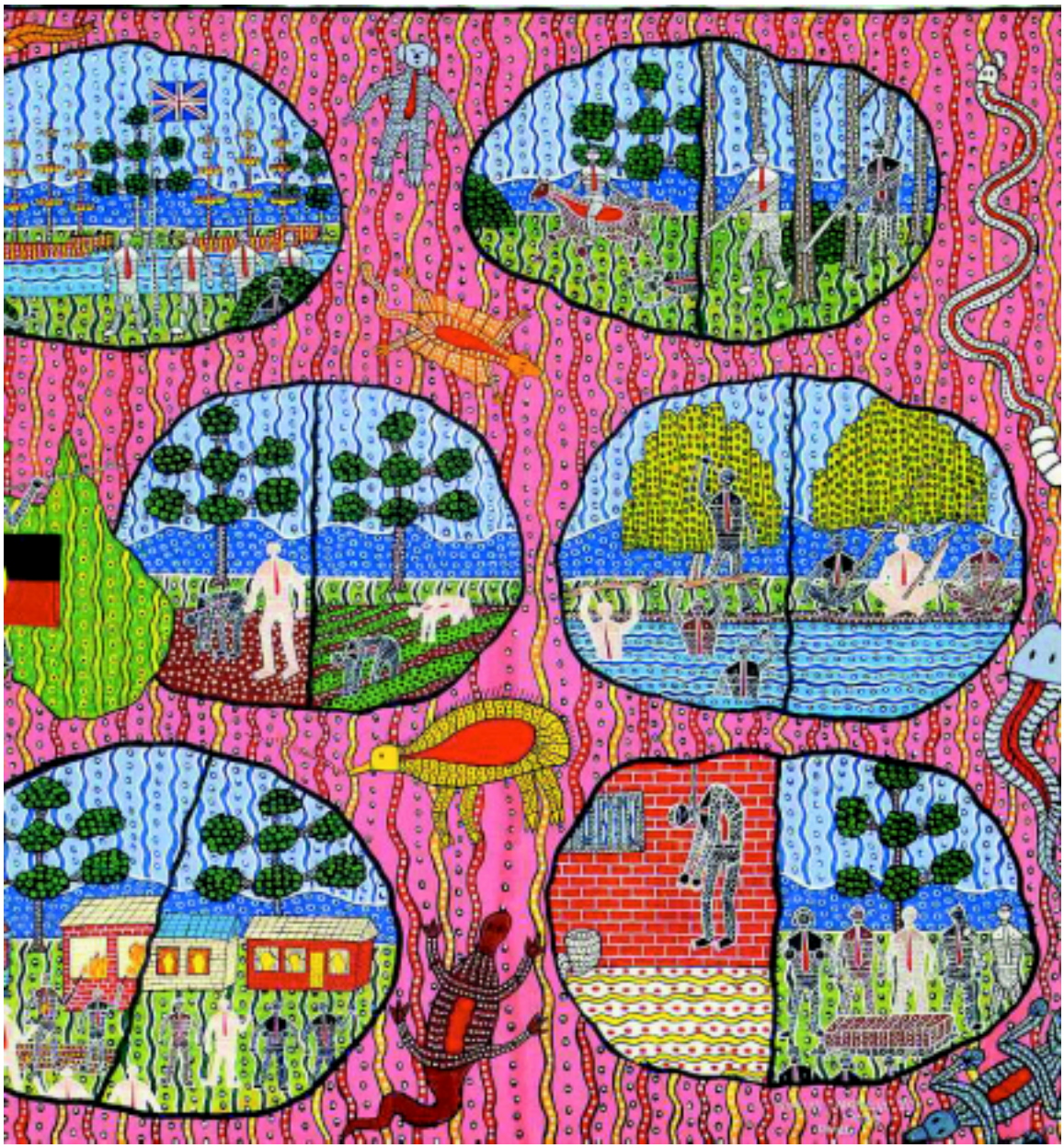
Example 1 is a painting done by a young Aboriginal inmate of Adelaide Gaol, Mitch Dunnet, in 1987, entitled 'Take the Pressure Down' (Sutton, 1988). The painting, with the Aboriginal Embassy flag as backdrop, distilled the powerful sentiments felt by Indigenous Australians during the lead-up to the Royal Commission into Aboriginal Deaths in Custody, which was established in 1987. The death is by hanging, the rope is a sheet, the socks are the same colour and frequently used in cell deaths. This presentation of suicide death gives it a martyr-like quality, as well as equating hanging death with individual and system injustice. This was a powerful image, it was made into a poster which was widely distributed, and the painting appeared in Peter Sutton's (1988) book *Dreamings* in the following year, a publication with wide circulation in Aboriginal as well as non- Aboriginal communities. The painting, according to Sutton, suggested the saliency and poignancy of tragic loss of life in the Aboriginal community.

Example 1

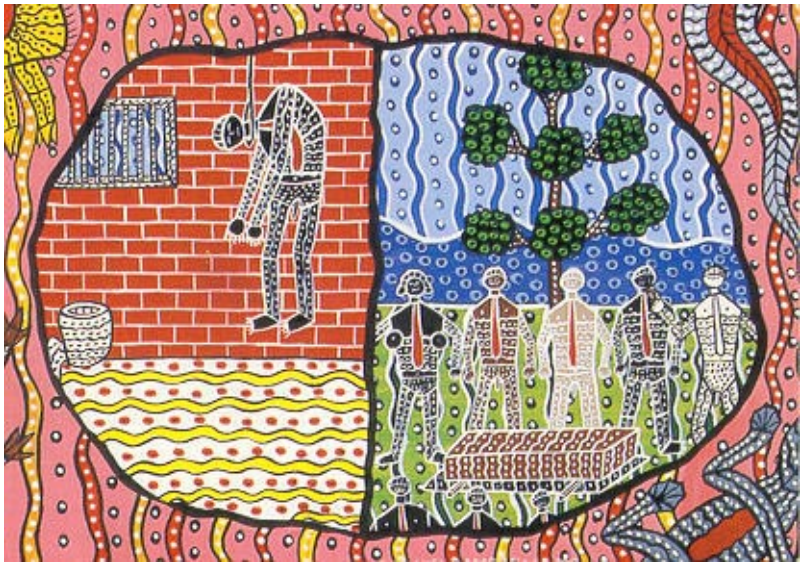


Example 2 on the following page is a panel from a larger painting by Robert Campbell junior done in 1988, entitled ‘Aboriginal History (Facts)’. The painting is a part of the permanent collection of the National Gallery and has been reproduced in many contexts, forming the cover illustration for a special edition of *Art Monthly* in 1990, and again for a special edition of the *Journal of Australian Studies* in 1992 (Attwood & Arnold, 1992). The painting depicts hanging as a slice of life, as an integral part of the history of contact, and as the culminating final panel (this page). Again the statement is political as well as symbolic, muted but violent. The Aboriginal flag is now centrepiece rather than canvas. There are lines, waterways, cell bars and, possibly, cords forming the larger backdrop and within each panel. All of the figures are wearing red neckties, suggesting the polite face of institutional racism and quiet desperation, and making a not so oblique reference to hanging. The trees and totemic species are all silent witnesses to the increasing violence, with the cracked panels providing Aboriginal windows on the real causes of Aboriginal deaths in custody. It is worth noting that similar hanging deaths in custody scenes have appeared in other works by Campbell, e.g., “Death in Custody” (1987) and ‘’Why Weren’t They Charged with Perjury?’ (1989). Campbell notes that “my paintings are very much what I feel in my own heart. Very personal” (Campbell, 1990, p. 88).

Example 2a

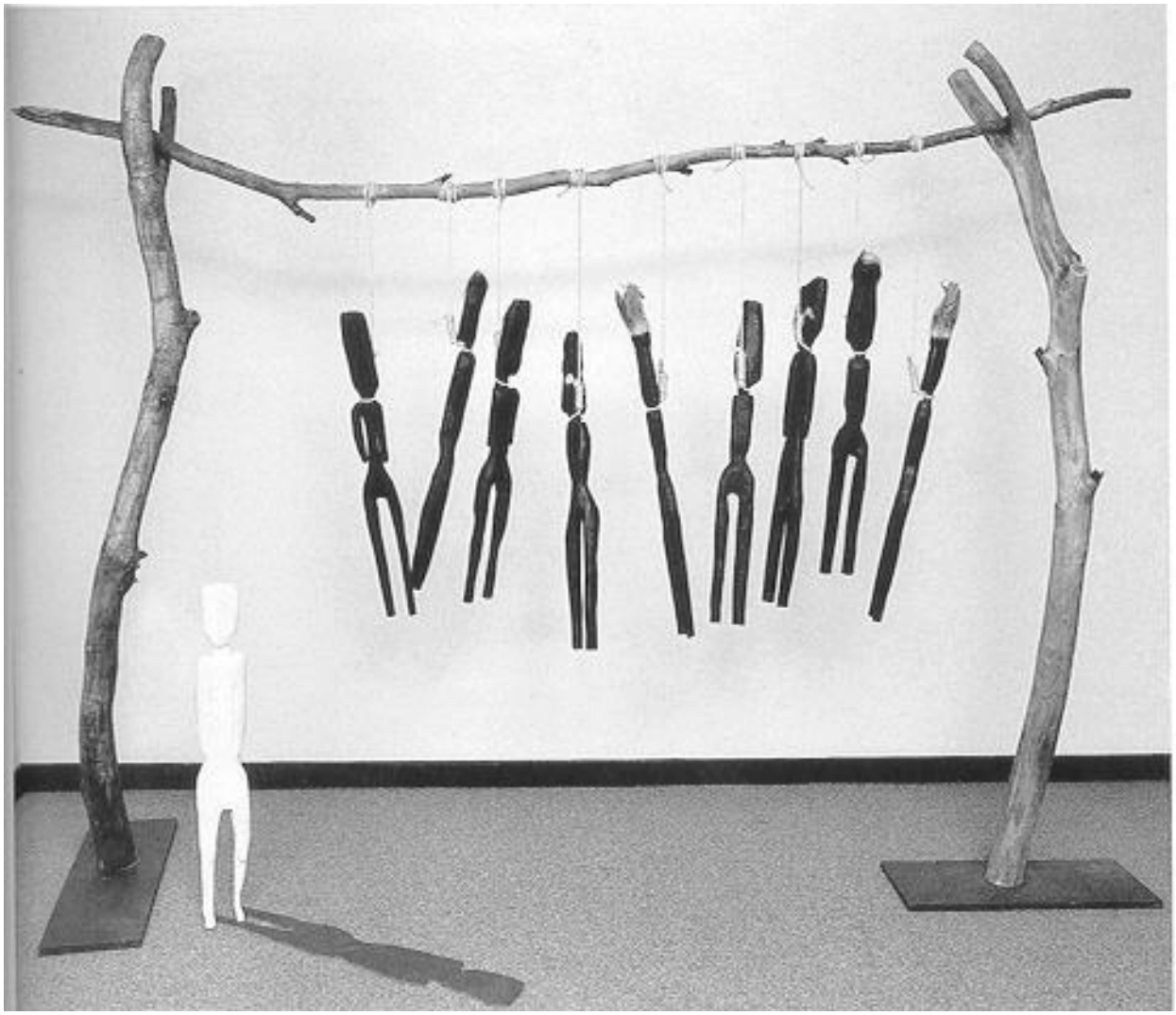


Example 2b (detail)



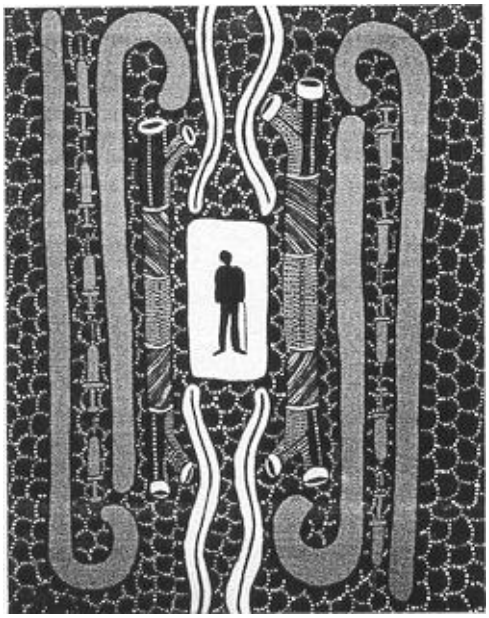
Example 3 is a sculpture, ‘Annihilation of the blacks’ by Fiona Foley which is a part of the permanent collection of the Australian National Gallery (Caruana, 1993). According to Wally Caruana, the curator of the Aboriginal collection, the sculpture “is a potent allegory of the treatment of Aboriginal people at the hands of the colonizers” (p. 188). It is worth noting the white figure standing watch over the hanging black figures, and the white shadow on the floor. It is also important to note that the upright forked posts and crosspole are a powerful symbolic vehicle in traditionally-oriented Aboriginal communities for shelter and home (Reser, 1977b). It is also a sacred complex and symbol for the first dwelling of the *Wagilak* in Arnhem Land, which is erected during the *Kunapipi* ceremony (Berndt, 1951), and within wait young Aboriginal boys waiting to be born again, as young men. These young boys are viewed metaphorically as flying foxes, hanging from the rafter, as the flying fox ancestral spirits brought circumcision to the central Arnhem Land clans and because the flying fox is a central totemic species to clans in this region. Fiona Foley often draws inspiration from traditional Aboriginal culture and life, while making powerful and contemporary political statements. All of this gives the sculpture a very strong traditional as well as contemporary symbolic quality, with multiple and intertwined meanings and messages.

Example 3



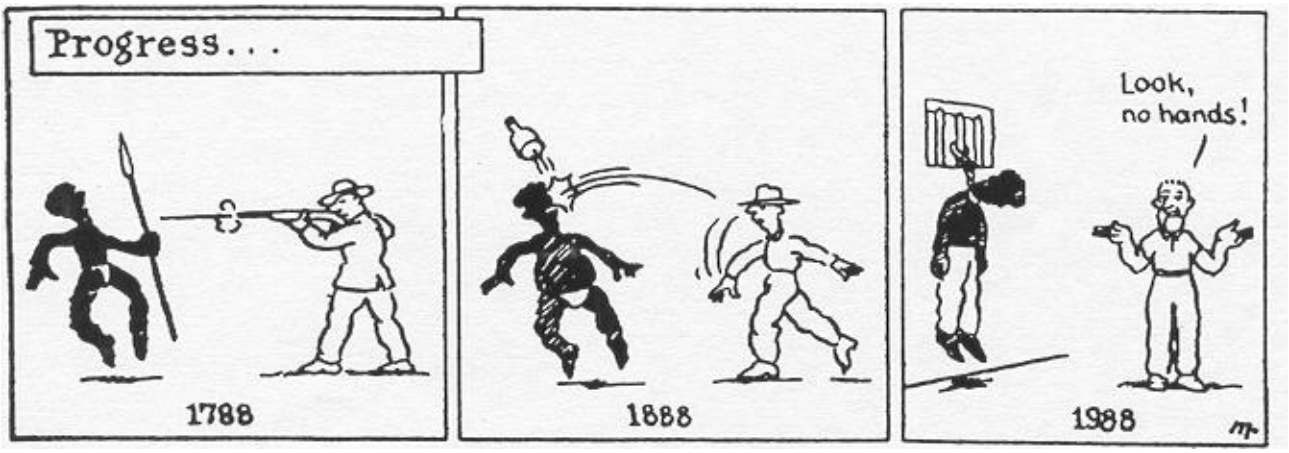
Example 4, ‘Tribute to Bobby Pepper’ (1987) is a painting by Les Griggs, an Aboriginal artist who has spent much of his life in children’s homes, youth centres, and eventually jail. The painting, like most of his work, uses images which come from and distil his immediate environment. His sister writes that “He uses images which are recognisable to anyone from his environment, which is basically 20th century living, such as bottles and cans representing alcoholism, syringes and grave stones representing drug addiction, nooses and bars representing deaths in custody, and kegs and locks representing incarceration. These are the issues and concerns of many urban Aboriginals.” (Griggs, 1990, p. 88). The painting salutes a martyr to the cause, another individual encircled and ultimately caught in this tightening noose. In such paintings it is easy to see how incarceration, alcohol, and death by hanging have become a stock symbolic complex that captures “the bitter life experience of the majority of urban Aboriginal people” (Griggs, 1990, p. 88).

Example 4



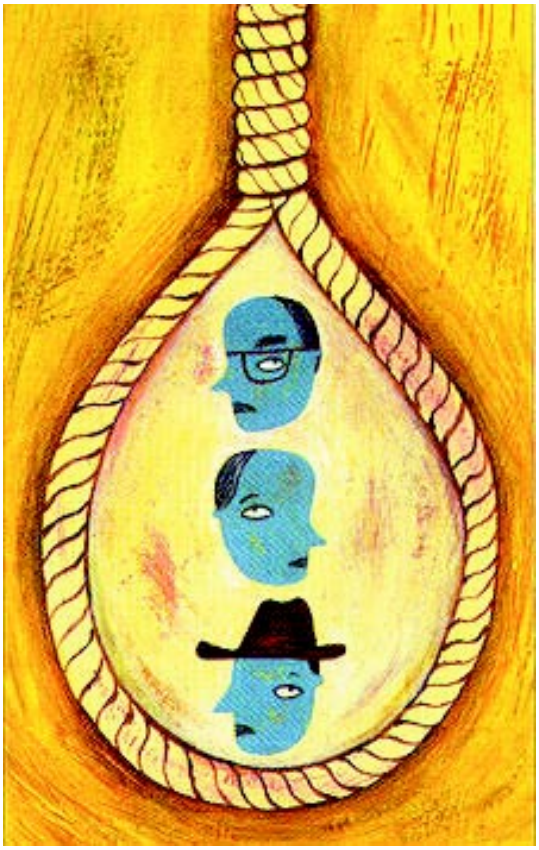
Example 5 is a cartoon entitled ‘Progress’ that appeared in the *Sydney Morning Herald* in 1987 (M. Martin/John Fairfax Group). It clearly shows the popular culture character and stereotypic character of such symbolism, and possibly a national consciousness and ‘concern’ about Aboriginal deaths in custody.

Example 5



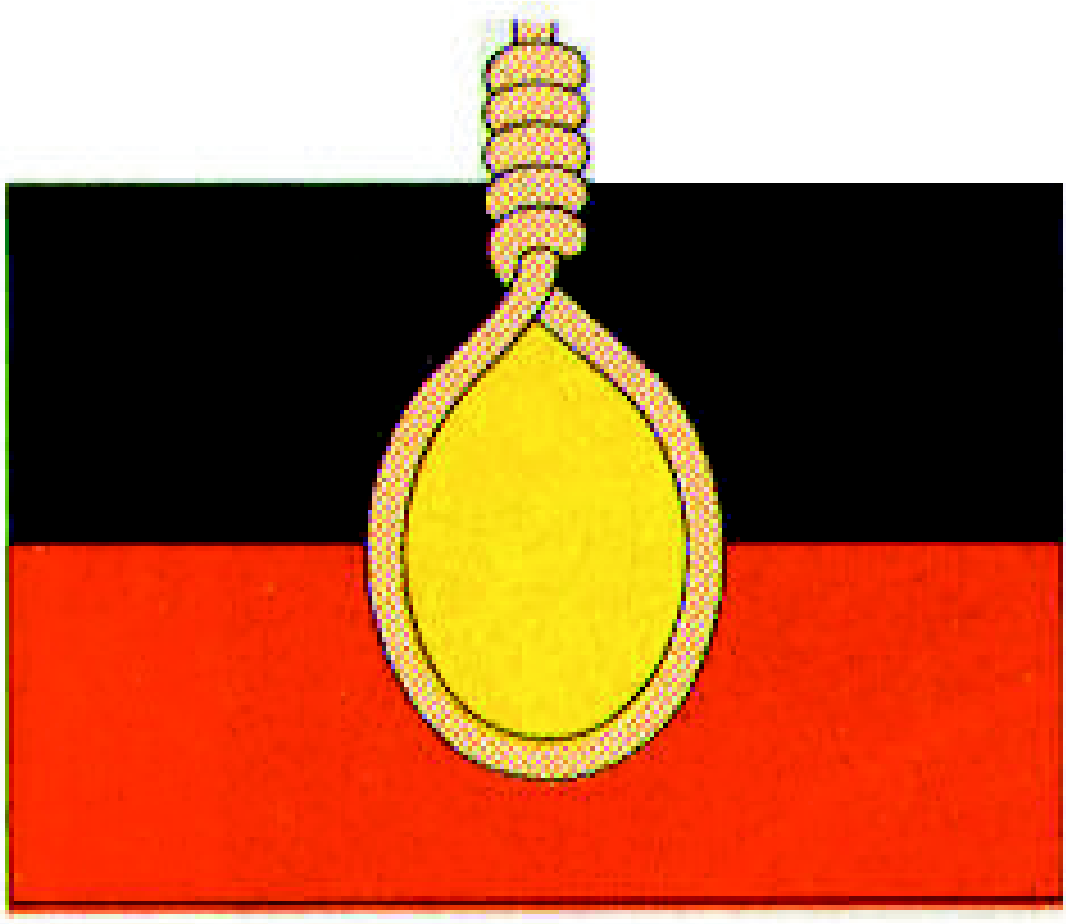
It is certainly the case that the imagery and language of hanging are ubiquitous, such as the recent political cartoon in the *Bulletin* depicted in Example 6 (Pascoe, 1998) with respect to another 'lost cause', the GST (in 1998). The difference with respect to hanging symbolism in Aboriginal popular culture and expression is that such deaths have become a very serious and everpresent leitmotif in people's lives, and the metaphoric qualities of being 'at the end of one's rope', of being 'strung out' and 'strung up', are particularly salient, provocative, and prophetic for many young Aboriginal people.

Example 6



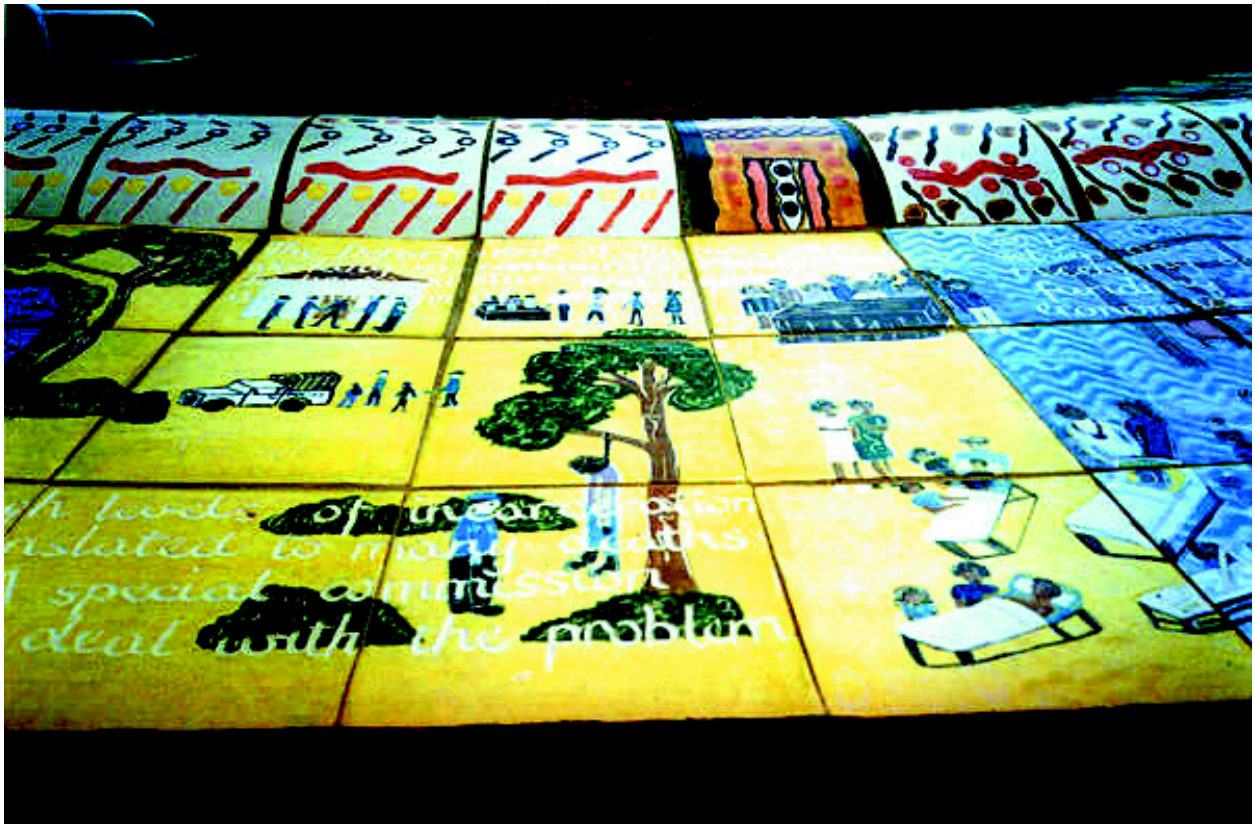
Example 7 is a logos developed by Time Australia to introduce their special features on 'Black Deaths in Custody' and the coverage of the Royal Commission into Aboriginal Deaths in Custody in the late 1980's. The first extensive coverage of this issue, which was featured on the cover of *Time* magazine, appeared in the August 24, 1987 issue (Robson, 1987) and was an eight-page feature. The feature logos is essentially the Aboriginal flag, with a noose encircling the central yellow sun motif. The symbolic messages here are interesting, and parallel the use of the flag as motif by both Mitch Dunnet and Robert Campbell. The use of the flag ensures that the message is political and ironic, representing as it does the Aboriginal nation and Indigenous Australia, in the lead up to Australia's Bicentenary. In this instance it is as though Indigenous Australia has been incarcerated and is either killing itself or the victim of institutional injustice. Again it is interesting that the noose, or death by hanging, becomes the central symbol here, connoting not just suicide but a seeming miscarriage of justice.

Example 7 (copyright 2000, Time Inc. reprinted by permission)



Example 8 is a panel from a 1998 initiative in the town of Cooktown at the base of Cape York, in the form of a ‘story wall’ (the ‘Milby Wall’) which illustrates the contact history of local Aboriginal groups. It is remarkable that death by hanging was deemed to be a critical element of the contact history of this far flung community by local Aboriginal people. The panel includes an interesting juxtaposition of a police van and a uniformed white individual who is looking at a black man hanging from a tree. The associated text clearly indicates that the context is ‘deaths in custody’: “The very high levels of incarceration in gaols translated to many deaths in custody. A special commission was set up to deal with this problem”. The overall image and suggestion, however, is as much that of a sentence as a suicide, and the hanging is clearly not in custody. There are arguably elements of resistance and martyrdom, notwithstanding a larger bicultural context and message of working together. These mixed and somewhat contradictory images convey the message that that all suicide deaths are, in a way, custody deaths, the product of an ‘injustice system’. The text again underscores this message: “The Department of Justice is working in communities and towns to bring justice and fairness to all aboriginal people”. Unlike other images of hanging which briefly elicit attention and concern on the cover of a magazine, in the newspaper, or on an exhibition wall, this ceramic tile commemorative and cultural heritage interpretive display will probably be on view for well into the first century of the next millennium.

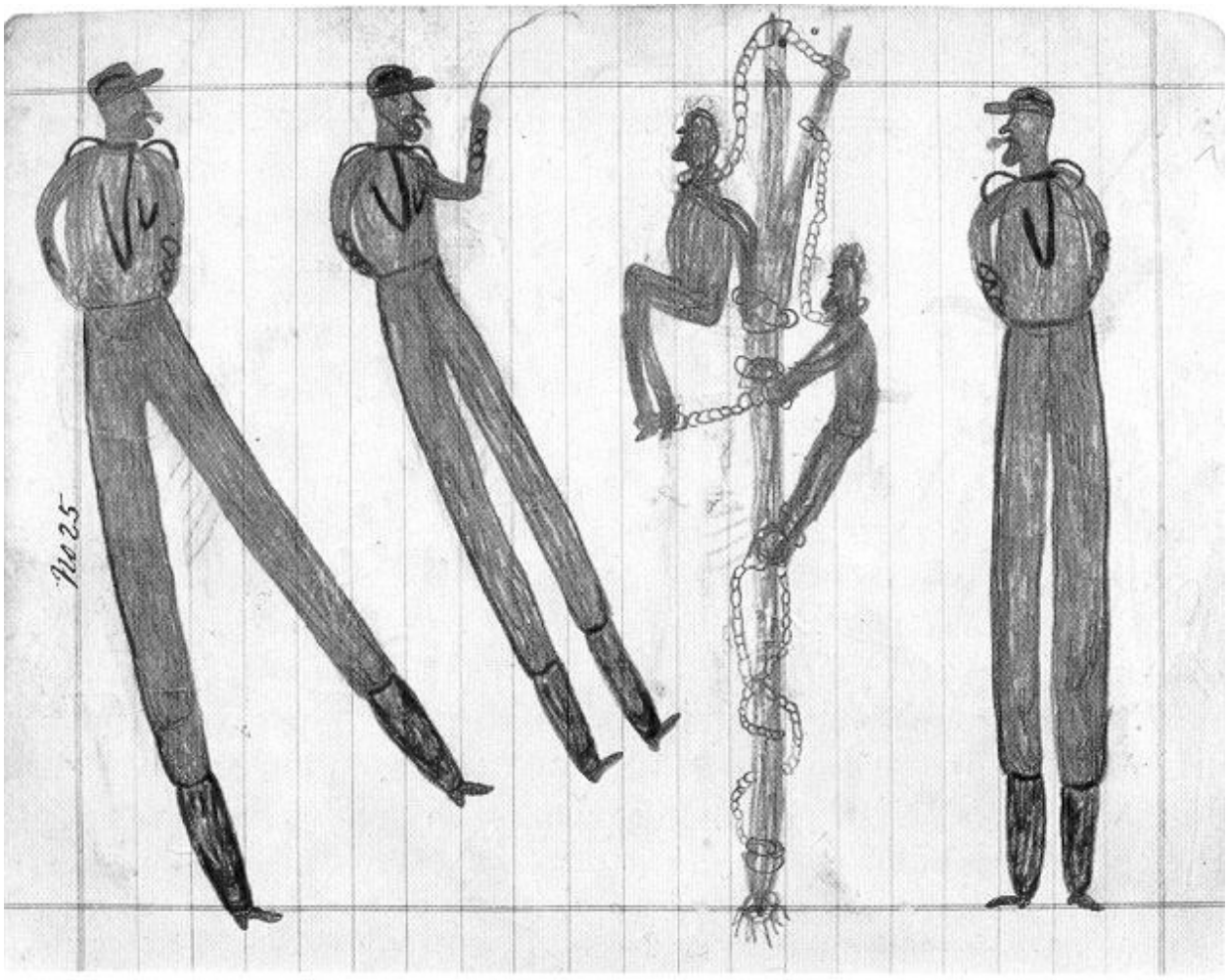
Example 8a



Example 8b (detail)

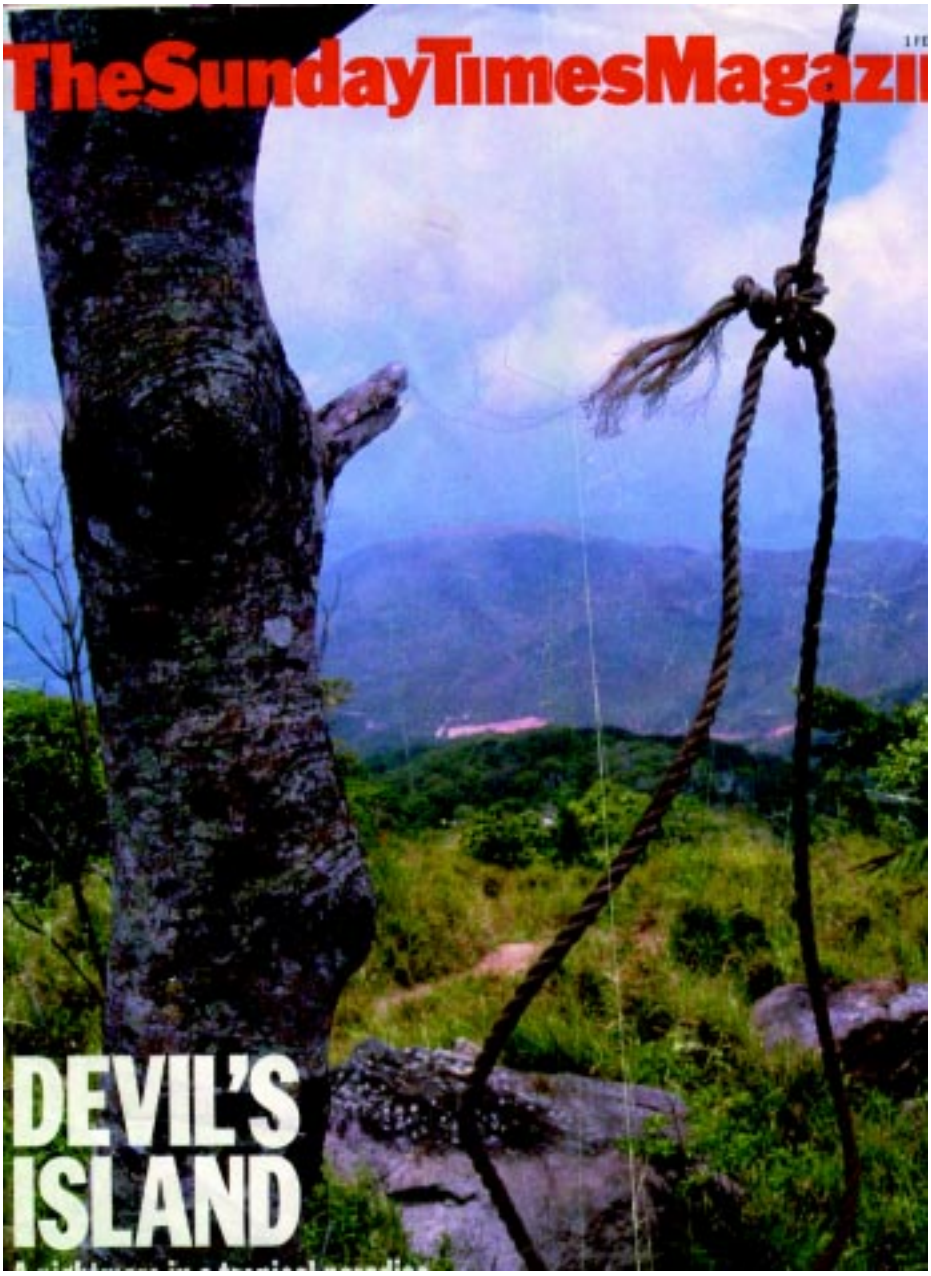
Example 9 is a sketch done by an Aboriginal stockman from the Palmer River area of North Queensland in 1898. The drawing depicts three individuals in the uniform of the Queensland Native Police presiding over the hanging of two other Aboriginal men. The caption and the sketch capture the everyday brutality of life in Far North Queensland, where native police killed an estimated 5000 Aboriginal people in the process of 'dispersal' and frontier 'justice' between 1849 and 1897 (Sayers, 1994). It is noteworthy that this was a sketch from the Cooktown area, where hanging and rough justice appears to have a substantial history dating from the Palmer River goldrush and the arrival of Dalrymple's expedition and a contingent of 13 native police in 1873. In this region we thus see the same images, the same representations a century apart and spanning five generations. Hanging is clearly an integral and indelible part of collective memory for Indigenous people of this, and probably other, regions. It is now a part of cultural heritage and interpretive display.

Example 9



Example 10 is the cover of the *Sunday Times Magazine* from February 1, 1998. It is a photograph of Palm Island, referred to on the cover as 'Devil's Island,' and the centerpiece is a noose hanging from a tree. The title and photograph set the tone for a journalistic expose of a 'suicide epidemic' on Palm Island, with the story alleging that 40 individuals have taken their own lives on the island since 1994, with suicides currently occurring at the rate of one a month. The accompanying narrative suggests that the common denominator in the deaths was that these young people were influenced by the spirits of others who had taken their own lives, and to some extent 'possessed' by the spirit of an Aboriginal individual taken from Palm Island in 1883 and exhibited in Barnum's 'Ethnological Congress', a road show of 'traditional' peoples from the four corners of the globe. Tambo's body was returned to Palm Island and buried in the spring of 1994. The cover, the accompanying photos, and the text portray a haunting and haunted landscape of violence, hopelessness, and despair. It is noteworthy that this cover story and photomontage appeared in Britain's *Sunday Times*. It is also worth noting that this article was copied and recopied by Aboriginal residents of those communities referred to, and was and remains a talking point for many people, including the young men depicted in the story

Example 10



Example 11 is an untitled painting by Michael Naden , a young Aboriginal inmate of Stuart Creek prison in 1999, 12 years after Mitch Dunnet's painting and 8 years after the publication of the findings of the Royal Commission into Aboriginal Deaths in Custody. The painting was part of a 'postcard exhibition' of prison paintings exhibited in Cairns at the Cairns Regional Gallery and in Townsville at the Perce Tucker Gallery in January and February of 1999. The painting has, as backdrop, a figure of a painted Central Desert Aboriginal elder, dancing. In the foreground is a hanging figure, with the body surrounded by a misty penumbra, suggestive of something more than deliberate self-harm and individual death. The colours of the painting have an ochre quality, and everything is 'behind bars', an imprisoned culture, a tragic but in some ways defiant death. It is noteworthy that countless paintings with similar themes have been painted by young Aboriginal men in custody and hung in similar community exhibitions around Australia. The hanging theme is pervasive, powerful, and immediately resonates with young Aboriginal viewers.

Example 11

The majority of these examples first appeared in 1987 and 1988, at the time of the establishment of the Royal Commission into Aboriginal Deaths in Custody. While the public and media reality at this time concerned Aboriginal deaths in custody, particularly Aboriginal hanging deaths in custody by young men, the Aboriginal community reality was that non-custody suicide deaths were escalating alarmingly in many communities. Such deaths outside of custody constituted dramatic and tragic statements of loss, both in the context of a tearing of the social fabric and individual connectedness to those who died, and with respect to a pervasive loss of control epitomised and symbolised by incarceration and hanging. The impact and suggestiveness of suicide deaths outside of custody on individuals in custody, was arguably as considerable as the wider community impact of suicide deaths in custody. While the events surrounding the Royal Commission, the establishment of the Commission, and media coverage of the Royal Commission hearings undoubtedly influenced the currency of hanging as symbol and statement, community realities provided context, first-hand experience, and triggering events (Reser, 1989b).

These examples are no more than a convenience sample of static paintings and figures, drawn from available printed material. The extent and distribution of such materials is very substantial. Television and commercial films, and newspaper and magazine depiction and or coverage of Aboriginal suicide death, however, is probably far more salient and influential (Comstock & Scharrer, 1999; Michaels, 1994; Strasburger, 1995). The symbolic messages conveyed in films and documentaries and theatre are also more embedded in the larger product, with self-injury and suicide becoming a leitmotif and undercurrent of a film, as in, for example, State of Shock or Walkabout. Finally, the importance of symbolic statements and communication in Aboriginal communities in Australia, and among young people generally, should not be underestimated. These are cultures where nonverbal text, image and statement are often oblique and indirect, as well as confrontingly up front (Michaels, 1994).

Preventive implications

The ubiquity and nature of these images and symbolic representations of Aboriginal suicide pose a number of theoretical and practical preventive questions. To what extent do these representations foster and mediate suicide through suggestion and imitation? To what extent do these representations confer or convey meanings of martyrdom, defiance, Aboriginality, recognition, justification, or viable option/solution? To what extent do such images and symbolic representations reflect or help to construct public accounts and explanations of Aboriginal and youth suicide? To what extent is the element or method of hanging an artifact of the relative difficulty of representing symbolically or actually depicting other methods of suicide? To what extent are youth, and Aboriginal youth in particular, differentially susceptible to and/or exposed to such symbolic representations? To what extent does this larger phenomenon of media representation provide a preventive avenue for the reduction of youth suicide in Aboriginal communities?

Answers to these questions are at best tentative, but they are worth serious consideration and further exploration. It is highly likely that such images do foster suicide through suggestion and mediation. Remote and urban Aboriginal communities both contain large groups of young people whose circumstances and cultural context provide a particularly sympathetic environment for the effectiveness and high currency of such powerful images and ‘statements’. The meanings associated with these images clearly include all of those mentioned, along with personal associations relating to loss, incarceration, and suicide attempts or deaths by relatives and friends. The symbolic depictions of Aboriginal suicide well complement public perceptions and understandings of the causes of such deaths, in terms of alcohol, police harassment, copycat

explanations, sorcery, poverty, unemployment, etc. (Smithson, 1991), and may provide individuals with explanations for their own feelings and behaviour. It is noteworthy that hanging has become such a stock symbol of Indigenous suicide and death in custody. It is very likely that the simple and effective depiction of a rope or noose has privileged hanging as a method in such representations, and confers the additional meaning of custody and injustice deriving from hanging as a form of capital punishment. It is difficult to know whether Aboriginal youth are differentially exposed to such symbolic representations of suicide, but it is clear that such images are particularly salient, poignant and powerful in their statement about Indigenous life circumstances and personal life experience for Aboriginal youth.

Does a better understanding of the roles which such images and portrayals play provide an avenue for prevention? The answer is a qualified yes. It would seem entirely possible to educate media producers, journalists, poster designers, film-makers, educators, and health promotion specialists to the possible problems associated with suicide material and themes which involve hanging suicide. It would still be possible to portray and discuss suicide without evoking the power and multiple meanings of this symbolic complex. While the painting of hanging themes by Aboriginal inmates and youth in detention facilities will undoubtedly continue, and may in fact be quite individually therapeutic, it might be helpful to not include such works in community exhibitions or feature articles about Aboriginal art. The two most powerful media channels with respect to symbolic suicide representations in Aboriginal communities are posters and films with Indigenous content. If suicide is an important theme or issue, it should be treated in a way which does not gratuitously exploit the power of ‘hanging’ as symbol, statement, verdict, and option.

Symbolic analysis: concluding comment

The preceding argument and set of observations is intended more as a review of possible factors, than an in any way definitive analysis. It is also the case that Aboriginal cultural contexts and community circumstances are dramatically heterogenous, and go from urban neighbourhoods and ghettoes to very remote, traditionally oriented communities, to larger, semi-remote, institutionalised communities which are each rather unique and non-generalisable. What is clear, however, is that a pattern of deaths has emerged which implicates hanging deaths as a particularly expressive and symbolic form of death in Aboriginal communities. Clearly the symbolic character and currency of suicide (and in particular hanging) derives from a larger history and popular culture including media representations and coverage of such deaths, but it also has very strong local meanings and associations relating to known individuals and relatives, local place meaning, previous personal instances of deliberate self-harm, and other local, community-based accretions of meaning. There is a high probability that this symbolic character of hanging in Indigenous communities, along with a latent but intermittently emergent culture of suicide and self-harm, have played an important causal role in the Indigenous suicides that have taken place in North Queensland over the past 15 years. While the symbolic impact of Aboriginal suicide deaths by hanging has been noted by many writers, this is typically in non-academic sources.

> It is difficult to see any good coming from the deaths of more than 100 Aborigines in the lock-ups and jails of Australia, but perhaps in some perverse way benefits will result. The young men and women whose journey through life ended abruptly, twitching against a cold wall with a twisted, torn shirt tied to a barred window, like some grotesque umbilical cord to the outside world—these people may be changing Australia. It looks as though they will succeed where judges and politicians and criminologists and academics and moralists and journalists have failed. (Graham, 1989, p. 183)

The Yarrabah story: 1900-1999

Background

The history of the Yarrabah community is well-documented (Craig, 1979; Hume, 1988; Thomson, 1989). It is a fragment of the wider mosaic of dispossession and discrimination which constitutes the history of Indigenous Australia since European settlement. While similarly characterised by racism, violence and State intrusion, the story of Yarrabah, as for all Aboriginal and Torres Strait Islander communities, is unique. It is, however, particularly closely linked to the experiences of Aboriginal communities in Queensland which, from 1859 when Queensland became a separate colony, through 1897 and the passage of the first of the "Acts" (the Aboriginals Protection and Restriction of the Sale of Opium Act) and most of the succeeding century, have been subjected to particularly odious controls and practices (as has been carefully described by Kidd [1998]).

In short, Yarrabah has a history spanning little more than one century since its founding as a mission in 1892 by the Gribble family, who ran it for the next seventeen years. The mission was supported financially from a patchwork of sources until 1911 when the Sydney-based Australian Board of Missions assumed responsibility, which continued despite tensions and conflicts with the Queensland government until 1937 when financial responsibility passed to the Anglican Diocese of North Queensland based in Townsville. Beneath a thin veneer of order, problems, rifts and tensions simmered in response to draconian controls which were compounded by mismanagement and by the forced colocation of disparate Aboriginal groups, including the relocation of children of mixed descent who had been removed through state-sanctioned abduction from their families and communities elsewhere in Queensland.

The social and health problems experienced by the residents of the mission had on numerous occasions been brought to public and political attention, with a strike and exodus (or expulsion) of many families from the settlement in the late 1950s. In June 1960 responsibility for the community passed to the Queensland Department of Native Affairs (later metamorphosing in 1966 to the Department of Aboriginal and Islander Affairs, and in 1975 to the Department of Aboriginal and Islander Advancement). In the service of bureaucratic expedience there followed a period of centralisation of the residents which has had long-lasting consequences, as Craig (1979) notes: "By relocating everyone into one township, the DAIA created an artificial community whereby enemies often found that they had each other as neighbors. The high population density within the main settlement increased social tensions and led to a rapid rise in drinking, violence, and public disturbance" (p. 80).

In the following decades Yarrabah only slowly was provided with the infrastructure and services available to nearby non-Indigenous communities. The community was fully electrified in 1965, a hospital was built in 1963, and a Maternal and Child Welfare clinic began operations in the same year with a residence for the aged opened in 1968. Only in 1973 were regular visits from a State Medical Officer commenced with an Aboriginal Heath Team being formed by Queensland's Department of Health, an ambulance service based in Yarrabah established in 1975. In 1965 the DAIA established a Community Council, Aboriginal Court and Reserve Police Force which, as Craig (1979) notes, was without any real authority. State police were subsequently stationed in the community from 1969, and in 1973 the DAIA established an alcohol canteen on the community. In 1968 the ration system that had been in place since mission times was removed and a cash economy was introduced. Thus began 'unemployment' and welfare dependence, the DAIA rationalising low wages as "training grants" (Craig, 1979), a continuation of State

misappropriation of Indigenous earnings that had been and continued to characterise Queensland Indigenous affairs (Kidd, 1998). Only in 1972 did Yarrabah residents gain access to Commonwealth unemployment benefits. Regardless, the DAIA continued to manage residents' bank accounts until 1974. In the following year "the Commonwealth overrode the provisions of Queensland's Aboriginals Act which allowed the DAIA to manage Aborigines' finances" (Craig, 1979, p. 82). In 1972 a paved road connecting Yarrabah to Cairns (and thus to the rest of the world) was opened, thus further eroding the extent to which the Department could maintain controls over residents' movements. In the next few years the DAIA administrators and staff gradually moved out of the community. However, it was a further five years until the first private enterprise was opened on the community.

The 1970s was a decade of tension between the Commonwealth and Queensland over the management of Aboriginal and Torres Strait Islander affairs, which culminated, at the end of the decade, in the Queensland government's gazetting of two communities (Aurukun and Mornington Island) as autonomous shires, thus subject to the Queensland Local Government Act, in order to head off Commonwealth initiatives to "curb some of the more repressive aspects of Queensland's Aborigines Act" (Craig, 1979, p. 40). It was only following these developments that the Yarrabah Council began to exercise any significant decision making power. In 1986 community self-management was increased with the gazettal of State reserves as Deed of Grant in Trust (DOGIT) communities (Yarrabah became a self-governing local government body in 1986). These state-wide communities are linked under the Cairns-based Aboriginal Coordinating Council, the peak State body representing the interests of residents of Queensland's discrete Aboriginal communities.

The first known Indigenous suicide in Yarrabah occurred in the mid-1970s. Around this time Daniel Craig was doing fieldwork for his PhD dissertation, "The social impact of the state on an Aboriginal reserve in Queensland, Australia" (1979). The following are several quotes capturing the circumstances about that time. Regarding poor housing and it consequences:

> The housing shortage has severe social, economic and medical repercussions for the Aborigines of Yarrabah. The overcrowding leads to social tensions, sanitation problems, and unstable residence patterns. Married couples can no longer expect to have their own residence as was the norm during the Church's administration. In fact they are lucky to have their own room. Because the houses are not theirs, most people take little pride in maintaining them. When a building needs repairs, they call on the DAIA to fix it. At present, Aboriginal houses are wearing out faster than the DAIA can replace them. Most were built shortly after the DAIA's takeover in 1960, and many are situated along a swamp where they are subject to flooding, backed-up septics, and termites. Combined with Yarrabah's rapid population growth, the present shortage will reach crisis proportions within ten years. (p. 112)

Regarding community 'identity':

> There is no overriding culture or set of values which integrates Yarrabah's Aborigines into a single unit. They came to the reserve from a variety of backgrounds and for several different reasons. Some were voluntary migrants, most were forced relocatees. The community's social contract is thus not based on cultural traditions held by the Aborigines themselves. Indeed, there are few such traditions left. Instead it is the result of their need to deal with each other and government authorities within the constraints posed by the reserve system. Present residence patterns, systems of exchange, local politics, and marriage are all adaptations to external pressures. They vary through time and space and represent strategies which enable Aborigines to survive under the reserve administrators' control. (p. 140)

Regarding the impact on men, Craig notes that: "men are suffering most acutely from the stresses of the reserve system. Great numbers have turned to alcohol, and wives often have to drive their inebriated husbands from their homes" (p. 151). The impact of this and other factors on family cohesiveness and function, he contends, was significant, noting that the: "destabilization of the family is impairing its function as an agent of social control .... A major reason for the breakdown of Yarrabah's vertical ties is the fact that different generations have assimilated different values and expectations" (p. 153).

In terms of alcohol use, Craig records that patterns of consumption were extreme: “90 to 95 percent of the adults drink, and two-thirds of the community’s residents are “heavy drinkers”...Whereas only five percent of Yarrabah’s women drank in 1955, there are now only five to ten percent who do not. As a group, people on Yarrabah spend between 50 and 60 percent of their income on alcohol. (p. 157). Furthermore, he observed that the: “younger generations on Yarrabah are growing up to accept current patterns of alcohol abuse are in fact normal. Already groups of twelve-year-olds can be seen passing the bottle on the beach and roaming the streets at night looking for parties” (p. 163).

Reactions and responses

Suicide and suicidal behaviour as a community issue and concern for Yarrabah is a story of the 1980s and beyond (there were several suicides in Palm Island in the 1960s and 1970s, a community with strong ties to Yarrabah). There are community reports of two suicides (of women, these have not been substantiated through records) in the 1950s. However, although isolated, the first instance of what might be considered contemporary suicide occurred in the mid-1970s. Separated by a decade from the convulsive losses of the mid-1980s, it was also separated by far more from the world which preceded it in which there was no precedent, no means for understanding such events let alone integrating them into the fabric of community life. A resident of the community, a young girl at the time, provided the following description which captures the inexplicable in the event:

> It was a hot sunny Saturday afternoon about 1 or 2 pm, the old swamp had been cleaned up and it was now an oval where young people played football and others got together. Some of us sat in the back yards of homes watching the game but also looking at passers by who were drunk and carrying on. A few hours before a [young man in his late teens] who was intoxicated, but wasn’t fully drunk, had [an argument] with someone. I think he then walked up to his [relative’s] house. I can’t remember where he got the gun from—whether it was on his way up to [that] house or what, but what I do recall is that he walked along so that everyone could see him holding the gun. Some young girls and I were sitting on the back lawn watching what was going on. Suddenly everybody stopped what they were doing and turned to look in his direction. I recall him saying “I’ve brought you down here to see me shoot myself”. His [relative] said something like “Where are we going?”, she didn’t realise what he was up to at that time until it was too late. He held the gun up to his chest, I think, and shot himself—everyone stood and watched, no one moved—I think because we weren’t sure what he was doing. Immediately after he shot himself there was a sense of shock, I had a blackout for about five minutes. When I come around everyone was screaming, crying and panicking. It felt as though the community suddenly became gripped by a complete darkness and that everyone was at a total loss about what to do, where to go or how to do anything. I remember the older people came running out of their houses trying to comfort the family and deal with the young man. The people who were drinking left their alcohol and showed concern for the family. For at least three or four months after this I think that the community was numb with deep shock and gripped with overpowering grief—nothing like this had ever happened to our community before. (Community resident, personal communication, 1999)

Reflecting back after what we now know has followed may have influenced recollection of these events. However, it is clear that, although its effects were profound, it seemed distant from the world and potential experience of those who remained behind. Much different is the same informant’s comments about feelings in the community during that period during the late 1980s and early 1990s during which such events became common:

> During the time when suicides happened the community felt a sense of despair, powerlessness, anger, fear, isolation, anxiety, numbness, confusion, shock, shame, guilt, uncertainty. Despair—feeling down and at a loss about what to do next; powerlessness- feeling out of control, not knowing what to do; anger—angry at the persons who killed themselves, angry at people connected to the individual, or angry at authorities. Community members also felt angry with [themselves] because they couldn’t do anything to stop the person from killing himself; fear—who’s going to be next, my son, my daughter, what happened to the guy who killed himself (religious beliefs); isolation—there was a sense that something was wrong with our community, we were different, maybe we were a problem community, the community inverted themselves; anxiety—tension ran high, people never really could relax and come down to earth, just when we began to

> make touchdown the news of another suicide would come to us, people had to keep their inner world flying above, a state of total loss, felt jumpy, had to keep looking behind our backs and to the side, even to the front; numbness- people's emotions froze, our mental processes froze, our spirits froze within us, before our frozen selves began to melt another suicide happened, so we reacted by going into freeze mode again; confusion—our inner world fell to pieces within us, hope had no substance in our inner world; shock—dumbfounded, someone just hit each of us with a baseball bat directly to our hearts, feeling of deadness, we stopped feeling; shame—we could have been better people, it was our fault; guilt—if only I did what he/she wanted, where did I go wrong; uncertainty—who will be next, what will I do if it happened to me, to my family. (community resident, personal communication, 1999)

In the following section events through this period to the late 1990s will be presented in order to contextualise the phenomenon of increasing suicides of the 1980s and to explore the various reactions and responses to these events. In doing this we will, as far as possible, allow the words of those people who were thinking, writing and talking about these issues to speak for themselves. Sources of information include published works, official reports and correspondence, meeting minutes, and diary entries.

The early to mid-1980s was a period of change and inertia. With the gradual reduction in Departmental intrusion there was increasing control from within the community and some improvements occurred. In the mid-1980s the first Aboriginal bishop was consecrated and a permanent (government subsidised) private doctor's surgery began on the community. However, many problems remained entrenched and some others became worse. In response to the consequences of excessive alcohol consumption the Council, in collaboration with the Church, established the first Alcohol Rehabilitation program on the community.

Despite these changes, in the mid- to late-1980s a first 'wave' of suicides occurred in the community which was, in some respects, little changed from what Craig had experienced a decade earlier. Thus, a nurse's report on the community in 1987 in which she reflects on recent suicides, has obvious similarities to his description of poor housing (the Powder Law Report (1987) also raised the issue of poor housing and social circumstances in relation to increasing rates of suicide):

> The lack of houses and the absence of maintenance on existing houses are the greatest obstacles to good health at Yarrabah today. 1208 people live in the township of Yarrabah in 164 houses and 250 people who have chosen not to join this unhealthy atmosphere live in temporary accommodation at the fringe of the township with no electricity.
>
> Because of the overcrowding the drainage and the septic systems are overloaded and there is NO WORKFORCE to deal with this, so blockages become serious breakdowns and very soon are an immediate threat to the health of the inhabitants of the house. Sometimes those paying rent have to get out of their house and live in a makeshift humpy until the fault is rectified—the smell is so bad. It is not uncommon for the sink and shower water and the septic overflow from one house to be running under the next house...
>
> If someone wanted to design a system to keep people down the Yarrabah housing system would certainly be part of it. People are wondering why there are so many suicides, they need to look no further than this. The amount of morbidity and mortality flowing from this cesspool of housing in this small community is incalculable but very tangible....
>
> Invariably as the Child and Welfare Committee unravels the problems of children they find themselves staring at the problem of overcrowding. It does not matter if the problem is one of parental neglect, continual sickness, truancy, child abuse, incest or alcohol or drug abuse, it always has the same roots in the overcrowded housing situation. Sometimes families have to be broken up because they simply have nowhere they can live together...
>
> Permanent unemployment is the norm. For the 850 people eligible for work there are 145 permanent positions, the rest are on unemployment benefits. Many young mothers receive supporting parent benefits. (Director of Nursing, 14/4/87)

Through the second half of the 1980s a series of suicides occurred, mainly by hanging but including two through firearms, all being male, most being young adults and alcohol being consistently associated. While the early deaths in this series attracted little interest outside of

Yarrabah, Indigenous suicide itself became a focus of national attention in the press at the end of the decade through the inquiry of the Royal Commission into Aboriginal Deaths in Custody and through works such as David Bradbury's (1989) documentary film *State of shock*, and Paul Wilson's (1985) book *Black death, white hands*. Both of these works dealt with the story of Alwyn Peters, a Cape York Aboriginal man who was tried for murder in 1982. Publicity surrounding this case fuelled public interest which was heightened by the subsequent works of Bradbury and Wilson. These drew attention to background social disadvantage and violence, including suicide and self mutilation. Two of the authors of this report commented at the end of the decade on suicide clusters and the impact of media attention (Reser, 1989; Hunter, 1989).

Around this time researchers from James Cook University in Townsville began working in and with the community to explore the circumstances and context of self-harm and community violence, and the contributing role of alcohol and substance abuse. Having examined hospital records from March 1983 to March 1999, Paul Reser (1995) documented:

> a total of 49 incidents of suicidal and parasuicidal behaviour ... involving 34 people, with a maximum of six incidents for any single individual. Five deaths occurred among males over the five year period, giving an annual suicide mortality rate for the population of 70/100,000. Three of these deaths were by hanging and two as the result of self-inflicted gunshot wounds. There were 41 incidents of deliberate self-harm involving 26 males with a mean age of 23.2 at the time of the behaviour and 9 incidents involving 8 females with a mean age of 20.2 ...
>
> Males do dominate both in the number of cases and in terms of repeated attempts. Predominant among males as a means of self-injury and suicide were methods of harm related to direct physical wounds, whether from gunshot or laceration. Ingestion of harmful substances predominated among females, though lacerations from knives and glass also were common. (p. 49)

From related research, the role of alcohol use and abuse was emphasised by Joseph Reser (1991) who commented that: "It is clear that in the north Queensland data the pattern of alcohol use by a number of heavy regular and binge drinkers is placing them at a much higher risk of attempting suicide. Indeed this risk is over 18 times higher than that for those who drink only lightly, occasionally or not at all" (p. 272). This analysis drew attention to the contextual factors associated with self-harm, Reser noting that: "Aboriginal suicides, both in and out of custody, reflect a number of contributing elements, some of these deriving from a traditional base, some from the exigencies of rapid change, institutionalised dependencies and social system collapse, and some from fortuitous historical and situational factors" (p. 276). He continued, emphasising that: "the medical model has largely excluded 'social' from its causal explanations of mental health problems" (p. 278). In the report of this research group to the auspicing body, the Aboriginal Coordinating Council, (Smithson et al., 1991) the following summary points were among those made regarding suicide across the five Aboriginal communities surveyed (of which Yarrabah was one): There appear to be three kinds of self-injury situations in Trust Area Communities:

1. People attack some object and get hurt in the process;
2. People, acting under the impulse of strong emotion, wound themselves though not, apparently, with any intention of killing themselves; and
3. People deliberately attempt suicide. (p. 52)

> When asked directly about it, 78% of attempters and self-injurers said they had been drinking at the time of the event. However, there was a marked difference between the men and women. Virtually all of the males (97.7%) said that their episodes involved alcohol use while only half (50%) of female episodes involved alcohol use. (p. 52)
>
> First-hand accounts of suicide attempts, self-injuries, and suicidal thoughts were dominated by mentions of alcohol, anger, relationship problems, and/or family breakdown or conflict. Relationship problems and family conflicts account for 34-35% of all explanations given for the attempts, self-injuries, and ideation episodes. Attempters and self-injurers expressed feelings of rage or anger to a greater extent than any other emotion (28.7% and 22.8% of all explanatory factors in their accounts respectively). (p. 53)

> Female attempters and injurers reported still suffering considerably greater emotional stress at the time of interview than female non-attempters and non-injurers. They had 3.5 to 9.3 times higher odds of feeling helpless, angry, alone, worthless, frightened, trapped, unable to cope, and depressed than the other women. For men, the only emotions that showed a substantially higher impact on attempters or self-injurers than on non-attempters were feelings of helplessness, being trapped, or depression (about twice the odds). (p. 55)
>
> There is a propensity for Aboriginal suicide attempters and self-injurers to suffer specific ill-health symptoms to a greater extent than non-attempters from the same communities. Some of these symptoms reflect heavy alcohol consumption (the male pattern especially), but others (particularly those with high odds ratios for females) may indicate emotional difficulties and stress.
>
> Aboriginal suicide attempters and self-injurers are far more likely to have recently suffered personal problems for which they needed help, sought or received such help, and/or taken medication to help deal with those problems, than non-attempters from the same communities. This trend is nearly identical for males and females. (p. 56)

This research demonstrated the interplay of environmental and emotional factors; the nexus of circumstances in which intense emotions, problems with relatedness and poor coping skills lay a foundation of vulnerability which, in the context of particular events and intoxication, led to the suicidal act. It was conducted at the end of a decade during which there was substantially increased activity in the arena of Aboriginal mental health nationally (Hunter, 1997a), with a volatile meeting of the Australian National Association for Mental Health (1980)—Aboriginals and mental health—in Brisbane at the beginning of the decade and the Royal Commission at its end. As a suicide in custody had occurred at Yarrabah the Commission had specific interest in the community and, for the community, the wider public attention attracted by the Commission's activities had particular resonance. As an immediate outcome, a new police watchhouse was constructed on the community.

Thus, following the 'cluster' of suicides through the mid- to late-1980s, and with the Royal Commission into Aboriginal Deaths in Custody proceeding (with the emphasis of its inquiries shifting to 'underlying causes'), external professional involvement, primarily social research, had begun. At the same time and responding to general and social health issues and concerns regarding the existing mainstream healthcare system, a "Proposed Health Care Plan for Yarrabah Community Council" was completed in 1988. This identified a set of perceived 'problems': i) no local control; ii) fragmented service; iii) no commitment to training; iv) primary health care principles not being employed; v) reluctance of community members to use the doctor on the community; vi) local skills not used; vii) no service for the aged; and, viii) poor attendance at the antenatal clinic. The Plan called for the setting up of a health committee to work towards the establishment of an independent and integrated health care system and presented the following guidelines for policy:

1. Primary Health Care as defined by W.H.O. "essential health care made universally accessible to individuals and families in the Community by means acceptable to them through their full participation".
2. The Community is the subject not the object of Health Care.
3. Community direction is established internally rather than externally.
4. Staff will be generalists and interchangeable within this Health Care System.
5. Priority health problems will determine Health Service functions.
6. All staff will be resources to people.
7. Only the medical work will be supervised by medical practitioners. (p. 14)

This plan insightfully anticipated issues and obstacles, these being 1) power; 2) co-operation; and, 3) resistance to change. Following the report, in 1988, the Yarrabah Health Council was formed. Funding was obtained from ATSIC for a building, and with support from the Yarrabah

Council, Council Health was formed, employing one Council funded health worker and two other workers funded through CDEP. Ironically, funding for this program was from the profits of the canteen. Not surprisingly Council Health functioned primarily as a forum rather than as a delivery point for services, with specific directions emerging later. Health service delivery remained the province of Queensland Health.

Concurrently, within the community, a small group of women had organised through the Anglican and Catholic churches and the Department of Family Services for a series of weekly seminars to explore and influence family dynamics in the community. This was provided by a Social Worker with another worker from Corrective Services providing similar workshops on issues such as dependency and codependency. These meetings occurred in 1990, in large part as a response to community concern regarding the impact of alcohol on the community (and as a cause of self-harm). Around this point in time videos produced by the Nechi Institute at Alkali Lake dealing with native Canadian responses to alcohol use and its consequences were shown on the community. In April of the following year, workers from the Nechi Institute were brought to Brisbane by the Department of Family Services and arrangements were made for them to visit Yarrabah where a community meeting was held involving families and workers from health, alcohol and related fields. These meetings included discussion of indigenous alcohol abuse and strategies developed in Canada, in the course of which the subject of suicide was raised. Later that year six community members visited Canada to examine alcohol programs. These activities reflected a shift to a community driven response to particular problems, but driven largely from one sector with particular views regarding causes and priorities, these being primarily focused on alcohol.

At this time, through the early 1990s, a second cluster of suicides was occurring (1991-1993). In 1991 the Cairns-based Mental Heath Services of Queensland Health became directly involved with a psychiatrist visiting the community in response to concerns from the community and the wider attention accompanying the Royal Commission. Following a first meeting with community workers, the psychiatrist reported on the visit during which he had sought to:

> explore the attitude and knowledge towards and about mental health and the mental disorder in the aboriginal community, attempt to assess what needs might be and explore ways in which we might become involved in servicing these needs...
>
> Their initial attitude towards us was understandably and expectedly somewhat cautious and there follows some of the points they made -
>
> 1. They have past experience of health professionals being involved with their people and omitting to liaise adequately with the health workers—they stressed that should we become such liaison would be imperative.
> 2. They asked us not to use “big words” since they would be unlikely to understand them.
> 3. They stressed that aboriginal communities are not uniform and that we should expect to find considerable differences between them.
> 4. They suggested that we liaise with the community’s doctor particularly to obtain the use of a room at the hospital if we were going to conduct “a clinic” but they also clearly felt that their role in preparing individuals to see us would be crucial.
> 5. It did not really become clear whether it would be better for us to see referrals initially in Cairns or at Yarrabah. There would appear to be a problem sometimes in the people getting money for bus fares and at least one worker felt that seeing people initially in Cairns would help them to get to know us and facilitate subsequently seeing them at Yarrabah...
>
> Alcohol abuse was clearly identified as the community’s number one health problem. The canteen however is now open from 10.00am to 10.00pm instead of from, I think, 4.00 pm to 9.00 pm. These workers felt that this has resulted in more acceptable drinking habits and a lessening of violence. (psychiatrist’s report, 3/7/91)

Following this meeting a regular clinical service was initiated on a monthly basis which focused primarily on the needs of community members with serious and chronic mental illness, the psychiatrist commenting after the first visit of the clinical team during which four of seven 'scheduled' patients were seen:

> The Health Workers had put quite a bit of effort into ensuring that people turned up for their appointments and I guess that 4 out of 7 is a reasonable strike rate. V is keen to discuss the management of the various patients and she clearly has a wealth of knowledge about their various relationships, support systems and so on. She was reluctant to sit in on any interviews and I think that this is something that we should talk about with the Health Workers as a group. (Several of them are presently absent on a visit to Canada).
>
> The facilities for interviewing patients are adequate and we were made to feel very welcome. They have a long list of potential customers for us and appeared pleased that we were coming back in 3 or 4 weeks time.
>
> My impression was that the clinic could easily take up a whole day and that part of it should entail regular discussion, education and liaison meeting with Nurses and Social Workers. (Letter to Council Chairperson, 25/7/91)

Not surprisingly, given the history of Yarrabah and its consequences in terms of pervasive distrust of institutions and institutional care, the optimistic goals were not necessarily realised, with the psychiatrist commenting candidly several months later that:

> While we have been meticulous in terms of doing what we undertook to do there have been misunderstandings and omissions regarding both the setting up of appointments and the teaching session which was arranged at our initial exploratory visit. Doubtless our culturally informed expectations that people will keep appointments and do exactly what they say they will do are unrealistic. (report, 15/10/91)

To this point in time there had been three suicides in 1991, two earlier in October. The Mental Health Services were attempting to set up a service, primarily on those with serious mental illness, and researchers from the Departments of Psychology and Sociology at James Cook University were specifically focusing on suicide and its social and psychological context. Not surprisingly, in the course of this work, considerable 'clinical' problems were encountered. Contact had been established between these parties, the psychiatrist commenting in the above report that the James Cook University researchers:

> were very concerned about the extent and severity of psychopathology which their research is revealing. Their ethical ground rules require that they attempt to seek help for disturbed individuals although the overall aim of the research is to help with the establishment of appropriate helping agencies within the community....
>
> We made it clear that we would be prepared to see anyone who they felt needed to be seen by us providing the community workers were involved and arrangements were made either for the individuals to be brought to us or the way cleared for us to visit them in their own homes. This seemed entirely acceptable and we left it at that. As regards to people they were particularly worried about they would immediately liaise with the community workers, decide on priorities and either bring the patients to us or take us to the patients. In the event we saw only 2 of the 8 patients who had been on our list and no emergencies. Clearly one of the major difficulties is going to be getting ourselves and those in need of our services together.... It seems to me that the community itself is going to have to take a fair amount of responsibility in this regard since it is clearly inappropriate for us to chase around looking for people whose names have been given to us. (report, 15/10/91)

As a consequence of this contact, referrals were made from the researchers, who had identified a group of young people considered to be 'at risk' to the clinical team. Among eight initial referrals was one seen by the research team:

> This [young man] was interviewed in the hospital. He has attempted suicide a number of times and has a [relative] who committed suicide. He was fidgeting markedly and was barely audible at times. He indicated that he was experiencing considerable shame, for a variety of reasons. He also stared intently at who was going down the road, etc. and was at times reasonably distracted and preoccupied. Lived [at another community] for six months last year, but also mentioned a stay of about a year recently [in prison]. He was evidently seeing a psychologist or a counsellor there. There are obviously serious conflicts with family members. [He] indicated that he felt like he was about to "go off" again, i.e. go crazy and the context and manner of his statement, and his general circumstances, suggest that a further suicide attempt is reasonably and imminently likely. He indicated that he would like to be able to talk with a counsellor. (letter from research team to psychiatrist, October 1991)

These comments and exchanges (regarding an individual who, some years later, died by suicide) capture an important issue. Largely in response to the ongoing tragedies at Yarrabah, and against the backdrop of national and local attention on the Royal Commission into Aboriginal Deaths in Custody, two mainstream organisations (made up, largely, of non-Indigenous professionals) confronted a problem for which neither was sufficiently equipped. The mainstream mental health service provided a clinical 'response' which was not informed by an analysis of the situation as a whole. Of necessity, this could deal only with those problems that presented 'clinically'. Those seen were largely community residents known to the system who had chronic mental illnesses. The academic team sought explanations at psychological and social levels and clearly saw a need for a particular type of response which was, not surprisingly, a psychological intervention, but which they were unable themselves to provide.

The following year (1992) the first author of this paper began clinical work in Indigenous communities north of Cairns. While this did not include Yarrabah (which remained serviced by a mental health team from Cairns), over the following years EH had intermittent contact with the community, on several occasions in relation to suicide. In mid-1992 the Director of Nursing wrote in response to a questionnaire that mental health services remained problematic: "because of cross cultural differences. Often an aboriginal TAFE counsellor who lives at Yarrabah is used because she is a good listener". As the suicides continued in 1992 it became obvious that those dying by suicide at that time were not those identified earlier in the community survey as being at risk (although a number of these young people did die over the ensuing years, often as a result of high risk behaviours). This simply emphasised the impulsivity and unpredictability of suicide in this context. Regardless the responses considered remained primarily clinically and crisis focused. After a meeting with the Chairperson of the Health Committee, EH recorded that he seemed:

> very sceptical of government involvement in health, seen as another mechanism for asserting state control and undermining Aboriginal autonomy....While he was somewhat suspicious he warmed, and suggested attending the Health Committee meetings as a mechanism for gaining entry...
>
> Police indicated that the vast majority of their activity was alcohol related. Felt that they had a reasonable relationship with the community at present. Indicated that there had been three suicides this year alone. Noted the particular disadvantage of not being able to take vulnerable individuals to a "place of safety" as they are able to do in the city. Recalled some instances of insensitivity to Aboriginal custom on the part of undertakers; specifically a recent death [of a community member] following which the undertaker [made unacceptable comments regarding the corpse]. The community was predictably enraged. [The Chairperson] appeared willing to work with any crisis team, and were unaware of such initiatives to date. (EH notes, 3/8/92)

At the same meeting another senior community member: "voiced some concern that [crisis intervention] would be problematic if it required outsiders coming into the community rather than having people from the community itself dealing with the issues. (EH notes, 3/8/92). Through the next year little changed save for the inclusion of an Indigenous mental health professional with the mental health team visiting Yarrabah on a fortnightly basis. In early 1993 increasing political pressure was brought to bear on the Health Department to respond by a local MP who had been contacted directly by community members seeking specific training in 'suicide prevention' (EH notes, 5/2/93). Soon thereafter a special meeting was held at Yarrabah to discuss mental health responses:

> "The initial focus of the meeting was defining the scope of the problem as it has manifested recently. I was informed that there had been at least 8 suicide attempts this year. Of these, two had been hospitalised, and there were negative feelings about that... of the rest (all of whom were male, and all of whom appear to have been intoxicated) one had been seen by [a research psychologist] and the other six had had contact with the [local] minister. None had had contact with health workers. It was felt clearly that these problems were capable of being handled at Yarrabah with staff trained in counselling. [The senior health worker] was particularly forceful in putting this argument, insisting along with others that this required both training and

> support, specifically with the provision of a centre, possibly through funding flowing on from RCIADIC. During this discussion it became obvious that there were considerable misgivings about the way in which the system worked at the moment. In particular they perceived there being many inappropriate admissions to hospital, often of people about whom there was no consultation with community members. It may also reflect feelings about the current doctor who is about to leave. Their feeling was that those who left to go to Cairns returned damaged, as 'Zombies'. (EH notes, 11/2/93)

The following day another suicide occurred and days later concerns were raised by a child guidance worker that children at the school: "were talking about suicide ... She reported that teachers there had told her that groups of young male students had been talking about suicide in a way that suggested male bravado, and that one boy had apparently been found imitating hanging with a hand held rope ... [other informants indicated] that the mother of the boy in question had "given him a good talking to" (EH notes, 16/2/93). That week, with considerable media attention on the events at Yarrabah, another meeting was held at the community with the local politician mentioned earlier:

> [He] seemed well informed, having been a teacher before entering politics and having spent time in Yarrabah in the 1970s. Indeed, the discussion later came round too the subject of education [and he emphasised] the need for the community to acknowledge and take responsibility in terms of authority over children. The point was made in passing that attendance at the school at Yarrabah was quite good, although [a teacher aide] explained this was largely as there was nothing else to do. The subject of CDEP also arose, with [the MP] viewing this as a problematic endpoint. However his primary concerns in terms of economics was for the location of retail outlets at Yarrabah in an effort to retain money in the community. Apparently there have been efforts to build a substantial market there for some time that have not come to fruition. However, in the meantime he last week opened the PubTab last week, which I viewed at lunch (it was very busy) and which was reported to have taken $38,000 in its first two days of operation (EH notes, 17/2/93)

Following on from the earlier contact with this politician and with funding from the Health Department, community members had organised for training in counselling to be given as a means of contending with suicide and self-harm. Pointedly, community members had chosen to approach the Aboriginal Studies program at Curtin University in Perth. Although it was agreed that members of the Mental Health Service working in Yarrabah should also attend, it speaks to underlying suspicions and reservations that one of the members of the Health Council opposed their attendance as he felt that they might undermine the initiative (EH notes, 17/2/93). Thus at this stage, as the second 'wave' of suicides passed (there were none in 1994), and while the focus for response remained at the individual risk level, community members were asserting that they must themselves have the skills to deal with crises and insisting on identifying who would best provide those skills, in this case Indigenous professionals. The Curtin course subsequently proceeded over three days with a focus on historical traumatisation and "cultural healing". Attendance was open to anyone, attracting mainly adults, many of whom were involved with ongoing programs with James Cook University.

During the following year, 1994, there were no suicides at Yarrabah. At the beginning of 1995, however, the third 'wave' of suicides began, with a number of suicide attempts and three deaths in the first months, including that of a man who had been a patient of the Mental Health Service. As the community found itself confronting further tragedies and anticipating, from experience, that the wave of suicide could continue unabated, a community meeting was called and organised with cooperation across Council Health, the Health Department (Yarrabah Hospital) and the Community Council. The gathering which occurred at the Yarrabah Sports Complex on February 16,1995, was a critical juncture. The Council had organised time off for all workers in Yarrabah, and by 9.30am there were some three hundred people milling in the Complex. There was also representation from the Aboriginal Coordinating Council and Queensland Health. What followed was a powerful outpouring of mixed emotions—of sadness, of anger, of bitterness and of despair. Subgroups formed and workshopped various issues, reporting back to the main gathering. What distinguished this meeting from others was not only the number of community residents

attending and their involvement, but that the discussion focused on both the immediate causes and the solutions emanating from within Yarrabah itself.

The following day another meeting was convened at the (subsequently disbanded) State Tripartite Forum, bringing together community members and workers, and representatives of mainstream health and mental health services. The Chairperson of the State Tripartite Forum, Mick Miller, revealed that the Health Department was allocating $50,000 towards addressing the problem at Yarrabah. Concurrently, the Aboriginal Coordinating Council had been approached by community members to provide funding for a suicide prevention workshop to be run at Yarrabah by Rose Education from New South Wales (representatives of which had been present at the meeting the day before). This was to provide training for 25 community members. Of the 28 individuals who had indicated interest, 17 were women.

Subsequently this workshop proceeded, with those attending becoming the core of a "Crisis Intervention Group" (CIG). From the community meeting and the training course, a list of some 62 'causes' and 66 possible 'solutions' was generated on which the CIG deliberated during its meetings over the following months. These were critical months during which the CIG gradually moved from a sense of crisis and confusion, to planning and clarity. Despite the delays in funding being made available, the community decided to proceed with whatever resources were available, forming networks across family and clan groups, and developing a base of voluntary workers. The following excerpts from the minutes of the meeting for April 4, 1995, suggest the sense of urgency and alarm:

> **********IMPORTANT POLICY**********
>
> THOSE WHO ARE COUNSELLING PEOPLE NEED SUPPORT FROM THE GROUP THEY THEMSELVES MUST NOTIFY OTHERS IF THEY ARE COUNSELLING SOMEONE AND NEED SUPPORT THEMSELVES. SELF AWARENESS NEEDS TO BE LOOKED [AFTER]
>
> Suggested that those on the Crisis Intervention Group should have an Identity Badge to show that they are on the team. So people can be aware who they are. [X] also mentioned that one of the counsellors needed counselling himself after depression had overcome him after counselling a person who had tried suicide.
>
> IMPORTANT POLICY
>
> DON'T PLACE YOURSELF IN DANGEROUS SITUATIONS OR DON'T GO ALONE. MAKE SURE YOU NOTIFY THE HOSPITALL OR POLICE OR FIND OUT IF THEY HAVE BEEN IN TOUCH WITH THE POLICE BEFORE YOU GO TO A PERSON WHO MAY BE DANGEROUS OR VIOLENT. (Crisis Intervention Group, minutes, 4/4/95)

Predictably, the focus for this group, while still reeling from the recent losses and continuing attempts, was on crisis response. Within a short period, however, a shift began towards a broader vision of response. At a meeting of the CIG held two weeks later discussion began of an intervention that would promote life rather than solely seek to respond to crises. The minutes record that:

> [this] vision is the same as most on the C'tee because there was disquiet that the C'tee was heading in the direction of highly-trained Uni counsellors as opposed to the idea of local people with their skills being used. Mick said that whoever the local Counsellors would be, they should be made aware and trained to use their skills to include a mixture of both Life Promotion and Prevention counselling with emphasis on Life Promotion. (Crisis Intervention Group, minutes, 20/4/95)

The minutes for this meeting also record an interim plan of action which would become the basis of the Yarrabah Family Life Promotion Program:

A plan of action was drawn up:-

Plan

- Suggest a list of names for potential Counsellors (done)
- Present to Council
- Present to Mick Miller
- Meeting of candidates for selection

Some other points

- The whole exercise should be a culturally appropriate one called the Life Promotion Programme Development.
- A broad response should be elicited from the community via awareness and consultation, and a networking system be set up between the different governing structures.
- Identify local elders including contemporary elders such as the local Govt Councillors and Church leaders.
- Develop training using local resources.
- Explore implementation of Community solutions.
- Explore better use of mainstream services, eg, Drug and Alcohol Abuse services, Community Mental Health etc.
- Mercy, Selma and Dr Hunter are to write up the plan individually with Mercy putting the final draft together.
- At what stage do we discuss and seek ongoing funding? (Crisis Intervention Group, minutes, 20/4/95)

During the following weeks a “Draft plan for Yarrabah suicide prevention, intervention, aftercare and healthy life promotions” was developed, demonstrating a fundamental shift towards being ‘solution focused’. The following was the “summary of plan”:

> This plan has been formulated out of the community consultations solutions to suicide at Yarrabah, February 1995.
>
> It is vitally important that the solutions be implemented in a culturally appropriate manner as this is the request of the community. It is important to remind ourselves that active counselling has been taking place in Yarrabah for the past 10-15 years by many concerned community members. These concerned members have been able to efficiently counsel clients with utmost satisfaction and members have been able to work with the limited resources available.
>
> The recent completed suicides have now brought to the community’s attention that we need to now take a step further and directly address the issue of suicide in more depth.
>
> Previously, concerned members who have counselled have operated on a volunteer basis for their work and have not been paid for their work. The Crisis Intervention Committee acknowledges the need to employ workers in this field of Suicide Prevention, Intervention, Aftercare & Life Promotions who will be trained to use an wholistic approach in a culturally appropriate manner and in the long term minimize suicide attempts by the Yarrabah people. As finance is needed to operate such a plan we therefore apply to the State Tripartite Forum for the one-off grant of $50,000 to be used to deal with the suicide issue.

In order to provide funding for two workers within the Family Life Promotion Program, the Yarrabah Council agreed to continue CDEP funding for two workers whose salary would thus be increased to a professional full time rate through the above one-off grant which also provided for modest incidental costs. The Council also provided office space, computer facilities and administrative support. What this demonstrates is a shift in direction (from crisis orientation to a

broader social intervention), emphasis of local action and solutions, and self-reliance (funding sought by the community and supplemented from the Council). Ultimately, it was not until August 1995 that funding was assured and the positions advertised, the duties identified being:

- Identify and work with young people at risk.
- Promote family unity.
- Develop communications between family members.
- Liaise with the Health Teams, Recreational Officer and Agencies within Yarrabah.
- Explore ways to use existing and or developing mainstream services.
- Promote community involvement in responding to the needs of young people, their families and community.
- Encourage community elders to participate in the project.
- Intervention in crisis situations after hours. (Yarrabah Community Council, vacant position, August 1995)

In parallel to these developments the Mental Health Services responded by supplementing the fortnightly clinical team with a Social Worker, who visited weekly and also provided short term funding for a nursing position three days a week to focus on improving service delivery in the community. However, despite the intent, this nursing position subsequently became crisis-oriented, being extended for three months after the eventual appointment of the two Family Life Promotion Officers (FLPO) to provide support and training. That support was largely for dealing with crises and debriefing. Despite the broader social goals the ongoing demands of crises in the community relentlessly focused the attention of this team on suicide attempts. The emotional demands that this made of the FLPO's, neither of whom had specific training, was considerable, compounded by the lack of protocols, problems with transport and safe accommodation, and the effects of functionally being 'on call' 24 hours a day. One informant describes the limitation of that period: "lack of effective protocol in place such as, psych professional based locally in Yarrabah to attend to crisis either during working hours, after hours and weekends. Transport and worker safety was also an issue as well as the need for skills development for the two new officers" (Mercy Baird, personal communication).

Not surprisingly these limitations resulted in burnout and staff change. Regardless, with persistence and maintaining active involvement of the community network (reinforced through use of the Yarrabah newsletter) stability was achieved and the following protocols developed for responding to crises utilising the hospital as the central point for contact:

Step 1 Community member informs either the police, hospital staff or family life promotion officers of client.

Step 2 FLPO respond within 10-20 minutes of being informed of client either in the community, police custody or in hospital.

Step 3 Clients are usually assessed by clinical staff in the hospital; if in the home the FLPO will assess client and try to get client to come to hospital for an assessment.

Step 4 If clients refuse to go to hospital FLPO gets family, friends or carers for client for client for next 24 hours.

Step 5 Families are debriefed and referred to other professional support if agreed.

Step 6 FLPO will continue to check on client over the next two weeks or longer if required, but family members and friends are the main support system.

The apparent lack of structure to this program resulted in considerable reticence on the part of the Health Department, which had provided start up funding, to continue this program. In

response to appeals from the community, in October of 1995 the Health Department agreed to continue funding the part-time mental health nursing position (two days per week) for a further three months to provide training for the FLPOs. Near completion of this period the nurse reported:

Objectives

The three main areas of the Life Promotion Officer position are:

a) Crisis Intervention

b) Support and networking other services

c) Long-term Family and Life Promotion Programs.

Direct hands-on education of the Life Promotion Officers is continuing, with current emphasis on intervention, interviewing techniques, legal issues; confidentiality and at-risk assessment. (nurse report, 29/11/95)

In order to improve competencies the workers attended a four day workshop in late 1995 run by the (Queensland Health, statewide) Young People at Risk Program. While the focus of activities remained on dealing with crises, the processes of dealing with the crises themselves and with the needs to support the FLPOs and maintain community investment in the project, served to broaden its scope towards wider issues of community wellbeing and community development. By mid-1996 there was a greater degree of stability and Mercy Baird was commissioned to undertake community consultations and produce a five year plan for the project. Salient aspects of the plan are as follows

We present to you in order of priority the solutions as seen from the Yarrabah Community perspective.

1 Family life skills

2 Culturally Appropriate Services

3 Education and Training

4 Other Projects”

“Further known contributing factors to suicide are:-

i) Unresolved grief

ii) Conflicts

iii) Depression

iv) Low self esteem

v) Domestic violence

vi) Unemployment

vii) Parental neglect. (p. 4)

Mission Statement

To use a Community Development Suicide Prevention Model to heal individuals, promote family life, support, encourage, develop, improve and empower the people of Yarrabah to help reduce the suicides and attempted suicides in the community.

To develop a locally owned culturally relevant Primary Health Care & Treatment Model such as Intervention, Prevention & Postvention to encourage individuals and families to move to a more healthy lifestyle, spiritually, physically, mentally and emotionally so to create a more socially acceptable environment. (p. 5)

Objectives

1 To use a Community Development Suicide Prevention Model with other agencies in the local community and elsewhere to reduce the suicides and attempted suicides in the community.

2 To empower individuals and families of Yarrabah through education and training programs to gain knowledge, skills and understanding to deal with the suicide problem from a holistic healing perspective.

3 To provide short term (24 hour) Crises Centre/Accommodation Family Life Safe Place for companionship, TELEPHONE CRISIS LINE, one on one counselling, grief and loss counselling, family support groups, information and self-awareness programs for survivors of suicide, and those who are at risk, so as to prevent any further attempt to inflict injury on themselves.

4 To provide Family Life Promotion Officers with the opportunity to develop personally and professionally with the knowledge and skills to ensure maximum efficiency and quality of service to the community people of Yarrabah.

5 To network and co-ordinate with all community agencies to encourage and support all people in the community, especially the 'Youth at Risk' of suicide to be involved and participate in all sporting, recreational and cultural activities, to promote unity amongst family and the community.

6 To promote healthy family life and equip people with skills in family life, through workshops in parenting, personal relationship development. (p. 6)

Through 1996 the project focused on consolidating skills (of the FLPOs and others) through workshops and in conjunction with the continuing mental health services from Cairns, and expanding the horizons of the project. This was influenced by events both within and external to the community. On the wider Indigenous stage and after a prolonged gestation, "Ways forward", the report resulting from a national consultancy by Pat Swan and Beverley Raphael on Indigenous mental health, was released in 1995. This report clearly emphasised the importance of holistic conceptualisations of Indigenous health and of community control. Within the community this was paralleled by increasing concern about the lack of community involvement in defining health priorities, directions and delivery, and a similar desire to embrace health as a holistic concept. In 1996 a five year development plan was produced for Yarrabah by external consultants (Nev Bates and Associates) who noted that: "While some excellent health initiatives have been undertaken in Yarrabah, existing services are limited and tend to operate in isolation from each other. A clear network between service providers is necessary" (p. 30). These comments echo those of the "Proposed health care plan for Yarrabah Council" completed nearly a decade earlier.

While the lack of integration of health-related activities and problems in their appropriate delivery to Yarrabah community residents had been long commented on, the experience of community members in responding at a community level to the tragedy of suicide was ultimately a significant factor in motivating action on the wider health stage. This resulted, in April of 1997, in funding being made available from Queensland Health to undertake a feasibility study (Baird et al., 1998) into a multi-purpose health care service:

> In early 1995 the community found itself in crisis when the rate of suicide among young people climbed to levels well beyond that experienced elsewhere in Australia. In response to this situation the community, with funding assistance from Queensland Health, established the Life Promotion program in 1995. This community developed and managed program has been effective in achieving a significant reduction in the number of completed suicides and suicidal ideation in Yarrabah. It was as a result of the success of this community based and managed program that there once again is renewed interest in the community to take greater control over decision making about heath and health service delivery. (p. 6)

The feasibility study was based on an action research model involving widespread community consultations and undertaken over eight months, coordinated by Les Baird and drawing on the expertise of a Harvard PhD student (Fiona Percy). While this study was proceeding through late 1997 and early 1998 other important developments in the community were occurring. Of paramount importance was the decision of the Yarrabah Council in response to increasing concerns being voiced about domestic violence and childcare, to close the alcohol canteen in August 1997. This did not cease alcohol sales within the community, but limited it to take-away sales. However, this action eliminated the canteen as a focal point for gatherings in which disputation and fights had become common. For the Council this decision necessarily involved accepting that income that would otherwise have come to the Council through alcohol sales would be diverted to the purchase of alcohol outside the community. Such significant social changes, which had consequences for violent behaviour in general, are clearly critical to interpreting changed patterns of self-harmful behaviour that followed.

As the consultations of the feasibility study proceeded it became clear that community perceptions of health foregrounded social, emotional and spiritual dimensions of health:

> 'Spirit', 'Land' and 'Loss' were the three key categories arising from focus groups held with community members in the first phase of activity of the feasibility study. These three categories contribute to an explanation of the community's interpretation of health and of the underlying causes of ill health in the community. In conducting additional focus groups with tribal elders further discussion around these categories gave rise to a deeper understanding of the relationship between land, spirit and health...
>
> The Yarrabah community identified the reclamation of 'spirit' or responding to the experience of hopelessness, as fundamental to the achievement of health improvement. The community reports that what comes with 'healing the spirit' is self-determination, the opportunity to be the author of one's destiny and to take responsibility for one's life. This means responsibility for one's health, and all of the behaviours that go along with this including decreasing alcohol consumption, reduction in violent and abusive behaviours, safe sex practices, reduction in smoking and physical exercise for example.
>
> Addressing social and spiritual health concerns does not, in the short term, respond to the ongoing high rates of morbidity and mortality in the community. Effective health planning and development of locally relevant primary health care services, at least in the foreseeable future, will be required to address the high incidence of morbidity and mortality. Without programs to address the health priorities identified in the following section Yarrabah people will continue to get sick throughout their lives and to die young. (Baird, Mick-Ramsamy, Percy, 1998, pp. 35-36)

Emphasising the importance of the community's experience of and response to suicide in considering Yarrabah's broader health needs, the first identified health priority in the feasibility study is socio-emotional and spiritual wellbeing, in which those responses are clear:

> Although the Family Life Promotion program has seen a decrease in both attempted and completed suicide over the past two years, and that suicide is no longer an 'out of control' issue, there remains however a legacy and culture of suicide in Yarrabah. Yarrabah sees suicide as being the result of the socio-economic and spiritual ill health relating to the historical issues and life experiences of the people of Yarrabah which is loss of land, loss of spirit, loss of culture, hurt, pain, intergenerational trauma and unresolved grief and trauma recent and past. The community would like to build on the existing program and employ two more Family Life Promotion Officers to extend the counselling service and develop community education and prevention programs. The community plans to set up a Socio-Emotional and Spiritual Well-Being Centre of Excellence to address the socio-emotional problems within the community setting. (p. 37)

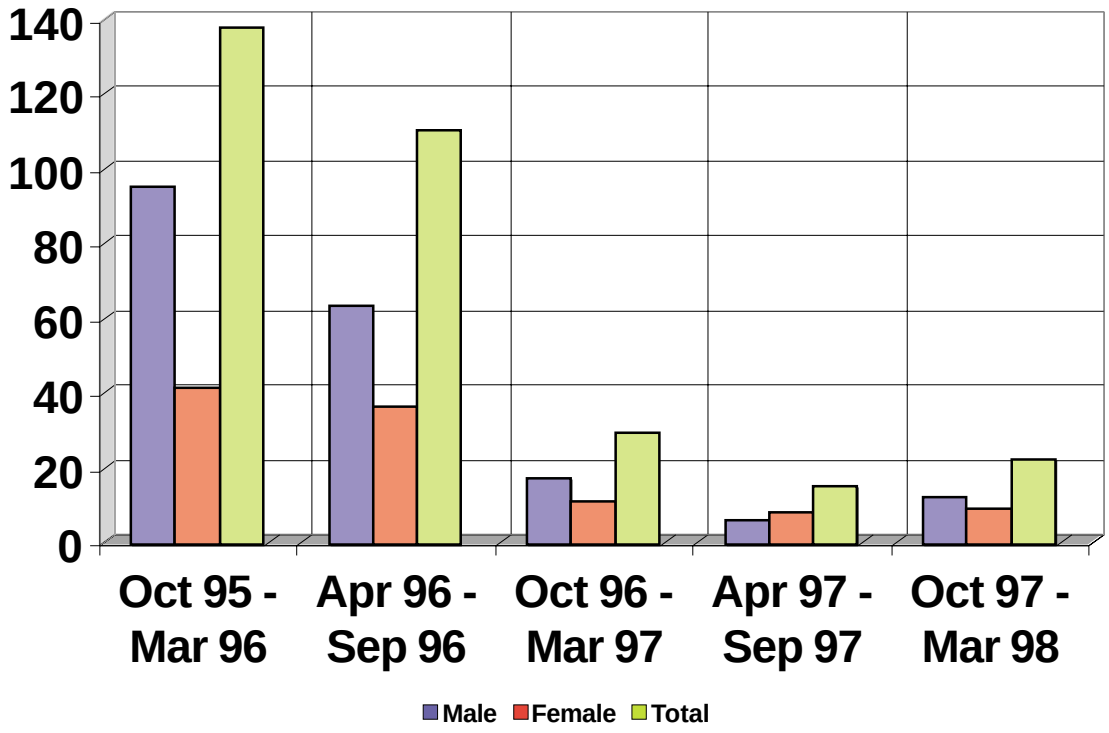
The years 1995 to 1998 thus represent a critical transition phase from crisis to coordinated response; from reactive interventions, to developing a proactive social response to those circumstances that predispose to vulnerability. In this regard the activities that developed in reaction to the waves of suicide impacting the community had functioned as a catalyst to broader social responses in the field of health that had been simmering but unrealised for a decade. There were, of course, factors outside this process which were similarly important. The closing of the canteen has been mentioned, another event being the opening in 1995 of the Yarrabah museum, which has since been a source of community pride and a focus for educational and cultural

activities. The museum and its activities have also helped to historically contextualise contemporary circumstances and problems, and in doing so to make more meaningful experiences and responses which have previously been confusing and divisive.

While three more suicides occurred in 1996 in the early stages of this transition phase, there were no more suicide deaths in 1997 or 1998. Furthermore, as demonstrated in Figure 5, the presentations to the FLPOs of individuals with attempted or threatened self-harm, fell substantially. In the three quarters to June 1996 there were between 45 and 50 incidents per quarter for males and 20 to 25 for females. These numbers fell to between 10 and 20 incidents for both sexes in late 1996 and continued to fall to below 5 incidents per quarter throughout most of 1998 for both males and females. Significantly, it is during this period that the canteen was closed, following which there was also a reduction in police interventions for alcohol-related problems and a reduction in hospital presentations for trauma (Baird et al., 1998). Coincidentally, as a close inspection of Figure 7 will demonstrate, while incidents fell dramatically, this was particularly the case for males, and while the number female incidents fell, it was, by contrast, far less dramatic, and there was, in some quarters, a reversal of the sex disparities with incidents involving females outnumbering those involving males. An interpretation of this provided by FLPOs and others is that the closure of the pub as a centre for congregation and disputation reduced the general vulnerability of males to the physical consequences of intoxication (the opportunities for fights being reduced), with the apparent reduction in overall consumption further reducing their vulnerability to the emotional and impulsive consequences. However, the shift in the location of drinking from the canteen to the home resulted in an intensification of tensions resulting from male (and female) intoxication in those settings and, consequently, an increase in female experiences of distress (Mercy Baird, Les Baird, David Patterson, personal communication, 1998).

Following the Royal Commission into Aboriginal Deaths in Custody, media reports (often sensationalised) on Indigenous suicide included specific reference to Yarrabah. Less formally Yarrabah's 'reputation' spread between Indigenous communities. Visiting a remote Cape York community in 1995 after an incident involving self-harm, the first author (EH) was told by a community elder that the young people in that community had that "Yarrabah talk". At that point in time Yarrabah had come to stand for something for which this other community had, to that point, little experience and limited capacity to explain, describe or meaningfully integrate. In the years since much has changed. As the beginning of this report documents, suicide is now common across Indigenous communities, generalising in this area as it has in other areas of Aboriginal Australia (Hunter, 1993). In addition, just as the word spread about the deaths in Yarrabah in the early 1990s, it also spread (though with less dramatisation) about the fall in the late 1990s. As a consequence, Yarrabah began to emerge as a model, attracting inquiries from communities far afield and hosting workshops for community representatives from across Far North Queensland. This included participation in a regional summit (Cape York and Torres Strait (Health) Alliance, 1998) and presentations on national television and radio. Media attention was generally (and perhaps understandably) narrowly focused on the crisis response role of the FLPOs rather than on the wider social changes that of which the FLPO program is a part, an analysis as simplistic as it is appealing.

Figure 7: Presentations of threatened or actual self-harm to the Yarrabah Life Promotion Officer Program, October 1995 to March 1998.



Reflections

The experiences of this community in responding to suicide have been presented in detail. We have done this to draw out what we believe are critical issues. We believe that the suicides in this area of North Queensland and, more specifically, in Yarrabah, clearly demonstrate a clustering effect, with concentration across time in space (particular communities) and in social groups (including families). The events of the last fifteen years were without precedent for this community and the reactions and responses which have occurred have been created largely by the circumstances of the moment. While, as noted at the beginning of this report, two suicide deaths occurred in Yarrabah in mid-2000 at a time when there was wider community instability, and while it is sadly unlikely that these will be the last completed suicides in Yarrabah, we believe that there is an underlying logic and strength in the way this community has sought its solutions.

Importantly, we also believe that it is the process undertaken by Yarrabah in defining its own responses and solutions, rather than the specific initiative that emerged at the end of that process, that is important. This cannot be overemphasised as, in seeking solutions to the tragedy of suicide affecting other Indigenous communities and regions, the 'Yarrabah program' has, at times, been set up as a model. Indeed, this is somewhat akin to the enthusiastic embrace of Aboriginal Canadian 'solutions' to Australian Indigenous alcohol problems in the 1980s. Their wholesale adoption in Australia missed the particular histories and circumstances of those Canadian communities—the process that led to their solution. Rather, we believe that communities may learn from the experiences of Yarrabah (as they may from those of the Aboriginal communities of Canada) in developing their unique solutions to their own identified problems. This may, of course, result in quite different approaches that rather than being based on a 'Yarrabah model' share a commitment to change and to learning from experience.

While not distinct, there are phases in the reactions at Yarrabah over the period in question. These may be considered as:

Consternation and confusion—at the outset there was limited ability for residents to make sense of events for which there was no precedent. As such there was no means by which to consider that an instance of suicide would become a pattern of suicides. Consequently, this was not a time of planning or responding but of grieving in the particular instance and, perhaps, an expectation (perhaps also informed by denial) that it would not recur.

Despair and desperation—as the first 'wave' of suicides progressed and as it became clear through the activities of the Royal Commission into Aboriginal Deaths in Custody that other areas were experiencing similar problems, there was confusion and attempts to locate responsibility for these deaths in specific causes. For certain groups in Yarrabah responsibility was largely attributed to alcohol. For mainstream health service representatives the problem was constructed as one of mental illness. For certain external experts the problem was of inadequate crisis response capacities, and for others, cultural trauma. This was a period during which 'solutions' were sought through specific external agency—mental health services and suicide prevention workshops. At this point suicide was clearly a concern for many members and groups within the community, but was not, in a political sense, a shared community concern.

Resignation and rejection—with the succeeding 'waves' of suicides particular understandings of these deaths developed and a degree of fatalism emerged in terms of expectations of further deaths. During this time there was increasing skepticism regarding external solutions, both in terms of research and in terms of the involvement of experts with supposed 'solutions'. This was a period during which there was increasingly a 'looking in' to determine causes and solutions. During this phase there was also an active 'looking around' and active integration of thoughts and ideas relating to suicide with broader social issues occurring in the community.

Commitment and collaboration—the pivotal year in Yarrabah's response was 1995, and the critical moment the community meeting of February that year. At that meeting suicide was clearly defined as a 'community issue' and urgent priority. It was also presented and understood in a larger social context with the Community Council undertaking significant commitments (including supporting the FLPOs and, ultimately, closing the canteen). The responses which followed were increasingly generated within the community and directed by the community. The associations that developed were sought rather than imposed. A shift occurred from simply attempting to identify individuals at risk and dealing with crises as they developed, to focusing on a condition of risk impacting the community as a whole. Regardless, circumstances were such (resource limitations, demands on energy and time, lack of support and training) that initial initiatives, regardless of the wider social frames being developed, continued to be crisis oriented.

Persistence and planning—through the most recent years activities at Yarrabah have continued despite initial difficulties and some setbacks. Although there were initial misgivings on the part of Queensland Health (regarding an approach which clearly did not fit easily into a institutional program framework), continued funding for the FLPO program was obtained. Elements of the response to suicide have been incorporated into wider initiatives but, more importantly, the focus has clearly shifted to attempting to address the underlying social issues predisposing to individual risk and, in so doing, focusing on the social, emotional, cultural and spiritual underpinnings of community wellbeing. Importantly, these processes have been actively supported by the Community Council and have defined a new mode of relating between community representatives and those State agencies and organisations which had previously worked in, rather than with, the community. This is best exemplified by the

community-driven initiative to establish a community-controlled integrated health service, based on those very principles.

There are several possible messages from the experience of Yarrabah. One relates to ownership and commitment, of the problems and to the solutions, at a community level. Another relates to the scale of analysis and response. Understandably, particularly in times of crisis, there is a pressure to concentrate on risk factors, those factors proximately associated with a particular problem, rather than the wider environment of risk. In the case of suicide this resulted in a concentration of effort on responding to individuals at risk (despite the manifest problems of identifying such individuals). What developed only slowly was attention to the features and needs of a community at risk and a consequent shift from crisis oriented clinical approaches to a broader capacity building orientation.

Commentary

What is tormenting the youth of Palm?
A question that's been asked from Butler Bay to Farm.
Is it society or is it alcohol and dope, maybe no job?
That's when they think there's no hope.

Could it be so much pressure building up inside...
The young mind thinking perhaps there's nowhere to hide.
Maybe a drink will solve the pain, and a smoke to calm the brain.

One thing leads to another, arguing with family,
Your father and mother. Run and hide and let out the tears,
The pain is there but not the fears.

Is it some force that's taking them away,
Or pressure of society from living day to day?
No one knows what's in another's mind,
When a psychiatrist will try to seek and find.

Nothing works and nothing ever will,
Its over...its gone over the hill.
It's slowly tearing the mind apart,
From head to toe then finally the heart.

Talking to someone but they just won't listen.
Life is full of hits and misses.
Finally it's back to the drink and smoke
Where it all ends at the end of a rope.

Winston Seaton, Palm Island

Introduction

In the above poem Winston Seaton, a resident of Palm Island, directs the reader's attention to a range of putative causal factors of suicide on Palm—historical, developmental, psychological, social—as well as to failed services and interventions. While this poem conveys a sense of inevitability leading to "where it all ends", the connection is not with any one of these factors in isolation, but with an unrelenting topography of disadvantage and trauma. This study has similarly considered a range of social, historical and psychological issues relating to suicide as they intersect in the deaths of Indigenous people, mainly young Aboriginal men, in northern Queensland. Put together, these strands suggest how historical, situational, intrapersonal, interpersonal, family and cultural factors combine, at particular points in time, to create a climate of heightened risk of harm in particular communities. Such confluences have resulted, among other outcomes, in patterns of self-harm and clusters of suicide.

As noted earlier, the authors of this report come from diverse professional backgrounds with different analytic orientations. Rather than minimising these differences, the commentary that follows will emphasise them intentionally; as no single construction can capture the multifaceted nature of this phenomenon, different perspectives provide the only means of ensuring both comprehensive coverage of relevant issues and identification of common themes. This is the first time that a comprehensive, systematic consideration suicide in particular Aboriginal communities has been undertaken in this manner. The picture that emerges is notably different to that provided by analysis based only on aggregate State-level data (Baume et al., 1998).

This combination of approaches provides insights into those historical, cultural and social processes which predispose to individual risk behaviour and which place communities at risk and which can, potentially, be influenced by community development, public health and clinical measures. By examining patterns of self-harm across time in this region it appears that communities may experience 'waves' of self-harm and that, at a particular point in time, different communities may be at different stages of such a wave, thus experiencing quite different levels of 'community risk'. This wedding of an epidemiological analysis with a social science perspective on the shifting picture of historical and cultural context and meaning in the face of rapid social change has cogent precedent (e.g. Janes et al., 1986; Kunitz, 1994; Manson & Dinges, 1988; Mirowski & Ross, 1989). However, this approach has rarely been applied in a systematic way to better understand Aboriginal mortality and morbidity (e.g. Gray, 1990; Hunter, 1993).

In addition to different frames of analysis, this research has also used different social levels in examining risk and preventive implications—individual, family, community and society. While the taking of one's own life is clearly a very personal and thus individual decision and act, it is also very much a family and, particularly, a community level phenomenon. It is a statement and communication to the family and community by those who take their lives, it is experienced, impacted, talked about, understood, and coped with within and by the family and community. However, it is the community which is the 'unit of analysis' that features in media coverage, which shoulders responsibility, blame, and both public shame and pity. It is the community's shared loss, pain, and resolve that is a critical element of any effective preventive effort. Very importantly, it is at the community level that danger signs appear first; it is at the community level that the risk condition or vulnerability emerges and exists. It is at the community level that patterns of self-harm begin to coalesce and take particular and meaningful form across region and time.

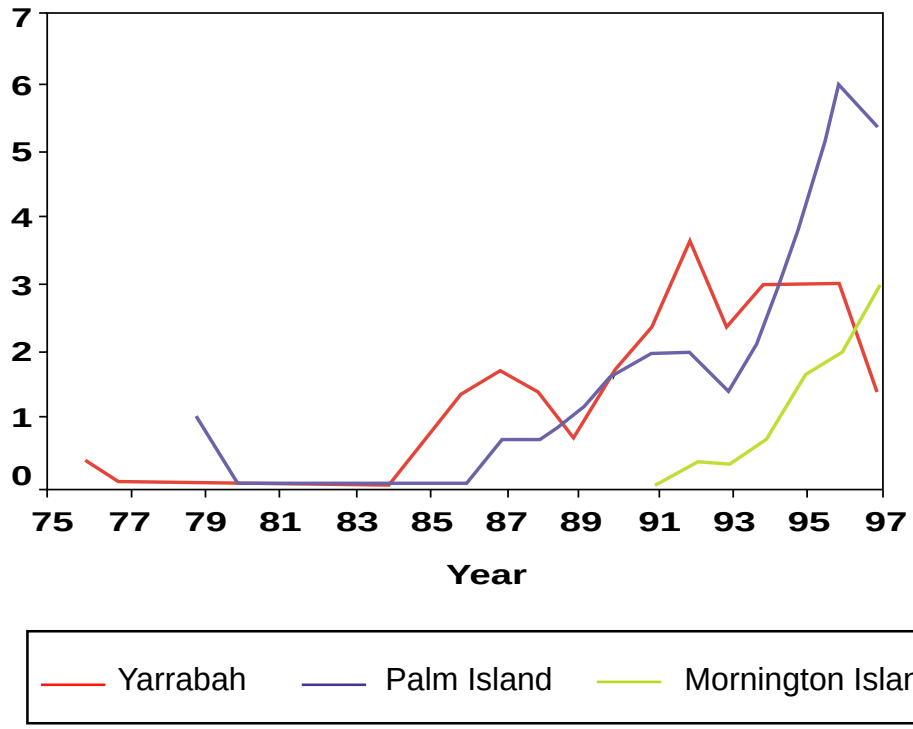
Fifty years of social science research and community development experience also tell us that it is at the community level that change is most effectively implemented. It is at this level that 'problems' must be identified, defined, prioritised, worked through, and addressed. This is particularly true of public health and preventive interventions. Throughout Australia it is community-based, community-level health and mental health programs in Aboriginal communities that are most effective in achieving real gains in health and wellbeing. It is at this level that data on phenomena such as self-harm can be most effectively collected, interpreted and utilised, both by the community itself, and by other locally active regional, state and national agencies.

From an epidemiological perspective, it is at a community level that the current picture of Indigenous suicide begins to emerge and coalesce. It is the patterned incidence of these deaths across particular communities and time, and the differences between communities, which allows for a more comprehensive understanding of the whole and a more objective assessment of risk. Only from this level of analysis can a determination be undertaken of what stage a particular community might be at in terms of the experiences of other communities of suicide clusters and 'epidemics'. Such a community level analysis also begins to suggest how suicide is transmitted as a culturally constructed response from community to community. It is at the community level that the contours of the cultural and symbolic landscape achieve definition.

We believe that it is important to appreciate that self-harm and suicide in Indigenous communities are part of a poignant 'idiom of distress' (Nichter, 1981) with respect to multiple contemporary social and health problems. As with all such 'idioms of distress' or 'illness narratives', the culturally informed understandings of people play an important role in the actual experience and expression of health problems and disorders—that is, understandings influence and 'drive' symptoms. In the case of self-harm and suicide, understandings of the nature and 'cause' of suicide may contribute to and help mediate further suicide. This is why it is important

that public health interpretations of epidemiological patterns necessarily consider the cultural context and meaning of a phenomenon such as suicide. While understandings and accounts can constitute a risk factor, they can also provide a critical avenue for public education and prevention. Contextualised and coherent explanations, validated by the experience of other indigenous peoples and other Australian Indigenous communities, can change assumptions and expectations. They may, thus, influence the risk condition of contemporary communities in which suicide is an institutionalised and normative response to emotional distress and interpersonal and interfamilial conflict.

Statistical analysis: patterns and correlates



The available data confirms that during the period considered in this study suicide became markedly more common in Queensland's Aboriginal population. North Queensland is responsible for a disproportionate number of these deaths (66%) and, as the data from the three separate communities identified in this report indicates, these have, in turn, disproportionately contributed to the losses in North Queensland. In Yarrabah, Palm Island and Mornington Island there has been an 'epidemic'-like increase in suicide. While the first identifiable cases date back some 25 years, the majority of losses have occurred over the last decade. Between 1990 and 1997, one third of all suicides of Indigenous Queenslanders occurred in these three communities; this proportion of total suicides far outweighs the expected numbers of suicides based on the distribution of the Indigenous population within the State (and would be further emphasised if one removed Torres Strait Islanders from the analysis). North Queensland also has a notably higher rate of increase in suicides annually than for Indigenous people in the State overall, with a four-fold increase over the period 1990 to 1997.

For Queensland as a whole the majority of Aboriginal and Torres Strait Islander suicides are male (88%) with the mean age at death being 26 years. The youthfulness of this phenomenon is even more evident in the three communities identified in this study. Typically, at least in the north, these deaths were by hanging, commonly in a public space or adjacent to the residence of

the person who suicided. This preponderance of hanging as a cause of death for Indigenous suicides contributes significantly to suicide deaths by hanging in Queensland overall, so much so that removing the Indigenous component of suicide from the State figures alters the ranking of method, placing hanging after firearms as the method of choice among non-Indigenous Queenslanders.

From the information available it is possible to construct a 'typical' Indigenous case. For the Far Northern Queensland region, it is a young Aboriginal male who has had a relative who has recently died from suicide. He is unemployed, or if employed, works part time on a CDEP project mainly involving manual labour. He has a history of heavy binge drinking and is intoxicated at the time of his death. He has either threatened or attempted to harm himself in the past. In the days or hours before the suicide some sort of interpersonal conflict occurred, either with members of his family or with his partner, either of apparent significance or what, to an outsider, might seem 'trifling'. The hanging, using material at hand such as rope or an electrical cord, takes place either in or close to his home, in a place visible to members of his family and possibly also to passers-by.

Such a 'typical case' may be helpful as an heuristic device but, even for those deaths that conform to this pattern, cannot explain any particular suicide occurrence. Furthermore, it provides no insights into the transitions that have occurred over time. In some respects suicide as a phenomenon has shifted from the police cell to the community. In Yarrabah, following an initial cluster of suicides in police custody in the late 1980s, there have been two later and larger clusters in the early and mid-1990s which involved no deaths in custody. One interpretation for this is that the measures introduced in the wake of the Royal Commission into Aboriginal Deaths in Custody have been effective in that particular setting to prevent suicides (deaths in prison custody from other causes have, in fact, increased), with no effect on general trends within the community. However, another and equally plausible explanation, is that these waves represent a single phenomenon which began with deaths in custody and which has persisted through generalisation to the wider Indigenous community. This interpretation suggests that the social context of the deaths in custody of the late 1980s and early 1990s was important both in the initial clusters of deaths and in its extension and perpetuation outside of custody. The Royal Commission into Aboriginal Deaths in Custody is itself, necessarily, a key factor to understanding that process.

Unfortunately there are very real limitations to data regarding Indigenous suicide, a point emphasised in the review of Aboriginal suicide in New South Wales by Tatz (1999). This study has also identified obvious difficulties with the available data. For instance, there is clearly some conflict between what the community defines as suicide and what actually becomes recorded in official statistics. Further, there is the problem of attribution of 'place'; for official purposes, suicide deaths are identified by place of death rather than by community of residence. From the community point of view, while not physically present, a person who is away remains very much a part of her or his community of residence and it is there that the social and emotional impact of loss is felt. We also found that there were accounts from community records and sources that quite clearly indicated death by suicide, but which were not included in official data sources, the specific reasons for the discrepancy being unknown. Regardless of these considerations, the rate and timing of suicides in the communities investigated are of concern even using the more conservative official figures; including other cases for which there is good evidence would serve to accentuate the scale of the problem.

A corollary of this finding with respect to data quality is that the communities themselves are not in possession of accurate and timely information. Our experience from this study is that individual communities are aware of suicide as a 'problem', but there is no precision in this perception. In none of the communities involved was there easily accessible data on mortality,

morbidity or social correlates at the community level. This has clear implications for planning on a community level, but also for ownership of the problem and its solutions. Only in Yarrabah were there reasonable figures on threatened or actual self-harm—this having arisen from a community-level development. We believe that the absence of effective data-management systems at a local level and, thus, relevant to local needs, contributes to confusion and, ultimately, fatalism.

The statistical analysis in this study has identified discrete clusters of suicides in this part of Queensland, as demonstrated in the figure opening this section. From an epidemiological perspective, there are features of this phenomenon that suggest parallels to an ‘epidemic’. While we are wary of such constructions, they are clearly present in the media and, thus, in the consciousness of many who consider Indigenous suicide, including many Indigenous people. Consistent with this construction there appears to be an original or ‘sentinel’ outbreak, this being the cluster occurring in custody in 1986 and 1987. It is noteworthy that 40% of all identified suicide deaths in police custody across Australia investigated by the Royal Commission into Aboriginal Deaths in Custody took place in Queensland, with six of these eight Queensland deaths occurring in police cells in four small Aboriginal communities (Reser, 1989b). The ‘sentinel cluster’ at Yarrabah thus occurred at a time of heightened public and community attention on suicide and deaths in custody.

Vulnerability on an individual level is ‘transmitted’ as a result of ‘memetic’ communication (of a set of consistent cognitions and behavioural options activated by a particular set of circumstances) through networks of family or others ‘exposed’, and leads to transmission from community to community where it may, given contingent social factors, lead to another outbreak. As with an infectious epidemic, contingent factors are those that increase vulnerability of the individuals within a group to such a point that transmission is enabled. In the case of Indigenous suicide this appears to involve a range of factors, necessarily including widespread heavy drinking and its attendant endangering behaviours among the those most vulnerable (young males). An epidemic is usually self-limiting, as also seems to be the case with suicide in these communities, terminating as a result of elimination of the vulnerable group (through death or changed circumstances), a change in the contingent social circumstances (for instance, alcohol becoming less available), or specific intervention (either in terms of crisis or prevention strategies, or as a result of community political initiatives). Finally, once a ‘naïve’ population has been ‘infected’, sporadic cases are likely to occur and, given the conjunction of the above factors, further epidemics may ensue.

Psychological analysis: overview of symbolic meaning and cultural context

The analysis of the role which powerful symbolic images of Aboriginal suicide by hanging may have played in past and current suicide deaths relies as much on argument as evidence, and is presented as a provisional and provocative analysis. That these images are important reflections and expressions of cultural context and meaning, and document an emergent culture of self-injury and suicide is more certain. The images and examples used also reflect a chronology of precipitating events and circumstances, both at the level of individuals and communities, across time and region, and with respect to larger events within Australian society (e.g., the establishment and course of the Royal Commission into Aboriginal Deaths in Custody).

These media, popular culture, and individual artist representations of hanging and Aboriginal suicide provide a window on sense making and individual and community understandings of hanging and Aboriginal suicide, as well as history and social and legal justice. In this respect these images and portrayals are 'social representations' (e.g., Farr, 1993; Farr & Moscovici, 1984) and 'social constructions' (e.g., Burr, 1995; Gergen, 1985) of these events, i.e., they are cultural products which express and convey particular understandings, value stances, and community responses to particular ideas, events or phenomena. The images also provide elements of the narrative sense-making and causal explanations which are being used to understand and come to terms with these events. They constitute an iconic, image-based argument, logic and explanation which is simple, immediate, persuasive and validating. The images, artist impressions and symbolic interweaving of elements are, of course, different and conflicting as one moves from Aboriginal perspectives and experience to non-Aboriginal popular culture perspectives, but such images meld, reconstruct, and interpolate meanings such that a collective image and symbolic complex emerges which captures and conveys particular and consensual understandings and conclusions. In the case of Aboriginal hanging deaths two separate phenomena have merged—Indigenous youth suicide and Indigenous deaths in custody. The symbolic and multi-referential character of hanging has aided this image-mediated sense-making, which carries with it connotations of courts, custody and sentencing, as well as lynchings, loss, despair, and defiance—paradoxically an expression and statement of no control at the same time that it is a statement of ultimate control. All such images of death and suicide are arresting, confronting, and impactful, particularly the hanging suicide of a youth or an individual from another culture.

What is perhaps most important in the present context is that such images in Australia, over the past two decades, have become ubiquitous and stereotypic. The message of these images and the understandings they reflect are, in part, that such suicides are acceptable, expected, to some extent inevitable, somehow a part of larger justice system processes and outcomes—and particularly common and normative in Aboriginal communities. What appears to have happened is that a growing indigenous and fourth world suicide phenomenon, and escalating youth suicide

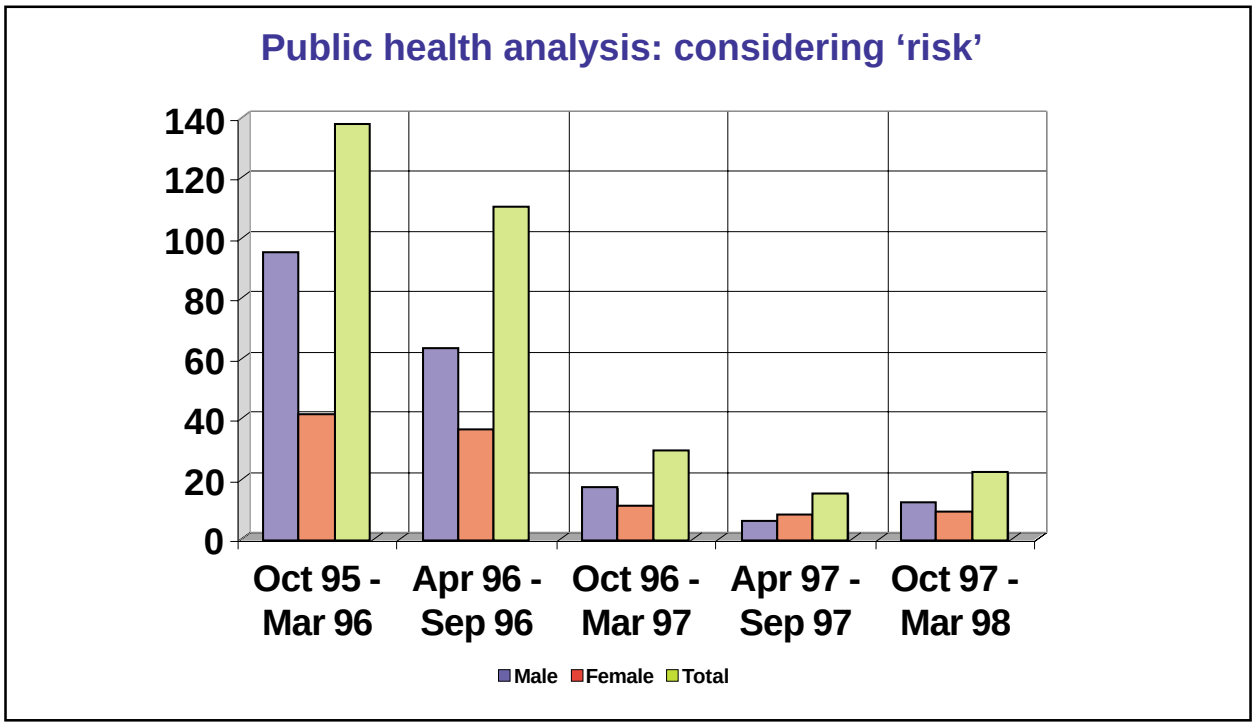
rates in Australia, combined to make youth suicide deaths in Aboriginal communities in Australia a important and growing problem from the mid 1970's. At the same time, societal and cultural changes in Australia, accompanying social problems, and institutional responses were such that the number of Aboriginal people ending up in custody was becoming ever more salient and unacceptable and an indictment of the history and treatment of Aboriginal Australians.

At a national level a number of well-publicised Aboriginal deaths in custody captured media and public attention and concern. Deaths in custody invariably suggest mistreatment and violence, and minority youth suicide deaths particularly so. There is little public awareness that deaths in custody are always much higher than non-custody rates and that hanging is a common cause of death in custody. At an Aboriginal community level the number of Aboriginal suicide deaths in custody caused great concern, and both the overrepresentation of Aboriginal men in custody, and the fact that many Aboriginal youth were being arrested and held on charges relating to alcohol and violence, ensured that an increasing number of Aboriginal hanging deaths in custody were taking place. In particular communities, the hanging deaths of known individuals and relations—brothers and uncles, neighbors and friends—had dramatic impact. In Yarrabah the deaths of three men in custody in a period of three months, followed almost immediately by hanging deaths in police cells in other Queensland communities (Doomadgee, Wujal Wujal and Aurukun), and the custody-related death by hanging of a popular and well known Yarrabah youth in Melbourne, all served to foster and consolidate a community understanding of youth suicide, hanging, and deaths in custody as being somehow synonymous and interconnected. These suicide deaths in police custody in North Queensland in 1986 and 1987 constituted 40% of the total number of Aboriginal suicide deaths in police custody in Australia between 1980 and 1988, the initial time period investigated by the Royal Commission into Aboriginal Deaths in Custody!

It would appear that the salience, symbolic importance, and media coverage of the Royal Commission into Aboriginal Deaths in Custody in Australia acted as a catalyst to the phenomenon of non-custody youth suicide in Aboriginal communities, with a number of Aboriginal deaths in police custody in North Queensland serving as an important precipitating event leading up to the establishment of the Royal Commission. These events brought national and international media attention and coverage to communities such as Yarrabah and Palm Island, bringing the additional distress of media scrutiny, sensational coverage, substantial misrepresentations, shame, and an even greater sense of loss of control over events and 'community' problems, issues and information. As well, at a community level, the already powerful elements of suggestion, imitation, identification and modeling were heightened and exaggerated by media reconstruction, amplification, and sensationalisation, for young people in particular. The experience of many fourth world indigenous peoples is that media treatment and coverage, and indeed professional accounts of such phenomena as cluster suicide, quickly leads to particular stereotypes and understandings that are internalised by individuals and communities themselves, as well as being reified and validated by popular culture images, representations, and iconic explanations (causal accounts) and narratives.

While such hanging images are also and obviously powerful political statements and cultural responses in the larger context of the politics of representation and resistance (e.g., Attwood & Arnold, 1992; Beckett, 1988; Cowlishaw, 1993), we have consciously steered clear of a 'cultural studies', 'media studies', or 'oppositional culture' analysis (e.g., Brady, 1992c; Colishaw, 1993; Michaels, 1994). While such an exploration would undoubtedly provide a cogent and compelling perspective on the social representation and understanding of Aboriginal suicide, and the value of a more multidisciplinary, multileveled theoretical consideration, it might have deflected our more purposeful focus on the possible mediating role of such images, and the psychological centrality of one's own experience and understandings, and of one's own body as statement, text, locus of emotion, and domain of control. As well, the brief of the research included an examination of the

specific nature, character and meaning of hanging in further self-injury and suicide. Our present focus and analysis, however, does include the critical importance of such issues as identification, reactance, and control at the level of individual experience, and the power of images and representations and shared understandings and accounts at both individual and community level. The language and frameworks we have used derive from and are informed by social and cross cultural psychology and psychiatry, and a cross-cultural health and mental health literature which views cultural context, history, meaning and sense making as an integral part of individual and community health and well being (e.g., Bruner, 1990; Chen et al., 1994; Dasen et al., 1988; Freund & McGuire, 1995; Howard, 1982; Hunter, 1993; Kleinman, 1987, 1988; Kunitz, 1994; Marsella et al., 1996; Reid & Trompf, 1991; Shweder, 1991; Sloan & Montero, 1990; Weiss & Kleinman, 1988).



Some three decades ago the suicide of an Indigenous Australian was a rare occurrence. As this study has documented, this is no longer the case; the rate for Indigenous young men is now higher than for young people in the wider society, the increase being particularly dramatic since the late 1980s. It is clear, then, that the risk of suicide within Indigenous Australian populations is increasing. However, as this work demonstrates, this increasing risk is unevenly distributed across both place and time. Furthermore, this and other work suggests that, in at least two senses, in considering Indigenous Australian suicide the concept of 'risk' must necessarily be broadened. First, the vulnerability of individuals to deaths as a result of self-violence must be located within changing patterns of deaths from interpersonal violence and other non-natural causes (Hunter, 1993). The association with alcohol is equally strong across these categories and must be considered not only in terms of the direct effects of consumption (intoxication and impulsiveness), but also in terms of its social and developmental consequences. The second is a reality well recognised by practitioners and reinforced by the findings of this research—whereas it is possible to identify particular communities where the risk of suicide is elevated (in which a substantial proportion if not all of the most vulnerable group—young men who drink heavily—may be considered 'at risk'), greater precision at an individual level remains elusive. Indigenous suicide is a highly impulsive act and, consequently, frustrates interventions that focus solely on addressing risk at an individual level.

These two dimensions of risk are closely related and, in considering their interaction, must also be differentiated. Clearly, risk is elevated for those individuals, particularly males from their teens through to the fourth decade of life, who are members of communities in which suicide has become common—the best indicator is at a social or community level, what we have called the **'community at risk'**. Furthermore, risk of death by suicide is associated with a particular lifestyle in which there is elevated potential for harm from a range of behavioural outcomes—that is to say, at an individual-level, the best indicator of risk is a **'lifestyle of risk'**. There are both obvious and less apparent features of the relationship between these two dimensions; to state the obvious in different ways, a community is at risk when lifestyles of risk are common or normative among young adults, and, lifestyles of risk are more common when a community accepts, tolerates or accommodates such behaviours among its members.

Alcohol misuse is a key association with both and may well function in a manner resonating with MacAndrew and Edgerton's (1969) conception of 'drunken comportment'. These authors contend that: "over the course of socialization people learn about drunkenness what their society "knows" about drunkenness; and, accepting and acting on the understandings this imparted to them, they become the living confirmation of their society's teachings" (p. 88). In this construction people become socialised not only to the way alcohol is used in a culture, but also to the manner in which its effects are manifest behaviourally and socially. Thus, in certain indigenous societies (including Indigenous Australians), heavy binge drinking has become normative among young adults and patterns of endangering and violent behaviour have emerged as expected consequences (Hunter, 1993; Reser, 1989c). However, there are communities and individuals for whom heavy consumption of alcohol is not currently associated with self-harmful behaviours. Such use of alcohol, then, appears to be a necessary but not sufficient precondition, its impact mediated by the associated lifestyle of risk but demanding certain other contextual factors for this to express as self-harm.

Alcohol and the behaviours associated with its misuse are thus clearly critical to understanding Indigenous suicide. This may appear, again, simply to be restating the obvious; alcohol has been consistently incriminated as an appealingly evident 'cause' of a wide range of social and health problems in Aboriginal and Torres Strait Islander populations for decades. In relation to suicide, this is entirely understandable; following a death by suicide there is generally a search for more-or-less proximate causes or explanations—depression, loss, illness, anger, hopelessness and so on. For most Indigenous suicides this usually points to or includes alcohol misuse and a recent event, the latter often appearing 'trivial' to the outsider's eye. However, these are at most the precipitants, tipping the balance against a background 'lifestyle of risk'.

There is some evidence to support this 'enabling' rather than causal role of alcohol use. For instance, research conducted in the Kimberley in the late 1980s (Hunter et al., 1991) on a stratified random sample of 538 Aboriginal residents of the region explored the association of alcohol and self-harmful behaviour, including both impulses to self-mutilation and suicide, and acting on those impulses. Both reports of past thoughts about and impulses to self-harm, and reports of acting on those impulses were strongly related to age, being more common among younger informants. While the association between frequency of alcohol consumption and impulses to self-harm was present but relatively weak (occurring across all groups regardless of drinking status or frequency of consumption), there was a much stronger relationship between frequency of consumption and having acted on those impulses. When age and gender were controlled for in the analysis, frequency of drinking and quantity of alcohol consumed per drinking day were only weakly associated with thoughts or impulses to self-harm. Further, frequency of drinking was only moderately associated with acting on those impulses. However, a very strong relationship emerged between the quantity consumed per drinking day and both self-mutilatory acts and suicide attempts. It thus appears that heavy intoxication functioned in this

group as an ‘enabling’ rather than a causal factor, facilitating the impulsive enactment of existing thoughts of self-harm. Patterns of heavy consumption inform and sustain the lifestyle of risk within which particular events and circumstances (including binge drinking) function as catalysts for violence, the objects of which (self or other) may, to a certain extent, be arbitrary (Hunter, 1993).

The less obvious aspect of risk is that which distantly precedes the event. That young adult Aboriginal males are currently at heightened risk of death by self-harm clearly reflects a vulnerability that relates to gender and age. Although this is also the case in the wider society, the concentration of deaths by suicide among young adult males is significantly more pronounced in the Aboriginal population and the rate of increase in suicide rates for this group is even higher than among young men in the wider population. However, while the concentration of deaths among young adult Aboriginal males may be attributed to characteristics of age (heavy drinking, reckless and endangering behaviour), it may also be a consequence of all that has preceded. In other words, the vulnerability of contemporary young adult males may have been informed by the nature of their childhood development and socialisation which, in turn, for those in the suicide-vulnerable age group today, is a function of the social circumstances of Indigenous communities in the 1970s and 1980s (Hunter, 1990; 1991; 1993). Similar analyses have been undertaken for indigenous populations elsewhere (e.g., O’Neil, 1986; Howard, 1974). If this interpretation is correct, that is, that young adults are at greater risk of death by suicide because of **developmental** factors rather than, simply, because of their age, then it has significant implications both for this group as a cohort, and for those younger Indigenous people exposed to similar developmental influences. It suggests, first, that those currently at risk may carry that risk with them as they age, vulnerability extending to more closely approximate the general pattern of the wider society and, second, that this age-group will retain particular vulnerability if the context of development and socialisation remains unchanged.

We believe that in terms of the relationships between age and risk, the vulnerability of young adult Aboriginal men reflects both **behavioural characteristics** of this age group, and the past **developmental experiences** of contemporary young to middle aged adults. We also believe that alcohol misuse is common to both. A lifestyle of risk clearly involves heavy drinking and its attendant endangering behaviour with patterns of binge drinking being associated with the transformation of impulses to self-harm into physical acts. However, this behaviour is not only an end point, but contributes to the social context of a community and, thus, to the developmental environment in which its children are being raised. That group at greatest risk today, young adult to middle aged men, are among the first generation across large sections of Aboriginal Australia to have grown to maturity since the convulsive social changes of the 1970s. While there are many features of those changes and their consequences, the social impact of widespread drinking (which became common around that time) on community life is both particularly evident—and enduring. Put simply, that generation among whom the risk of death by suicide is particularly high (and among whom lifestyles of risk are common) have grown up in communities in which lifestyles of risk associated with alcohol misuse were becoming common and entrenched among those who were beginning to parent and who constitute the contemporary middle to older aged population. While a young adult lifestyle of risk in association with drinking is common to both groups, they are distinguished by both their propensity for self-harm and their childhood environments.

These interpretations are neither new nor unique to Indigenous Australia. In a submission to the Canadian Royal Commission on Aboriginal Peoples (1995) for a special report on Aboriginal suicide, Chief Jean-Charles Piétacho of the Mingan First Nation evocatively described an environment of developmental risk:

> Collective despair, or collective lack of hope, will lead us to collective suicide. This type of suicide can take many forms, foreshadowed by many possible signs: identity crisis, loss of pride, every kind of dependence, denial of our customs and traditions, degradation of our environment, weakening of our language, abandonment of our struggle for our Aboriginal rights, our autonomy and our culture, uncaring acceptance of violence, passive acknowledgment of lack of work and unemployment, corruption of our morals, tolerance of drugs and idleness, parental surrendering of responsibilities, lack of respect for elders, envy of those who try to keep their heads up and who might succeed, and so on. (p. 38)

Chief Jean-Charles Piétacho's submission captures a psychosocial state in which past and present combine to create an atmosphere primed for self-harm. In a sense this may be considered the **'risk condition'** (Hawe et al., 1997), a confluence of historical, developmental and contextual factors that includes widespread lifestyles of risk, and that is a precondition for a community being at risk. Lifestyles of risk endanger those engaging in such behaviours directly and immediately, but also increase the developmental vulnerability of those children and young people in families impacted by such behaviours. A community is at risk when such behaviours are widespread and there is an atmosphere of resignation or fatalism. Together, this constitutes the risk condition.

Reflections and implications

This project has identified numerous factors that are related to Aboriginal suicide in North Queensland and very probably elsewhere in Australia. These factors interrelate in complex ways that defy a simple pathways approach—there are many pathways to harm and the risk condition in Indigenous communities appears to provide more than sufficient explanatory power in relation to particular suicides. Indeed, this echoes findings from the Canadian Royal Commission on Aboriginal Peoples (1995). Having commented that "a significant number of Aboriginal people in this country believe they have more reasons to live than to die" (p. 2), the Commissioners note that: "By and large, the research tells us more about why a few people choose death or self-injury than why most choose life" (p. 20). The Canadian report similarly identifies a range of causal factors: psycho-biological; life history or situational factors; socio-economic factors; and, culture stress, which is defined as: "the loss of confidence by individuals or groups in the ways of understanding life and living (norms, values and beliefs) that were taught to them within their original cultures and the personal or collective distress that may result" (p. 21). These factors, the Commissioners contend, have "created lives characterised by risk" (p. 21).

The findings of the Canadian Royal Commission are of obvious relevance in considering suicide in Australia's Indigenous populations, not only in terms of the similarity in social circumstances, but also with respect to background factors. Indeed, the Commissioners:

> concluded that high rates of suicide and self-injury among Aboriginal people are the result of a complex mix of social, cultural, economic and psychological dislocations that flow from the past into the present. The root causes of these dislocations lie in the history of colonial relations between Aboriginal peoples and the authorities and settlers who went on to establish 'Canada', and in the distortion of Aboriginal lives that resulted from that history.
>
> We have also concluded that suicide is one of a group of symptoms, ranging from truancy and law breaking to alcohol and drug abuse and family violence, that are in large part interchangeable as expressions of the burden of loss, grief and anger experienced by Aboriginal people in Canadian society.
>
> On both grounds, we are convinced that an adequate response to the crisis of suicide among Aboriginal people cannot be limited—either to crisis services in the absence of long-term family and community supports, or to narrowly focused suicide prevention programs without reference to the web of related social problems in which communities may be caught. An adequate response to suicide must entail an overall healing strategy. It must speak to the many forms taken by self-destructive behaviour in Aboriginal communities and to its underlying causes. It is not enough to treat desperate individuals and the immediate sources of their despair—although such treatment must be the starting point of a comprehensive suicide prevention strategy. As well, Aboriginal people must gain the means to address long-standing needs of families and communities and to redress the imbalance of power between themselves and other Canadians from which so much distress flows. (p. 2)

Our analysis of Indigenous suicide in North Queensland is, fundamentally, consistent with these findings from Canada. Viewing the available material from different professional and analytic stances, a series of images have been constructed that, superimposed, provides for depth of vision beyond the two-dimensionality of 'monocular' analyses. In this final section we shall address implications arising from each point of view in turn and then address common themes.

From the **statistical** analysis carried out on data describing suicide in the Queensland Aboriginal population both conclusions and caveats are warranted. Since the late 1980s suicide and self-harmful behaviours have become increasingly common in North Queensland Aboriginal communities. This study has been fortunate in being able to access information judged to be both complete and accurate on deaths by suicide from a number of communities, drawing on both official statistics and community-based information. Through the analysis of such data it has been possible to demonstrate empirically that suicide is indeed a serious problem, that the risk is much greater in the Aboriginal population (particularly the young male population) and that such acts are not random, but tend to be patterned across place and time.

In our discussion we have characterised the pattern of suicide as 'epidemic'-like. In drawing this comparison, it is not suggested that suicide acts as a simple contagion, or that patterns of suicide will 'naturally' conform with the distribution or transmission features of an infectious disease. However, the contagion model is useful to the extent that it forces consideration of these features, in the case of self-harm the element of memetic communication being a behavioural 'option' to people undergoing crisis. Rather than a social 'pathogen' of suicide, it is the idea of self-annihilation as a possible course of action, which is in turn influenced by an accompanying set of associations (political, emotional, cultural...). The mechanism of this contagion between Aboriginal communities across northern Queensland is very different from those affecting behaviours in other documented cases of suicide clusters. In this case it is not the media primarily that is responsible for spreading 'the word' (though, as we have clearly suggested, it has played a significant part), rather the dense social and interpersonal networks that exist within and between Aboriginal communities in the north are the vehicle. Once established in a community's consciousness, suicide becomes another possibility in a behavioural repertoire, interacting with other constructive and destructive means of coping.

Having drawn these parallels, we are aware that there is a real danger inherent in conceptualising suicide as an epidemic or, indeed, in medicalising self-harm. Such constructions may support fatalism in the face of what appears to be intractable social problems. Alternatively, as many effective treatments and preventive measures exist for infectious diseases, it might be presumed that there are 'treatments' similarly able to contain self-harm. Clearly, neither is the case. Indeed, the medical model construction of suicide may itself become a risk factor, either entrenching fatalism or unrealistically suggesting simplistic solutions.

The findings of this study emphasise the necessity of timely and appropriate data collection by Aboriginal communities. While reliable regional and supra-regional collections are critical for planning and monitoring interventions, this level of information is not sufficient for planning at a local level. While there are obviously difficulties to be overcome before local communities are in possession of the necessary resources and skills, there is no reason why the collection of relevant information, about self-harm and related factors, cannot be undertaken at a local level.

Much has been made of the trend in youth suicides, rightly a serious social and public health issue, which has attracted both media attention and directed government funding. What has not been adequately established, in particular in the northern part of Queensland, is how much of this perceived elevated risk of suicide among the young in the population is attributable to age, and how much to Aboriginality. As demonstrated in the history of self-destructive behaviour through time in Yarrabah, a noted persistence is the case. While no simple connection exists between acts

of deliberate self-harm, suicide threat and actual suicide, the fact that those recorded as committing suicide invariably demonstrated a history of self-injury or threat does point to increasing levels of risk through time. As this youthful population ages, more people will enter the age range of increased risk, while risk is retained in aging cohorts who are currently engaged in self-destructive behaviour.

From a more **psychological** perspective it appears that the volatile ingredients are a precipitating event or set of events, at least three or four individuals in a community at high individual risk, often from high risk families, and perhaps some underlying and unresolved interpersonal or community conflicts. Against this background, a week of binge drinking, a death, news of a hanging of a known individual from another community, all can trigger a wave of individual responses embedded in a community culture and collective response. We contend that, regardless of the apparent 'meaninglessness' of such behaviour to the casual observer, it is, rather, suffused with both conscious and unconscious meanings, both private and shared.

Understandings and explanations exist and operate a number of levels, including individual, community, media, popular culture and professional levels (Antaki, 1981; 1988; Gregg et al., 1979; Semin & Gergen, 1990). What we have offered, with respect to symbolic meaning and cultural context, is an academic and professional explanation and account of the salience and importance of hanging suicide. In this instance we are addressing how media representations and images, and symbolic connections and associations, influence popular culture and community level understandings and accounts, and how these in turn influence and mediate self-injury and suicide. We are aware that such professional accounts and explanations can influence and impact on both media coverage and community understandings, and that there are important issues and considerations here relating to professional and academic representations (e.g., Farr, 1993; Sampson, 1993). We would note that one of us is an Aboriginal person with extensive experience working in an Aboriginal community as the coordinator of a suicide prevention program. We are also very cognisant of the fact that accounts and explanations such as those offered here are typically used to inform and direct interventions, programs and policies. Indeed we have attempted to creatively canvas alternative ways of thinking through the issue of Indigenous suicide in the communities in which we have worked, in the hope that such reflection might 'throw out' novel and effective prevention implications and possibilities. This has made us think carefully about the possibility that **accounts and explanations of suicide can constitute important risk factors in their own right**, as they are directly involved in the understanding and experience of suicide, and are implicated in suggestion, imitation, identification and modeling, as well as expectations and self-fulfilling prophesy. Indeed we have attempted to make the case that community level accounts and explanations of suicide contribute to risk to the extent that they communicate and validate external attributions, fatalism, possible and positive options, etc.

What is not often discussed or considered is that alternative accounts and explanations can also serve as important and effective preventive interventions in their own right. Such accounts and causal explanations, however, must be cogent, credible and congruent with community cultural context, expectations, and requirements. In an Aboriginal cultural context this requires explanations that can become community accounts and understandings, that can address and counter existing understandings, and that have the potential in turn to influence and inform their own prevention efforts. It is arguable that in the absence of alternative and credible accounts and explanations, Aboriginal communities have generated their own community-based, media-influenced, experience-limited explanations for why this youth suicide phenomenon, and other social problems, were becoming such a salient and distressing part of everyday life in these communities. Accounts such as those featured in the London Sunday Times simplify, caricaturise and distort community level accounts and understandings, but also strongly influence and

'validate' certain understandings. Accounts and explanations are also strongly influenced by images, symbolic expression, and media representations, such that narratives and causal explanations are even more condensed, image-based, and less likely to be critically analyzed and evaluated. The logic, argument and causal analysis becomes an iconic argument and logic, with an appealing and immediate message and explanation.

From this symbolic analysis perspective we believe that what is needed are alternate ways of thinking about and explaining Aboriginal youth suicide:

- which counter existing and risk-laden community level accounts;
- which counter suggestions of external control, compulsion and invitation;
- which separate suicide death from deaths in custody;
- which sensitize individuals and communities to the simplistic and problematic 'logic' and cue value of particular images and symbolic representations;
- which sensitize communities to the role of images and representations in facilitating suggestion, imitation, identification and modeling;
- which are culturally and community sympathetic in providing a satisfying and useful explanation that has clear prevention and solution implications;
- which clearly underscore the mediating role of alcohol; and,
- which the community can assimilate and integrate into their own narrative and account of why these phenomena are taking place in their community and how they are responding to this challenge.

It may be possible to frame such discussion of accounts, explanations and sense-making in terms of 'narrative' approaches. Indeed many personality, social psychological, and clinical and counselling approaches in psychology make particular reference to the fundamental importance of causal explanation and attribution processes in sense making, and emphasise the narrative structure and storied quality of individuals' accounts of their own and others' experience and life 'stories' (e.g., Bruner, 1990, deRivera & Sarbin, 1998; Harvey et al., 1990; McAdams, 1993; Sarbin, 1986). Such narrative approaches have been very cogently applied to cross-cultural differences in narrative traditions, story elements and lines, and illness representations (e.g., Geertz, 1983, Howard, 1981; Kleinman, 1988b; Shore, 1996; Vinden, 1998). Importantly, narrative approaches are increasingly used in counselling and therapeutic contexts (e.g., Freedman & Combs, 1996), including in Aboriginal settings. Following the Royal Commission into Aboriginal Deaths in Custody narrative therapy approaches were adapted in South Australia to address collective experiences of loss and grief and were subsequently expanded to broadly address recovery from traumatisation (Aboriginal Health Council of South Australila, 1995). The current research findings and our own collective experience would suggest some caution in uncritically embracing narrative therapy as a best practice and evidence-based intervention strategy in the case of a community facing elevated youth suicide risk. However, the cogency of 'changing the story' at a community level with respect to an acceptable and credible explanation and account suggests that this may constitute a very promising avenue for intervention and prevention.

The **public health** perspective has sought to consider, variously, the idea of 'risk' and has foregrounded community development responses. This analysis emphasises the importance of addressing those underlying social inequities which inform the risk condition (Hawe et al., 1997). Clearly this is an issue of national importance which, sadly, will probably proceed fitfully and slowly. While this must be pursued, it is imperative that it not be to the exclusion of more targeted approaches (Hunter & Garvey, 1998). This is a critical tension that Syme (1997) has commented on in terms of promoting health in disadvantaged populations:

> insisting only on fundamental and revolutionary social change is dooming us to programs that will take years and generations to take effect. Since it is difficult to implement such major social change, it is easy to ignore inequalities because, they say, nothing can realistically be done about them. Moral outrage about inequalities is appropriate but may be self-indulgent. If we really want to change the world we may have to begin in more modest but practical ways. (p. 9)

This research supports the importance of underlying social disadvantage in the development of a condition of risk in Indigenous communities. Our findings are consistent with those from Canada suggesting the importance of the socio-psychological legacy of colonisation. However, the changes that have been demonstrated across place and time in North Queensland, and the experience of Yarrabah, suggest that it is possible to reduce the likelihood of the condition of risk being manifest as self-harm, even in the face of continuing social disadvantage. To that extent we are in agreement with Syme; our findings indicate particular opportunities for intervention at four levels; individual, family, community and society.

At an **individual** level Indigenous communities must clearly have access to a range of effective, appropriate and accessible crisis and counselling services. These should, however, be available regardless of the pressing demands resulting from clusters of suicides. This is an equity issue; such services are a basic right of Indigenous communities, not a solution to this particular problem. As Kosky and Dundas (2000) note in reviewing Queensland youth suicide by hanging:

> Mental health services are clearly inadequate for indigenous people in rural Australia. Eighty per cent of indigenous people living in rural areas do not have mental health services located within 25 km of their dwelling. Only 35% have access to a permanent doctor. (p. 840)

The predictable conjunction of self-harmful behaviours and alcohol use, and of dual diagnoses generally, should alert health care providers to the critical opportunities afforded them to intercede (Tucker, 1999). It is thus imperative that those working in Indigenous primary care settings have knowledge that alerts them to the risks at an individual level and skills to intervene constructively. There has recently been produced for the OATISHS a set of clinical guidelines to address alcohol-related problems in Indigenous primary care settings (Hunter et al., 1999), one section of which deals with alcohol and potential or actual self-harm (included as Appendix 3). The cross cultural literature on youth suicide, depression, emotional coping, and substance abuse suggests that issues of risk assessment, intervention, comorbidity, and mental health must make reference to cultural context and meaning to understand the nature of links between depression, drinking and suicide, and that these personal and shared meanings are ultimately what determines whether a particular and seemingly comorbid behaviour indicates psychopathological distress or a more benign coping strategy (e.g. Marsella & Dash-Scheuer, 1988; Kleinman & Good, 1985; O'Neil, 1986; O'Nell, 1993).

As our report demonstrates, Indigenous suicides commonly occur within a family setting and reflect family issues and dynamics. This, and the developmental impact of social contexts in which suicides are now occurring suggest important family implications. The family is a developmental crucible, the vessel within which events are made 'meaningful' and where they subsequently amplify, resonate and echo, with both immediate and delayed consequences. Flowing from these realities are several implications. Support for families generally which facilitates both the development of stability and resilience should be considered a priority. These must necessarily take into account cultural and local considerations.

Because of the damaging potential of lifestyles of risk, particular attention and resources should be made available to mitigate the immediate and developmental impact for families in which there are members caught up in such lifestyles. The familial clustering and the apparent potential for unresolved grief, and modelling in families in which suicide has occurred, clearly emphasises the importance of developing effective postvention strategies as a preventive measure—not only to address the immediate communicative potential among those at risk, but also to recognise and

respond to the developmental implications for younger family members. These strategies should be informed by the symbolic and representational issues addressed earlier.

At the **community** level there are suggestions from this study with implications both for causation and for response. We have discussed already the utility of the risk condition rather than risk factors in considering the community at risk. Implicit in this interpretation is a threshold effect which has, by others considering the issue of youth suicide, been identified as a "tipping point". According to Goldney (1999) the tipping point: "implies that there is a background base rate of a phenomenon, which results from many factors, and that there is a threshold or "tipping point" which once breached allows for a dramatic increase in the phenomenon" (p. 1). Goldney continues:

> It is important to note that the "tipping point" is consistent with the public health model that focusing on so-called high risk preventive/treatment strategies may not be the most effective way of tackling a community problem such as suicide. Thus, when there is mass exposure to risk, as is the case with the well established but unfortunately non-specific risk factors for suicide, even if there is only a low level of risk there is an opportunity for broader measures of control to exert an influence. For example, a small shift in one of the contributing sociological factors to suicide, a shift which just influences the "tipping point" to such behaviour in a large population, may have a far more wide-reaching effect on overall suicide rates than a more specific intervention aimed, for example, at treating those afflicted with depression or substance abuse. This is consistent with the public health "prevention paradox" that "a preventive measure that brings large benefits to the community offers little to each participating individual". (p. 1)

We contend that at the community level the most effective mechanism for addressing the threshold effect is through health promotion and community development initiatives. The experience of Yarrabah strongly suggests that this must necessarily include a fundamental reassessment of the community's relationship to deaths by suicide of its members—of owning the problem and seeking the core elements to solutions within the community itself. This may require a radical shift in tolerance or acceptance of certain behaviours, and instituting measures, at times unpopular, to address particular issues. This was the case with the decision by Yarrabah Council to close the canteen. This may not be an easy option for other communities, for instance, some communities in Far North Queensland are in the invidious position of being reliant on the sale of alcohol to fund essential community activities (Hunter et aal., 1998). However, those responsible for community governance and the wellbeing of residents should be aware of the health and social consequences of their decisions. This will require, as noted above, access to timely, reliable and locally relevant information, as well as the skills and resources to think broadly about community level responses.

At the level of Indigenous **society**, and its relation to the wider Australian society, clearly issues of social justice and reconciliation are critical. However, as already noted, that will be ongoing for a long time and, as in the earlier quote from Syme, there should meanwhile be investment in "modest but practical ways", that is, in addressing equity in the provision of appropriate and effective services to Indigenous communities, and in developing specific projects and programs addressing elements of the wider picture. Particularly salient in this regard is alcohol, which has been a recurring theme throughout this report. The demonstrated relation of heavy drinking to endangering lifestyles in Aboriginal communities (Gladman et al., 1998) and of binge drinking to the enactment of self-harmful impulses (Hunter, 1993), clearly signals that measures to address Indigenous alcohol misuse is a necessary component of any comprehensive approach. It is also, we contend, critical to strategies aiming to support the developmental environment of contemporary and future Aboriginal and Torres Strait Islander young people.

Considering interventions

From the above we believe a logical set of potential interventions flows. These are neither exhaustive nor, alone or in combination, sufficient to prevent further clusters of Indigenous suicide (using the contagion metaphor, the potential for self-harm is now endemic, population level 'immunity' is not a feasible or useful concept but prevention is). However, we also believe that the measures which follow are essential to any strategy that attempts to comprehensively address this important area. While the authors of this report have brought their own disciplinary perspectives to the analysis, the range of suggestions that follow is set within a public health framework, specifically, a set of initiatives that span the mental health spectrum of interventions, now commonly identified as the Mrazek & Haggerty (1994) model, which has been adopted by the National Mental Health Promotion and Prevention Working Party (1999) as the framework for the Mental Health Promotion and Prevention National Action Plan (subsequently re-released as the Mental Health Promotion, Prevention and Early Intervention, National Action Plan), and also in LIFE (Life is for Everyone), the national framework for suicide prevention (National Advisory Council on Suicide Prevention, 2000).

The mental health spectrum of interventions adopted in both of these national strategies defines three broad domains of mental health interventions (because of its focus on wellness rather than disorder, mental health promotion is not included in the intervention spectrum), these being: 1) prevention (universal, selective and indicated); 2) treatment (case identification and standard treatments; and 3) maintenance (compliance with treatment and reduction in relapse, and after-care). In terms of prevention, universal interventions target the whole population, selective interventions target individuals or subgroups at risk of developing mental disorders, and indicated interventions target those identified as having either precursor or prodromal features of, or predisposing markers for mental disorder (otherwise known as early intervention). An adaptation of the spectrum which includes mental health promotion (Hunter, 1997b) is presented graphically as Appendix 4. Mental health promotion may be considered as those activities which seek to increase: "The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities ... and achievement of individual and collective goals consistent with justice" (Australian Health Ministers, 1991).

While the spectrum of activities provides a framework for action, the Mental Health Promotion and Prevention National Action Plan also emphasises the importance of a developmental perspective in presenting opportunities for intervention, that is, taking account of the phase-specific needs, capacities and vulnerabilities of human social and emotional maturation. This orientation is also reflected by the in the recommendations contained in the report *Pathways to prevention: Developmental and early intervention approaches to crime in Australia* (National Crime Prevention, 1999). Indeed, there appears to be an intersectoral convergence across national social and health policy and initiatives that foregrounds a developmental orientation. We believe that this is appropriate and long overdue.

The recommendations stemming from this study are presented in a form consistent with the mental health spectrum of interventions. We acknowledge, as do both of the above important national initiatives, the importance of considering developmental factors and implications in the framing of interventions. Self-harm and child development are areas of immense sensitivity and the importance of appropriate process must ever be in the foreground. The recommendations that follow are far from exhaustive and, as the description of the experiences of Yarrabah should suggest, be they consistent with our suggestions or not, any interventions must be negotiated through and with Indigenous communities and organisations such that they support the capacity of Indigenous individuals, communities and organisations to exercise control over their own lives and destinies.

We believe that for initiatives to be effective they must necessarily have community support and in their implementation empower Indigenous individuals, communities and organisations. Planners must address sustainability as there is a very real potential for harm in projects that raise expectations only to disappear at the end of the funding cycle. Finally, initiatives should be considered in the light of State and Commonwealth strategies in the arena of self-harm as well as other related areas (such as crime prevention, substance misuse, and mental health promotion and prevention). We believe that to be effective, strategy in the area of Indigenous self-harm must include approaches across the following areas:

Health promotion and universal prevention—whole of community approaches

- Support for community development initiatives, particularly those fostering family wellbeing and an optimal childhood developmental environment;
- culturally appropriate school-based and community organisation-based programs to foster the development of emotional coping skills;
- support for developing a robust evidence base for such interventions including the transfer of the requisite evaluation skills to Indigenous communities and organisations;
- fostering intersectoral cooperation and collaboration such that communities have access to best practice, evidence-based, multidisciplinary programs and expertise;
- support for community to community dialogue and exchange of experiences, knowledge and skills relating to community-level responses to Indigenous self-harm;
- support for appropriate and acceptable health promotion and prevention initiatives aimed at reducing population level alcohol consumption;
- avoidance of negative stereotypes of Indigenous peoples and of Indigenous suicide in the mainstream media; and
- empowering communities through access to information including:
  - collection of accurate, reliable and relevant material at a community level which is available in a timely fashion for service and community planning;
  - collection of accurate information relating to Indigenous suicide at National, State and regional levels, and mechanisms for making this available in a timely manner to health and social workers and researchers engaged in and with Indigenous communities;
  - development of Indigenous expertise at all levels to collect, analyse and utilise the above information with adequate resources and support to sustain these activities; and
  - development of social indicator systems relevant to the area of community risk

Selective prevention—groups at elevated risk

- Facilitating discussion and dissemination of information regarding the potential negative impact of particular constructions of Indigenous suicide through Indigenous organisations and to Aboriginal and Torres Strait Islander communities;
- development and implementation of strategies to influence media reporting and portrayals of violence and self-harm;
- development of a strategy to address and counter current beliefs and understandings which present suicide as a reasonable and normative response to experienced pressures and emotional pain, and understandings which promote the notion that an individual is being encouraged or compelled to take their own life by others who have died in this way;
- support for health promotion and prevention initiatives aimed at Indigenous drinkers to prevent or reduce binge drinking;

- family support programs for those families impacted by lifestyles of risk, particularly those with a cross-generational history of coping problems and high-risk behaviour patterns; and
- statutory and resource support for communities to develop local strategies to address alcohol misuse.

Indicated prevention and early intervention—individuals at elevated risk

- Appropriate and adequately resourced community-based crisis response strategies capable of responding to instances of threatened or actual self-harm;
- adequate community-based capacity to respond to the immediate needs of individuals and families affected by a recent suicide (postvention);
- support for the development of appropriate approaches to counselling in communities;
- appropriate mainstream support for the above activities; and
- ensuring that primary care practitioners working with Indigenous patients are trained in the primary care management of alcohol-related problems and have the knowledge and skills necessary to manage self-harmful behaviours.

Standard treatments

- Direct access for Indigenous Australians to the same range and quality of emergency and mental health services (adult and child) as is available to the wider Australian population;
- ensuring that these services are functionally accessible, that is, appropriately adapted to the cultural needs of Aboriginal and Torres Strait Islander people;
- developing appropriate programs for the effective management of Aboriginal and Torres Strait Islander people with dual diagnoses (coexisting mental health and substance misuse disorders); and
- support for the development of alternative treatment approaches, including appropriated therapies (such as narrative therapy) and Indigenous therapies (Hunter & Garvey, 1998).

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Appendix 1

AISRAP Suicide Register: determination of suicide flow chart

ANY GIVEN DEATH		
	Examine cause off death as stated on post mortem	If not possibly a suicide DO NOT ENTER
	Possibly a suicide (e.g. drug toxicity, asphyxia, gunshot)	
	What is the actual method of suicide (9 digit ICD Code)	
THIS ALONE = ENTER AS PROB*	Did the method of death have a high likelihood of being a suicide (intent stated on post mortem eg: hanging, self inflicted gunshot wound, carbon monoxide) rather than possibly being a death by illness, accident of homicide?	NO = ENTER AS POSS*
YES = ENTER AS BRD*	Any witness to the actual suicide event (eg saw deceased jump from building)?	
YES = ENTER AS BRD*	No = was the intent stated (verbally or written)?	
YES = ENTER AS BRD*	No = any prior suicidal behaviour or attempts?	
YES = ENTER AS PROB*	No = Any history of psychiatric illness?	
YES = ENTER AS PROB*	No = Any significant stress (eg break up of relationship)?	
YES = ENTER AS PROB*	No = Did the deceased make an obvious effort to die (secrecy, complex plan etc)	
	NO = ENTER AS POSS*	

*** BRD = Beyond Reasonable Doubt**
*** PROB = Probable**
*** POSS = Possible**

According to the above approach, cases AISRAP codes cases according to three options (Baume, Cantor & McTaggart, 1998):

- Beyond reasonable doubt (greater than 90% certainty). The information supplied makes reference to one or more significant factors which, in combination, constitute a pattern highly indicative of suicide.
- Probable (50-90% certainty). The evidence provided is not sufficient to allow for a judgement of beyond reasonable doubt but is more consistent with death by suicide than by other means.
- Possible (20-50% certainty). Where the available evidence suggests a substantial possibility of suicide but this is short of probable. The inclusion of this category allows for later clarification through the collection of additional information in specific research projects. (p. 1)

Appendix 2

Suicide by year and gender, Queensland Aboriginal and Islanders (1990-1997, 1997 incomplete)

		Female	Male	Total
Year	1990	2	10	12
	1991	2	11	13
	1992	1	9	10
	1993	0	12	12
	1994	1	17	18
	1995	4	31	35
	1996	3	36	39
	1997	5	11	16
Total		18	137	155

Appendix 3

Alcohol with potential or attempted self-harm (Hunter, Brady & Hall, 1999)

Typical presentation

The primary care practitioner is called in the middle of the night by a health worker who relates that relatives of a young man have come to her house in distress. They have informed her that their 18 year old nephew has been drinking heavily and after an argument with an uncle has threatened to hang himself. He has been walking around holding a rope repeating "I can do it". This young man is not known to the practitioner but informants reveal a recent relationship break up.

Supporting information

Distinguishing an intentional attempt to die from a threat without intent is difficult. All threats should be considered seriously. While non-fatal deliberate self-harm is common among both males and females, completed suicide is more common among Indigenous males. Most deaths are in the 15 to 30 year age range and are likely to have resulted from use of violent (and thus more immediately lethal) means, particularly hanging and firearms (Harrison, Moller & Bordeaux, 1997). Indigenous suicide is usually impulsive and often occurs in the context of intoxication or in its aftermath. Indigenous suicide has only emerged as a significant problem in the last 20 to 30 years and the patterns of vulnerability remain labile.

For the primary care practitioner, the critical issue is dealing with the crisis at hand. Information should be sought regarding the event in question (where, how, precipitants, others present), and the individual's use of intoxicants (amount and timing), history of past attempts and past mental health problems. Additional information sought should include family history of attempted or completed suicide, recent personal events (such as relationship break ups, fights or deaths in the community, particularly if by suicide or other violence), the social and environmental context (social supports), and the availability of means for harm. Mental status examination should seek to explore intent, degree of planning, continuing self-

harmful ideation, perceptions of her or his current circumstances, capacity for future orientation, and the patient's expressions of hopelessness and helplessness.

Aims of intervention

The primary aim is to ensure the patient's immediate safety. If a weapon is involved it is not the practitioner's responsibility or role to attempt to disarm the patient, as threatened self violence can easily transform into violence to others. Measures should be instituted to maintain safety or supervision in the ensuing period, with arrangements for subsequent follow-up and evaluation.

Management—general

Assessment must include consideration of the patient's actions and stated intent as well as whether there are other features of the mental status that require immediate attention, for instance, whether the patient has significant withdrawal symptoms or delirium tremens, or whether there are psychotic features such as hallucinosis or paranoid ideation. After ensuring safety, attention should be directed to those conditions. In their absence, the practitioner should

attempt to engage the patient after discussion with responsible family members and other health workers. If a patient is prepared to talk, with or without an accompanying family member or health worker, the practitioner should gain the patient's confidence and define a short-term course of action that is clearly communicated to the patient, relevant health staff and the patient's relatives.

Management—refractory or complicated

Intoxicated individuals threatening self-harm are, more often than not, extremely agitated. If there is a weapon the police or community police should be involved. Onlookers should be discouraged, or the person given the opportunity to remove themselves from their presence. After ensuring that the situation is not imminently dangerous the practitioner should begin talking with the patient. The dominant affect may be anger or shame rather than depression. The practitioner (or Indigenous intermediary if that is more appropriate) should maintain a non-threatening and non-judgmental dialogue with the aim of gaining the patient's trust and confidence rather than uncovering psychological issues. The practitioner should be empathic, with the focus in the present, reflecting the patient's emotional state, rather than interpreting it.

Where possible it is safest to hospitalise or observe such patients until they can be fully assessed after the effects of alcohol have worn off. In some rural communities 'rooming in' facilities have been set up in association with the local hospital for such situations, allowing the patient to be medically monitored rather than be evacuated to an urban facility. These options may not be possible or may be rejected by a patient about whom there are persistent concerns but who does not appear to fall under the provisions of the Mental Health Act. In this event the practitioner should strive to maintain the confidence and trust of the patient and ensure that the patient leaves in the care of a responsible relative or health worker. He or she should not be left alone or provided with alcohol. The practitioner should communicate this to the patient's relatives and make sure that accessible firearms and other weapons are removed. Occasionally, sedation may be required. In the absence of withdrawal, psychotic features or unmanageable behaviour, the primary choice should be a benzodiazepine (diazepam) or a sedative antipsychotic (thioridazine). Time taken to manage these symptoms may also allow the patient to settle and the effects of alcohol to subside.

Further issues for consideration

Practitioners should seek to develop supportive relationships inside and outside of the community and be willing to use them. It is usually inappropriate and often counterproductive for the practitioner to take sole responsibility for management. Other health professionals or relevant community members should be involved (and perhaps take the lead).

Unfortunately, even the most experienced practitioners are confounded by the unpredictability of such situations; not every explosive situation can be defused and a suicide may occur. For the primary care practitioner this can be an emotionally devastating experience. Its effects may be compounded if the death has occurred in the context of widespread drinking, reverberating rapidly through the community. At such times the practitioner will have numerous and often competing demands made—to provide clinical care to other members of the community, to attend to the body of the deceased, to meet the needs of relatives and friends, to discuss the events with the police and work supervisors, to find out if there is anyone else at risk. It is recommended that practitioners take the time and space to maintain clear thinking, and take honest account of their own limitations in dealing with the situation. It is strongly recommended that the practitioner seek debriefing after such a situation has been managed. Many government services provide access to support and debriefing, including by telephone.

Key Points

Self-harm, threatened or potential

- Set a high criterion for accepting that the situation is safe.
- Situations involving intoxication and/or impulsivity are usually not safe.
- Liaise early with a psychiatrist.
- Prevent further drinking and keep the patient engaged or supervised until the situation is clarified.
- Reassure and observe in a safe, non-reinforcing environment.
- Communicate clearly with relatives and local staff.
- Use medications only with clear indications.
- Ensure active follow-up.

Appendix 4

Mental Health Spectrum of Interventions