ITEM 1.

New survey highlights impact of Aboriginal and Torres Strait Islander mental health conditions

28 April 2016

The National Mental Health Commission welcomes today's release of the Australian Bureau of Statistics' *National Aboriginal and Torres Strait Islander Social Survey, 2014-2015* (NATSISS). This survey provides a range of information about the lives and wellbeing of Aboriginal and Torres Strait Islander peoples, including for the first time those with self-reported mental health conditions.

Professor Pat Dudgeon, National Mental Health Commissioner and Chair of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), said:

"The survey provides further evidence of the greater support needs of Indigenous people living with mental health conditions, and their need for better access to mental health and support services. In particular, it highlights the need for integrated services that can work with both physical and mental health issues, and connect them to smoking and drug use reduction programs, as well as break down isolation, and provide support with education, employment and housing.

"The survey has implications for the Primary Health Networks (PHNs) and a recovery-oriented, consumer centred mental health system as it relates to Indigenous people. There is also implications for the National Disability Insurance Scheme as it works to support Indigenous people with a psychosocial disability. All these need to take into account the greater needs of Indigenous people with mental health conditions as they work in our communities."

Professor Dudgeon continued: "At the national level, and as the National Mental Health Commission recommended in its 2014 National Review *Contributing Lives, Thriving Communities*, dedicated Aboriginal and Torres Strait Islander mental health planning is required to meet these additional needs as well as to ensure a consumer focused mental health system that works effectively with cultural differences.

"We also need Indigenous mental health leadership at regional and state levels. The *Gayaa Dhuwi (Proud Spirit) Declaration* was developed by NATSILMH to provide a framework for Indigenous leadership in mental health and suicide prevention, and could be used to guide these efforts."

In closing, Professor Dudgeon noted that while further analysis was required, the NATSISS results are likely to confirm a continuing 'mental health gap' - measurable across several indicators of mental health - between the Indigenous and non-Indigenous populations.

The full publication is available on the Australian Bureau of Statistics website.

Representatives from the National Mental Health Commission will be attending the National Aboriginal and Torres Strait Islander Suicide Prevention Conference 5 - 6 May in Alice Springs.

"Even the most disadvantaged Australians should be able to lead a 'contributing life,' whatever that means for them and this simple goal will be our touchstone and yardstick."

Chair Prof Allan Fels AO
National Mental Health Commission

ITEM 2.

Aboriginal and Torres Strait Islander suicide: origins, trends and incidence

Page last updated: 2013

While suicide is believed to have been a rare occurrence among the Aboriginal and Torres Strait Islander people of Australia in pre-colonial times, it has become increasingly prevalent over recent decades, accelerating after the 1980s, albeit with variations in rates and in geographical distribution from year to year (ABS, 2012).

For example, the Royal Commission into Aboriginal Deaths in custody (RCIADIC, 1991) drew attention to the links between substance misuse and mental health disorders in the years and months before most of the deaths that it investigated. It also highlighted the disproportionate number of these deaths (over three-quarters) where there was a history of having been forcibly separated from natural families as children. The interconnected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion were all acknowledged by the Commission as contributing to the heightened risk of mental health problems, substance misuse and suicide (Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice; 2010).

The mobility of Aboriginal and Torres Strait Islander peoples between remote communities and regional centres, particularly in the more remote areas is another anomaly of Aboriginal and Torres Strait Islander suicide that needs to be recognised. This means that these locations need to be considered as part of a larger system when considering the occurrence of suicide and its impact on communities.

The age distribution of the Aboriginal and Torres Strait Islander population is much lower than that of the non-Indigenous population because of higher child-to-adult ratios and shorter than average life expectancy. This has important implications for understanding the psychological impact of suicide on families and the available community response capacity in terms of supports and services for treatment and prevention. It is also relevant to another distinct feature of Aboriginal and Torres Strait Islander suicide: the phenomenon of ‘suicide clustering’, where an unusual number of suicides and episodes of suicidal behaviour occur in close proximity to one another within a particular community or region (Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice; 2010).

It should also be noted that there have been significant peaks and clusters of suicides in some regions in the context of a generally wide distribution across most states and territories, particularly those with significant remote populations. There are significant fluctuations in rates from year to year in some states (De Leo et al, 2011).

Reducing suicide and suicidal behaviour among Aboriginal and Torres Strait Islander peoples is now a public health priority for all Australian governments (SCRGSP, 2009; 2011). The most recent Australian Bureau of Statistics (ABS) data on suicide in Australia reported that an average of 100 people of

Aboriginal or Torres Strait Islander origin ended their lives through suicide each year over the 10 year period from 2001-2010 (ABS, 2012). In 2010, suicide accounted for 4.2% of registered deaths of Aboriginal and Torres Strait Islander peoples (NSW, Qld, WA, SA and NT combined). After adjusting for the different age profiles of the two populations, the suicide rate or Aboriginal and Torres Strait Islander peoples was 2.6 times the rate for non-Indigenous Australians.Top of page

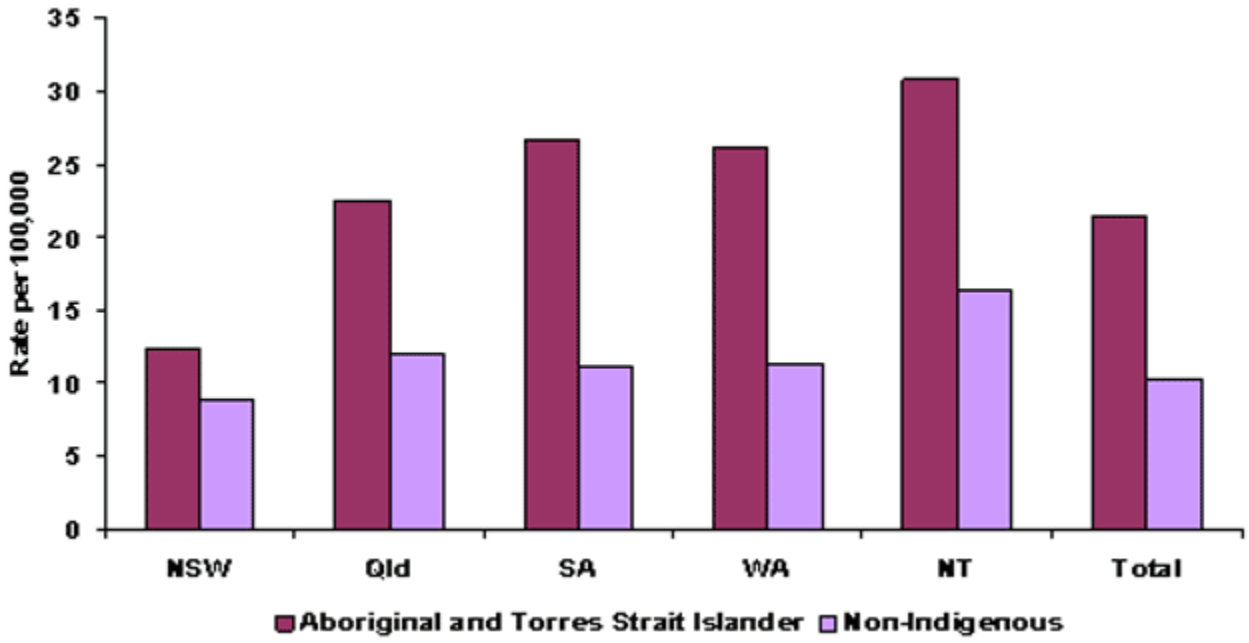
The 2012 ABS data for the period 2001-2010 show the overall (all ages) rate of suicide for Aboriginal and Torres Strait Islander peoples was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females. However, there was also significant variation in the age-standardised rates of Aboriginal and Torres Strait Islander and non-Indigenous suicide between the five jurisdictions having reliable Aboriginal and Torres Strait Islander mortality data. Due to small numbers it is difficult to detect significant variation by geography. Figure 1 shows that the Northern Territory appears to have the highest Aboriginal and Torres Strait Islander suicide rate of all jurisdictions, followed by South Australia, Western Australia and Queensland, all with substantially higher rates than New South Wales.[8]

Aboriginal and Torres Strait Island peoples also take their own lives at younger ages than non-Indigenous Australians, with the majority of suicide deaths occurring before the age of 35 years. Figure 2 shows that in the period 2001-2010, the greatest difference in rates of suicide between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians was in the 20-24 years age group for females and the 25-29 years age group for males.

The highest age-specific rate of Aboriginal and Torres Strait Islander suicide was among males between 25 and 29 years of age (90.8 deaths per 100,000 population), four times the rate for non-Indigenous males. For Aboriginal and Torres Strait Islander females, the highest rate of suicide was in the 20-24 age group (21.8 deaths per 100,000 population), five times the non-Indigenous female rate for that age group. For the non-Indigenous population, the highest rate of suicide occurred among males between 35 and 39 years of age (25.4 deaths per 100,000) and for non-Indigenous females (6.6 deaths per 100,000) at consistent rates across the age groups between 35 and 54 years of age.

The prevalence of self-harm presents a different picture, with rates of hospitalisation for intentional self-harm many times higher than the rate of completed suicide for both Aboriginal and Torres Strait Islander and non-Indigenous persons, with females hospitalised at higher rates than males (Figure 3). In 2008-09, the rate of hospitalisation for non-fatal intentional self-harm was higher for Aboriginal and Torres Strait Islander peoples (3.5 per 1000) compared to non-Indigenous people (1.4 per 1000) (SCRGSP, 2011: 7.68). For this same period, a higher rate of hospitalisation for non-fatal, intentional self-harm was recorded for Aboriginal and Torres Strait Islander females (3.9 per 1000) compared to Aboriginal and Torres Strait Islander males (3.0 per 1000), with both rates higher than hospitalisation rates for non-Indigenous males and females. Hospitalisation for self-harm was also higher in remote areas (4.1 per 1000) compared to major cities (3.5 per 1000) (SCRGSP, 2011: 7.68). A recent survey found that the estimated proportion of the population that would self-injure at some point in their lifetime for Aboriginal and Torres Strait Islander peoples was 17.2%, which was 2.2 times that reported by non-Indigenous participants (OR 2.2, 95% CI 1.5-3.3) (Martin et al, 2010: 15). Because of limitations in sampling (random telephone survey), this study almost certainly significantly understates differences in lifetime prevalence of self-injury between Aboriginal and Torres Strait Islander and non-Indigenous persons.Top of page

Figure 1: Age-standardised rates of suicide by jurisdiction and Indigenous status, NSW, QLD, SA, WA and NT, 2001-2010[7]



Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 Suicides Australia, 2010

Text version of figure 1

Jurisdiction	Aboriginal and Torres Strait Islander rate of suicide*	Non-Indigenous rate of suicide*
NSW	12.4	8.9
Qld	22.5	11.9
SA	26.7	11.2
WA	26.2	11.3

NT		30.8	16.4
Total		21.4	10.3

* Rate of suicide per 100,000

Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 Suicides Australia, 2010

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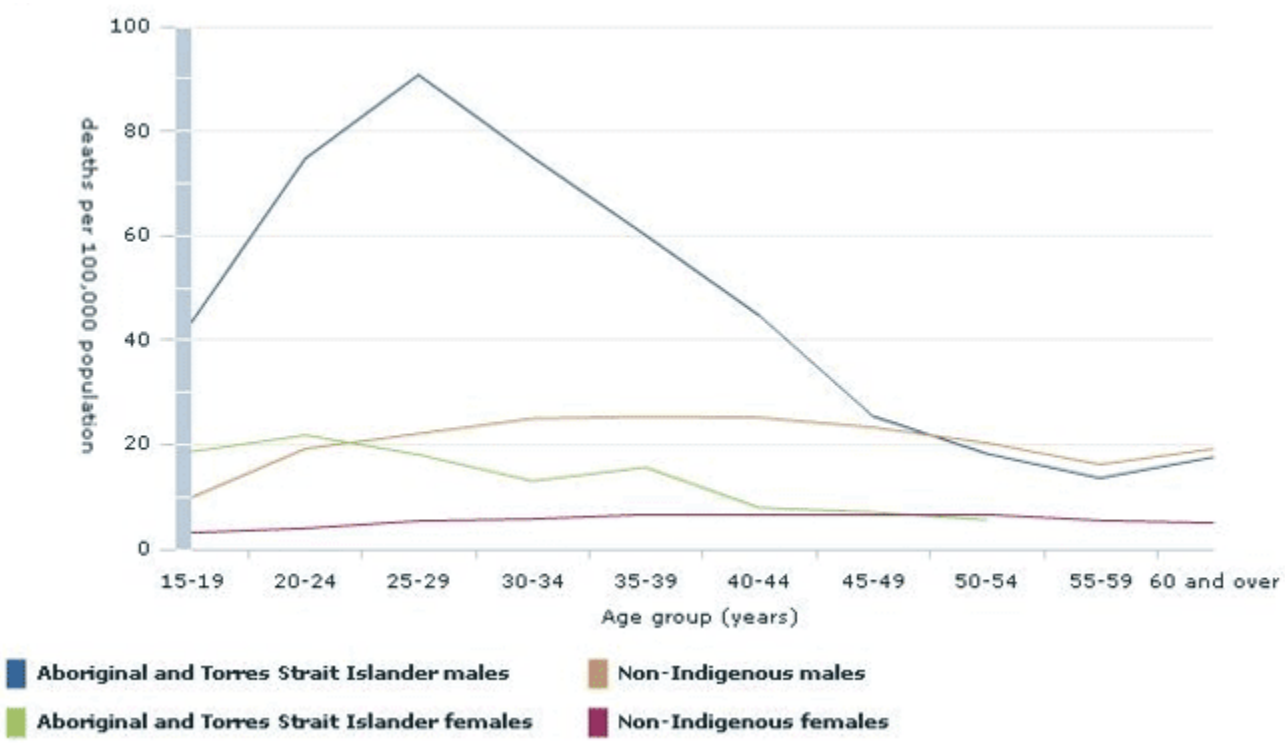
Figure 2: Age-specific suicide rates by Indigenous status and sex, NSW, QLD, SA, WA and NT, 2001-2010



Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 Suicides Australia, 2010

Text version of figure 2

Age group (years)	Aboriginal and Torres Strait Islander males*	Non-indigenous males*	Aboriginal and Torres Strait Islander females*	Non-indigenous females*

15-19	43.4	18.7	9.9	3.2
20-24	74.7	21.8	19.2	4.0
25-29	90.8	18.1	22.1	5.4
30-34	75.0	13.1	25.0	5.8
35-39	60.1	15.7	25.4	6.6
40-44	44.7	7.9	23.2	6.6
45-49	25.5	7.1	23.2	6.6
50-54	18.3	5.6	20.3	6.6
55-59	13.6		16.2	5.5
60+	17.6		19.2	5.0

* Rate of suicide per 100,000

Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 Suicides Australia, 2010

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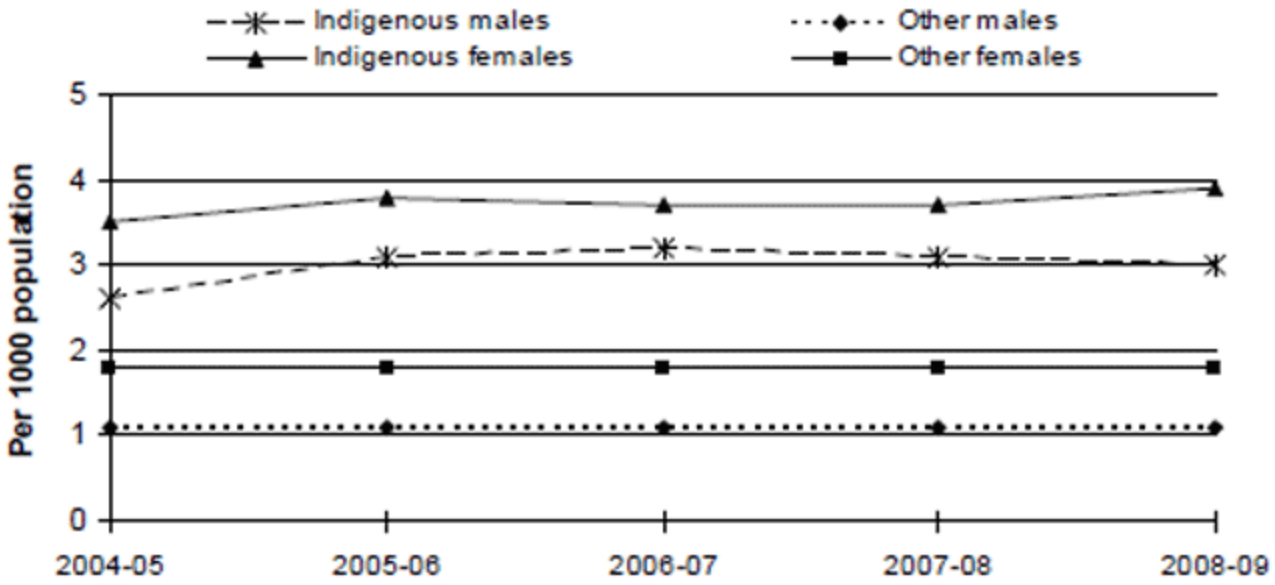
Figure 3: Age standardised non-fatal hospitalisations for intentional self-harm, NSW, VIC, QLD, WA, SA and public hospitals in the NT.



Source: SCRGSP, 2011: 7.68

Text version of figure 3

Year	Indigenous males*	Other males*	Indigenous females*	Other females*
2004-05	2.6	1.1	3.5	1.8
2005-06	3.1	1.1	3.8	1.8
2006-07	3.2	1.1	3.7	1.8
2007-08	3.1	1.1	3.7	1.8
2008-09	3.0	1.1	3.9	1.8

* Rate per 1000 population

Source: SCRGSP, 2011: 7.68

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Footnotes

[7] Age-standardised rates take into account differences in the size and structure of the population and are therefore more reliable for comparison purposes.

[8] Note: Due to small numbers recorded in Vic and Tasmania, data for these states are not shown to protect privacy.

Selected statistics

>30%

Percentage of Aboriginal people who are suffering from some form of psychological distress; same figure for all Australians: 20% [8].

12.4%

Percentage of Aboriginal people aged over 45 years with dementia. Same rate for non-Aboriginal people: 2.6% [1].

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Times Aboriginal people living in remote communities are more likely to develop dementia than people living in countries such as Africa, India or Indonesia [2].

ITEM 3.

Mental health worsens “dramatically”

A report in 2014 found “dramatic” increases in Aboriginal rates of youth suicide, anxiety and depression, as well as cognitive disability and mental health among offenders, and perinatal mental health [6].

Government programs need to take a long-term view rather than employ quick “start and stop” programmes or provide too narrowly focused and inadequate mental health services.

Aboriginal mental health and suicide still need to be researched more.
Improving mental health outcomes will have a flow-on effect to other areas, including reducing high incarceration and substance abuse rates.

Risk and protective factors for Aboriginal mental health

The following risk factors are interconnected, and a person with mental illness might show any number of them.

- **Widespread grief and loss.** This includes grief about the loss of culture, land, connection, and many more areas, often connected to the history of invasion.
- **Stolen children.** The impact of the past Stolen Generations and ongoing removal of children puts a lot of mental pressure on people, especially when government departments just follow procedures.
- **Unresolved trauma.** Trauma is a huge factor in Aboriginal health and an agent for many health conditions. If unresolved, trauma can debilitate a person and be passed on to the next generation.
- **Loss of identity & culture.** When Aboriginal people are separated from their culture and identity, for example when they don't live on their traditional homelands or don't know where they are coming from, they don't feel complete or search for who they are.
- **Discrimination and racism.** Discrimination based on race or culture, as well as racism, can have a huge impact on any person's mental health.
- **Few economic opportunities.** Due to other factors, many Aboriginal people are economically and socially disadvantaged. If you have to constantly worry about finance or how you are perceived by others, this worry contributes to mental illness.
- **Poor physical health.** Physical health problems contribute to the feeling of inadequacy and exclusion, and some people might stop socialising or exercising. 23% of Aboriginal people reported having both a mental health condition and one or more other long-term health conditions. [10]
- **Incarceration** Being imprisoned has a huge effect on people's mental health.
- **Culturally inappropriate treatment.** Especially the health area is prone to assess Aboriginal people with non-Aboriginal criteria, or expose them to culturally insensitive environments.
- **Violence.** Domestic violence, as well as violence in prisons, for example, contributes to poor mental health.
- **Substance abuse.** When Aboriginal people misuse substances to ease their inner pain, it can lead to follow-on issues, such as depression.

Despite the risk factors, there are also some positive, or protective, factors that help Aboriginal people deal with mental illnesses [9]:

- Social connectedness and sense of belonging
- Connection to land, culture, spirituality and ancestry
- Living on or near traditional lands
- Self-determination
- Strong Community governance
- Passing on of cultural practices

Traditional Aboriginal healing methods can support mentally ill people to recover, for example South Australia's Ngangkari program.

Source: https://www.creativespirits.info/aboriginalculture/health/mental-health-and-aboriginal-people#ixzz58Am1V7oN