ACCSCIENCE PUBLISHING

Journal of Clinical and Basic Psychosomatics

PERSPECTIVE ARTICLE

Bridging the gap: Policy recommendations to address suicides committed by Indigenous youth in Victoria

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Abstract

The Aboriginal population comprises 3.3% of the total Australian population, and youth represent 19% of this segment. In general, the Aboriginal inhabitants of Australia experience discrimination, limited access to education, and low socioeconomic conditions, and exhibit high mental disorder rates. The rate of suicide attempts by the Indigenous people of Victoria increased by 75% in 2021. This study examined the possible risk factors associated with suicides committed by Indigenous youth in Victoria. It focused on the health profiles of Victorian Aboriginal individuals, identified stakeholders who could help improve their mental well-being, addressed the needs and issues related to Aboriginal mental health, and examined substance abuse in this population segment. Finally, recommendations are offered to mitigate the studied problem. Rising suicide rates represent an urgent concern because they reflect the diminished mental health conditions of a society, particularly among its marginalized populations. It is crucial to develop an integrated suicide prevention act that takes into account the biological, psychological, social, cultural, and spiritual determinants of this population.

Keywords: Suicide; Mental health; Youth; Aborigine; Victoria; Australia

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Citation: Shoib S, Das S, Saeed F, Chandradasa M, Zaidi I. Bridging the gap: Policy recommendations to address suicides committed by Indigenous youth in Victoria. *J Clin Basic Psychosom*. 2025;3(1):52-58. doi: 10.36922/jcbp.4217

Received: July 11, 2024

1st revised: November 6, 2024

2nd revised: November 20, 2024

Accepted: December 2, 2024

Published Online: December 30, 2024

1. Introduction

As per the 2016 census, 0.9% of the Victorian population identifies as Aboriginal in origin. The Aboriginal people represent 3.3% of the total Australian population, and youth aged between 15 and 24 years form approximately 19% of this segment.[1] The education levels of Indigenous Victorians are improving, but their incomes and quality of life remain low compared to the non-Indigenous population and require further enhancement.[1]

The perception of discrimination and inequity is high among Indigenous Australians.[2] According to "The Youth Survey 2019," half of the surveyed Aboriginal youth were

optimistic about life, approximately one-third suffered from psychological distress, and almost 30% experienced bullying that impacted their sense of well-being.[3] In addition, Aboriginal youth were thrice more likely to experience homelessness than their non-Aboriginal peers.[3]

Suicides are also 3 times higher among Aboriginal youth under 18 than among other young Australians. This rate becomes 12 times higher than other Australians[4] if we only consider young people aged below 15 years. This section of Aboriginal youth exhibits poor educational attainment and employment, experiences forced cultural and housing-related displacements, perceives discrimination, and lives in poverty from youth to adulthood. The traumas and cycle of poor attachment continue from adolescence to adulthood for the First Nations people because they lack stability in early life. Transgenerational trauma stemming from historical abuse and forced displacement is often an underlying factor in youth suicides.[5]

In 2021, Victoria registered a 75% increase in suicide among the First Nations people compared to previous years.[6] Places in regional Victoria such as Mildura and Shepperton reported the highest suicide frequencies. Coroner's reports reveal that Aboriginal and Torres Strait Islander people in Victoria died by suicide at a rate three and a half times higher than non-Indigenous people between 2018 and 2021. Some themes related to deaths by suicide have emerged in recent years: anxieties resulting from suicide committed by a member of a close-knit community, the absence of support for people struggling with substance abuse, and increasing incidents of incarceration, domestic violence, loneliness, or failed relationships. The coronavirus disease 19 (COVID-19) pandemic and multiple lockdowns negatively affected the mental health of Aboriginal youth.[6] Several suicide prevention strategies are being implemented but suicides among Aboriginal youth continue to rise. As the Ottawa Charter suggests, integrating social, cultural, family, community, and personal factors will result in a better understanding of the prevailing problem.[7]

Thus, this study aims to deliver a snapshot of the present circumstances related to suicides by Aboriginal youth. It also attempts to outline the engagement of potential stakeholders to prevent suicides.

2. Health profile of the Victorian Aboriginal and Torres Strait Islander people

Children born to Victorian Aboriginal mothers are twice as likely to register low birth weights as babies born to non-Aboriginal mothers.[8] A Victorian Aboriginal woman is 45 times more likely to experience domestic violence than a non-Aboriginal woman.[9] An Aboriginal child in Victoria is 8 times more likely to qualify for child protection services than a non-Aboriginal child. Aboriginal Victorians are 4 times more likely to be homeless than non-Aboriginal people. Moreover, Aboriginal people aged above 18 years use tobacco 3 times more than non-Aboriginal people. Furthermore, Aboriginal Victorians are more than 4 times more likely than other Victorians to visit medical emergency facilities for alcohol-related reasons. Further, Aboriginal Victorians are approximately 3 times more likely to suffer from severe or extreme emotional distress than members of other communities.[8]

3. Needs and issues related to Aboriginal mental health

Dickson's systematic review revealed elevated rates of suicide, self-harm, and suicidal ideation in Indigenous youth vis-à-vis the non-Indigenous population. Common risk factors for suicides by Indigenous youth include a history of incarceration, substance use, and more significant social and emotional distress.[10] Heard's qualitative study explored discrete themes underlying perceived barriers to implementing suicide prevention strategies and reported perceived powerlessness, skill deficiencies, lack of resilience apropos factual discussions, perceived absence of professional support, and other systemic issues as commonplace themes.[11]

Cox conducted a focus group discussion and reported that mentoring, cultural values, and community cohesion were vital for the health and well-being of Indigenous communities.[12] Nasir and Kiseley's community consultation study highlighted factors that were counterproductive for suicide prevention programs in remote communities: inconsistencies in the content and delivery of gatekeeper training, time-consuming and unsustainable programs, and irrelevant materials. Societies must focus on the social, emotional, cultural, and spiritual underpinnings of community well-being in developing suicide prevention strategies.[13] Existing cross-cultural studies have identified some common themes associated with youth suicides, for instance, poor mental health literacy, cultural issues, lack of access, high stigma, unstable finances, and housing.[14]

Varied difficulties have been pinpointed to underpin the high suicide rates among Aboriginal youth in Victoria. The extant research suggests that 90% of Aboriginal people with mental health issues have expressed suicidal ideas in the last 12 months. Furthermore, mental health issues, including depression, have been detected in 90% of the population of individuals who have attempted suicide.[6,15] Females are more likely to attempt suicide but males have a higher rate of suicide deaths. Young people who do not conform to conventional gender roles are at greater

risk of committing suicide because of discrimination, rejection, and harassment: For instance, youth identifying as LGBTQIA+. In addition, individuals in remote communities are at greater risk of death by suicide because of limited support systems and restricted access to mental health resources.[6,15]

The risk of suicide is further escalated by the negative mental health effects of substance use and impulsive behaviors associated with it. Substance abuse is also intricately linked with domestic violence, unstable family dynamics, and myriad physical health issues.[6,15] In addition, the COVID-19 pandemic and multiple lockdowns imposed in Victoria impacted the mental health of the Aboriginal population.

Moreover, transgenerational trauma causes epigenetic changes and results in neurodevelopmental deficits.[16] Family violence and systematic discrimination also often retrigger trauma.[6,15] Transgenerational trauma must be addressed to prevent suicides, especially in communities affected by systemic oppression and historical trauma. The impact of trauma that remains unresolved across generations can manifest in community violence, substance misuse, and suicidal behaviors. Effective strategies focus on establishing trauma-informed services that respect cultural practices, build community resilience, and support cross-generational healing. The existing research emphasizes community-driven programs such as culturally embedded counseling and education, which help individuals connect with their identity and heritage, buffer against the adverse effects of trauma, and promote psychological well-being.[17] Out-of-home care is 10 times higher among Aboriginal children, and child protection notification rates are 7 times higher than the frequencies for non-Aboriginal children. In addition, a sizable proportion of the Aboriginal population lives in poverty with limited satisfaction of basic needs. It is known that poverty, inadequate access to health care, lack of trust, and overcrowded living conditions impact the mental health status of First Australians and increase their suicide risks.[15]

Specific cultural, historical, and political considerations contribute to the excessive prevalence of mental health problems in Aboriginal and Torres Strait Islander people and mandate a rethinking of traditional models and assumptions. In 2018 – 2019, 31% of Aboriginal Australians and 23% of Torres Strait Islanders aged 18 years and above reported experiencing severe or very severe emotional distress.[18]

4. Substance abuse and suicides by Indigenous youth

Substance abuse among Indigenous youth is regarded as a triggering factor for suicide and self-harm attempts.[19] The need to address the issues of substance abuse among Aboriginal youth is significantly unmet and requires immediate attention to prevent further damage.[20] Aboriginal youth reported less sociocultural control and exposure to modern adversities after colonization. Per the data obtained from the Australian Institute of Health and Welfare, alcohol abuse has doubled in the last decade in Aboriginal youth compared to non-Aboriginal populations. However, a steep decline in alcohol consumption has been observed in the community since 2022. The 2018 – 2019 National Aboriginal and Torres Strait Islander Health Survey compiled data on illicit substance use among First Nations people aged 15 years and above. The findings revealed that 25.2% of this population had used illicit substances in the past 12 months, and males reported significantly higher usage (36.7%) than females (21.1%). Age was also found to influence substance use, with younger people (15 – 29 years) reporting higher rates (32.9%) than individuals aged 45 years and above (21.2%). Marijuana, hashish, and cannabis resin were the most commonly used substances, and 24% of the respondents (31.4% of the males and 17.7% of the females) had used these items. Other substances such as heroin, cocaine, non-medical analgesics, sedatives, amphetamines, and ecstasy were reported in lower proportions, and the use of each category ranged between 3.3% and 5.9% of respondents.[18] Many remote communities are concerned about substance abuse among their youth and are worried about the ineffectiveness of prevention strategies.[20]

Psychological distress and low self-esteem increase the risks of substance abuse. Conversely, higher self-esteem, resilience, confidence, and a sense of ownership reduce the consumption of substance abuse in a population.[21] Chances of substance abuse are also diminished when health is prioritized, literacy is emphasized, and youngsters engage in sports. Low educational attainment, school dropout, and unemployment increase the risk of cannabis and other drug abuse among First Australians.[21] Moreover, young people who have been incarcerated are at higher risk of abusing cannabis, tobacco, and methamphetamine.[21] According to Snijder, younger people aged between 15 and 24 years are more prone to substance abuse and drinking and driving offenses. Males are more likely than females to abuse alcohol, smoke tobacco, and commit driving offenses. Peer pressure, social isolation, broken families, domestic violence, and partners with substance abuse issues increase the chances of substance abuse and relapse.[21] Indigenous populations in urban areas encompass high-risk factors for alcohol abuse and illicit drug use, whereas Indigenous people living in rural areas display higher likelihoods of tobacco use and drinking offenses.[22] Cannabis, crystal methamphetamine, and tobacco are increasingly available

among young populations because their access is unregulated.[21] A study conducted with Aboriginal women revealed that hopelessness, depression, and despair can result in alcohol abuse and suicide.[23]

A person struggling with substance abuse is 10 times more likely to commit suicide than the general population.[24] A meta-analysis pertaining to youth populations disclosed that substance abuse significantly increased suicide risk.[25] Substance abuse often causes impulsivity, reduces inhibition, or triggers ongoing stressors. Thus, people struggling with substance abuse feel incapable of coping with their circumstances; in general, alcohol abuse can increase suicide risk by 65%.[26,27]

5. Recommendations to help reduce suicides among Aboriginal youth in Victoria

The *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 – 2019* was developed to guide governments, communities, service providers, and individuals to identify key issues and prioritize action areas. This policy document acknowledges the need to implement culturally safe, evidence-based procedures to lessen damage from drug- and alcohol-related difficulties. The perspective is focused on reducing demand, supply, and harm through procedures that reflect the ownership of the Aboriginal community.[28] Thus, approaches to mitigate such damages must consider the biological, psychological, social, cultural, and spiritual determinants of substance abuse.[29]

Considerable stigma is attached to Aboriginal communities accessing healthcare, which is implemented using Western concepts and principles.[29] Perceived discrimination and absence of trust in culturally unsafe hospital environments often create a vicious cycle. Thus, Aboriginal youth do not seek appropriate care because they fear stigmatization.[30] Culturally safe community and school-based education programs must be instituted to improve resilience in Aboriginal communities.[31] Care-related policies and activities should be developed after consultation with Aboriginal leaders and persons with lived experience.[32] Currently, strategies focus primarily on hospital-based treatment. A home-based design should be optimized, which will require funding and workforce development.[29]

Evaluation strategies should measure the impact, acceptability, and appropriateness of programs designed to reduce suicides among Aboriginal youth. Such evaluations may be accomplished through community surveys or focused group discussions between healthcare workers in specific communities. The impact of programs can be measured through outcomes such as per capita alcohol and drug consumption, the number of presentations to emergency care facilities in each period, and data related to incidences of self-harm and suicide. The ratio of per capita substance consumption and healthcare access can provide awareness of the community's trust in the system. Follow-up consumer and carer surveys conducted after the completion of each home-based drug rehabilitation program can serve as excellent indicators of the effectiveness of newer strategies. Measures of specific outcomes such as the Health of the Nation Outcome Scales represent effective assessment tools for such rehabilitation programs.[33]

The benefits of culturally safe community-based programs include wider accessibility, trustworthiness, fewer restrictions, community acceptability, and family-focused and evidence-informed care provided in less intense environments. However, such programs can be resource intensive, require experienced and confident clinicians, be challenging to implement in remote settings and require robust risk mitigation processes in cases of worsening health.

A compelling need exists for widely available and accessible screening tools to assess and manage healthcare and rehabilitation programs. Targeting subpopulations mandates experienced, youth-friendly clinicians who are confident about providing evidence-informed treatment. The treatment approach should be culturally safe and should be developed after consultation with young people with lived experience. Appropriate referral pathways should be stipulated if the young person receiving treatment requires more intensive hospital-based care, which would boost the confidence of ground workers as well as family members. Young care receivers often value confidentiality regarding their treatments; thus, clinicians should be trained in the nuances concerning individual and family rights.

6. Identifying stakeholders to improve mental well-being

Indigenous suicide prevention stakeholders should be able to inform, support, or contribute to the implementation of integrated approaches to suicide prevention in community settings. At least one stakeholder should participate from each of the various groups such as community governance bodies, elders, health professionals, educational services, and recognized local leaders. The stakeholder composition can vary depending on the regional or metropolitan status of communities. The availability of the workforce and services can also influence the participation of different stakeholders.[34] Stakeholders function essentially in systems-based suicide prevention programs adopting structured governance and community-centered approaches. For example, the Tasmanian Suicide Prevention Trial Advisory

Group and the Primary Health Network (PHN) were instrumental in establishing guidelines, identifying priority groups, selecting focus areas, and providing foundational support for regional implementation. Their key responsibilities entailed ensuring that local working groups composed of community members, volunteers, and local organizations could operate effectively and tailor their suicide prevention activities to specific community needs. Working groups supported by host organizations such as local councils were responsible for the direct implementation of activities and endeavored to adapt the lifespan framework to the regional context. The PHN acted as a connector, facilitating essential partnerships with local organizations (e.g., the Coroner's office) to support data access and resource sharing. Host organizations helped bridge the gaps between the national model and local needs, leveraging community insights and fostering engagement to ensure that the undertaken activities were relevant and sustainable in their communities.[35] Multisectoral team members can introduce discrete strategies such as peer-to-peer suicide prevention training in the youth, understanding the distinctive needs of communities, and pushing local authorities to release funds. Further, stakeholders must advocate for the implementation of newer services, research, analyses, and evaluations of existing programs. Stakeholders need to codesign high-quality, culturally appropriate suicide prevention services for high-risk youth, create awareness, and motivate their specific communities to engage in the concerned programs.[36]

7. Youth-focused programs: A critical analysis

Varied programs focusing on culturally informed approaches that resonate with Indigenous identities and values have been designed to specifically address youth suicides in Australian Aboriginal communities. The "Yiriman Project" is a prominent example of such a program that involves at-risk youth in the Kimberley region. Young participants connect deeply with their heritage through bush trips and activities such as land care and cultural storytelling. These processes foster a sense of belonging, resilience, and community identity in the participants. Evaluations of the Yiriman Project have reported its positive effects on the mental well-being and reduced suicidal ideation of participants. Nevertheless, the program confronts pitfalls such as its excessive reliance on intermittent funding, which makes sustained efforts challenging.

Another initiative titled "Alive and Kicking Goals!" targets Aboriginal youth aged between 15 and 24 years. This program integrates suicide prevention messaging within peer education and sports settings. It leverages community sports events and deploys peer mentors to destigmatize mental health discussions and encourage help-seeking behaviors. Reports indicate that participants gain confidence and acquire knowledge about mental health resources. However, the program's reach is sometimes limited because of insufficient resources and geographic constraints in remote areas.

"Tough in It Out" is another notable program that aims to enhance resilience in Indigenous youth by building mental health awareness and inculcating practical crisis management strategies. This program is delivered through workshops, tackles common mental health issues, inculcates emotional regulation skills, and promotes peer support. The program effectively builds youth confidence in handling mental health challenges. However, its limited scale and inconsistent funding hinder it from wielding a broader community impact.

The *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* emphasizes culturally specific interventions targeting social, emotional, and mental well-being across multiple age groups and includes specific components for youth. It encourages community involvement and ownership and aims to empower Indigenous communities to drive customized suicide prevention efforts. The program is promising but its impact is often hampered by challenges in measuring long-term outcomes because of the absence of consistent evaluative frameworks.

Each of the mentioned programs highlights the critical role of culturally tailored approaches to prevent suicides by youth in Aboriginal populations. However, common pitfalls across initiatives include funding instabilities, limited scalability, and gaps in long-term outcome evaluations. These difficulties underscore the need for more sustained investment and systematic evaluation processes to comprehensively understand the effectiveness of programs and ascertain their potential for wider applications.[37]

8. Limitations

Our study is descriptive and based on a mix of peer-reviewed and gray literature. The studied topic is relatively under-researched; therefore, we were compelled to include information obtained from discrete well-recognized government websites. Furthermore, some information could have been updated during or after the publication of this paper because of continuing developments.

9. Conclusion

Understanding the conceptual framework underlying suicides by the Indigenous people in Victoria enables a

more wide-ranging grasp of suicide-related behaviors displayed among First Nation people in other countries. Numerous cultural differences exist between them, but a few similarities may be found in their cultural explanations. We believe this study could offer researchers in other nations some ideas about working on suicide prevention in Indigenous populations in their countries.

Acknowledgements

None.

Funding

None.

Conflict of interest

The authors declare no conflicts of interest.

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Conceptualization: Sheikh Shoib
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Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Availability of data

The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

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