10. Towards Alleviation

> There are always simple solutions to complex problems. And they're always wrong.
>
> —H. L. Mencken[1]

> Existential therapy focuses on death, isolation, meaninglessness and freedom issues, which are easy for American Indians to understand. Death crises occur more often for American Indians at an earlier age and, furthermore, the deaths of their ancestors (which came close to genocide) remains a powerful tribal memory. American Indians are aware of their isolation from mainstream culture. They are both isolated geographically and suffer from racism ... *Suicide by the American Indian, for example, may be seen as seeking freedom in death.*
>
> —David Lester[2]

Suicide 'prevention', especially in North America, is undertaken by doctors, who are mainly psychiatrists, psychologists, and mental health workers who are generally social workers or nurses. In the case of Indians and Alaskan Natives, tribal 'gatekeepers' are also involved in some programs.[3]

Only three grades of strategy are delineated. Primary 'prevention' focuses on psychiatric disorder, education of the physician doctors (and then of the children and parents), the provision of 'good general mental health services', psychotherapy for traumatised and sexually abused children, attempts to predict suicide, and a toning down of media hysteria about the subject of suicide. Secondary strategies include establishing suicide prevention centres, medical emergency services and hotline telephone services, and restricting access to lethal weapons. Tertiary strategies can only apply to those who have tried suicide but failed: essentially this involves counselling for those who make 'suicidal gestures'.

I prefer the words 'alleviation' or 'mitigation' to the conventional 'prevention'. One can only *prevent* what one *knows* is likely to happen, and then only of one can clearly identify a cause which can be ameliorated or mitigated. We do not know the causes of youth suicide. 'Prevention' has not diminished youth suicide in Australia, New Zealand, North America, the Scandinavian countries, Scotland, Sri Lanka or the Pacific Islands, in each of which the rates of youth suicide have escalated markedly. All we can do is try to slow, or deflect, the development of trends towards attempts at suicide.

More diverse people and professionals than those listed above are needed for successful alleviation. Who they should be will emerge from the following analysis.

Key Messages:

- **We do not know the causes of youth suicide. The best we can do is alleviate or mitigate what look like trends, or movements, towards suicide. We can't *prevent* it.**

- **Alleviation is not the sole domain of 'mental health' personnel. A wide range of people and skills is needed.**

I have assembled my conclusions and recommendations under nine headings: (1) philosophies and theories of suicide; (2) research directions; (3) 'prevention' projects; (4) treatment practices; (5) Aboriginal initiatives; (6) Aboriginal and non-Aboriginal co-operative programs; (7) coronial matters; (8) suicide and the role of the police; and (9) practical 'capacity-based' workshops, explained below.

1. The liberation of suicide ...?

(a) Biomedical or ethnic-centred philosophies

'An ethnoscientific or biomedical approach alone will lead us to a lot of mistakes.'[4] This was the considered view of James Shore in summarising the (significant) conference on American and Alaskan Native suicide in 1994. His suggestion is simple: to integrate both the biomedical and the ethnic-centred to arrive at a 'balanced and broader biopsychosocial perspective'. However, it is never simple to have new models accepted and implemented.

Were there to be an integration, then the greater accommodation would have to come from those with a biomedical bias. They appear convinced that biomedical research will provide the key to preventing suicide. That biochemical and genetic causes underlie suicide is, as I argue below, probably the most harmful proposition in suicidology.

Shore writes that most suicide research is descriptive rather than analytical. My view is that it should also be critical. There is a smugness and distancing about the accepted approach to suicidology which concentrates more on 'scientific method', chi square correlations and other statistical treatment than on understanding the individual's behaviour. It is also a way of avoiding getting emotionally involved with the suicide himself or herself. The vivid display of statistical pyrotechnics does not alleviate suicide any more than does the pathologising of suicide as a psychiatric disorder.

(b) Suicide needs all the lenses that can be focused on the phenomenon

Those working in this area need to be steeped in the history of suicide, and in the attitudes to suicide of medicine, religion, law, sociology and psychology to suicide; to be exposed to critiques of those attitudes; to be aware of the theories of writers like Hillman, who provide much broader and liberated perspectives; and, above all, they need the portraits of 'indigenous' communities, as provided so succinctly by Lester at the beginning of this chapter, which may induce a different way of thinking about 'indigenous' suicide—because it is different.

Key Messages:

- **Suicidology needs to liberate itself from a monocultural, narrowly-focused biomedical model.**

- **A separate Aboriginal suicidology must be established, with a greater focus on historical, political and social factors.**

2. Research directions

(a) Biochemical or genetic 'predisposing' factors

The research into biochemical or genetic factors which predispose people to behave in a certain manner is damaging to the people under scrutiny. There is no evidence of any fruits of such research. This direction is inapplicable to whole populations of people defined as Maori, Aboriginal, Amerindian or Inuit, where physical and cultural differences within the groups so defined are often greater than their similarities.

There was such an attempt at 'biological determinism' in the Northern Territory in the 1970s. The [then] Welfare Branch, responsible for Aboriginal affairs, was under media and parliamentary pressure about high Aboriginal infant mortality rates, then between 100 and 150 per 1000 live births as compared with 9 or 10 for non-Aboriginal infants. The Welfare Branch commissioned research into 'the psychological causes of infant mortality'—in effect asking the chief researcher, a zoologist, to see if there was an 'inherent genetic predisposition' in Aboriginal women to see their babies die! The huge report produced a negative conclusion, but her short chapter on the socio-environmental causes of infant mortality—all of which were the responsibility of the Branch—was excised with a razor blade before being made public.

I do not impute bad motives to those who now suggest research into these areas. However, it must be kept in mind that there are some people in biological research who do seek a genetic basis for race superiority and attempt to validate immutable biological determinism, which would then provide the physical proof for their ideologies

of racial hierarchy. The current discourse is in the field of sport, where arguments are adduced to show that black athletes have a genetic, or an evolved, metabolism that gives them musculature, speed, a set of reflexive actions and peripheral vision unknown to, or genetically *denied* to, non-blacks. John Hoberman's *Darwin's Athletes* has, I believe, demolished these propositions. The flaw lies in the ability of such genes and biochemistries to emerge in unbelievably short time spans. Thus 100m sprinters are said to win because they have descended from West African slaves: it is contended that they either had to endure great hardship, or escape from slavery in order to survive. Whatever their circumstances, one must presume that they had to endure or escape over longer distances than 100 or 400m. This model also presumes that they had been slaves for aeons, which is also a false presumption. In similar vein, if there is a genetic basis to Aboriginal youth suicide, why did it take until the 1960s to surface?

Key Message:

- **There is nothing of value to be gained by searching for a genetic or biochemical basis for suicide in youth who are members of a 'race', and whose 'racialness' might conceivably carry such a biologically determined predisposition.**

(b) Categorisation

(i) Research is needed into the categories of suicide I suggested in chapter 6:

- accidental risk-taking suicide;
- focal suicide;
- 'political' suicide;
- 'respect' suicide;
- grieving suicide;
- 'ambivalently rational' suicide;
- 'appealing' suicide;
- 'empowerment suicide'; and
- 'lost' suicides.

Categorisation is not understanding as such, but it does go some way towards explanation, and this may assist in the review of strategies for alleviation.

(ii) Research is needed into 'slashing up'**:** these acts of self-harm may not be self-harm, but rather an affirmation of life by seeing warm blood flow, or as the psychiatrist Neil Phillips suggests, a release from tension.

(iii) Research, and coronial practice, need to accommodate the extended tripartite

definition of suicide: those beyond reasonable doubt, those which are probable, and those which are possible.

(iv) Research should address attempted suicides, seeing them as part of a continuum, not as a separate category of 'the serious ones' and those 'who make gestures'. We know that many who try will try again, and that many who are dead had tried before. It is more logical to treat all who appear to try as being serious about wishing to end their lives.

(v) Research should give more attention to the increasing rates of both parasuicide and suicide among young females. I found that young females are as ready to engage in violent or aggressive behaviour as males, with teenage pregnancy the only prophylaxis against gang membership, petty crime and possibly more serious crime. Girls use tablets in preference to ropes and can often be resuscitated. However, female hanging is beginning, and those who are 'serious' will doubtless come to see the efficacy of that method.

(c) Age ranges

Research needs to abandon the conventional but inconvenient World Health Organisation cohort group of 15 to 24 for 'youth'. In the Aboriginal, Maori and Indian domains, there is every reason to narrow the focus onto an age grouping of 12 to 18 or 19. There is also an urgent need of a special category of child suicide, from 8 to 12.

(d) A separate Aboriginal suicidology

Research in suicide requires a separate Aboriginal suicidology. The Aboriginal and Maori phenomena are not a subset, a footnote, a by-product of 'mainstream' research data. No other cultural group in each of the two countries have the same origins, backgrounds, histories, socialisation, cultural milieux, family structures, experiences of racial discrimination, and alienation as do Aborigines and Maori. To persist in the search for 'standard' causality and to assume that a suicide is a suicide regardless of context is to be, at the least, unscientific and simplistic.

Key Messages:

- **Categorisation of Aboriginal suicide is useful in alleviation programs but does not of itself produce understanding of causes.**

- **Research directions, in a separate Aboriginal (and Maori) suicidology, should encompass attempted suicide, female 'slashing up', and female youth suicide in general.**

- **However convenient for World Health Organisation statistics on health, the 15 to 24-year-old cohort is inappropriate for a definition of Aboriginal and Maori youth: 12 to 18 is a more realistic range.**

- **A new category of child suicide, from 8 to 14, is required, since such suicides are indeed occurring in both communities.**

3. 'Prevention' approaches

(a) The National Youth Suicide Prevention Strategy

There is both activity and innovation in suicide 'prevention' strategies in Australia.[5] The National Youth Suicide Prevention Strategy, allocated $31 million between 1995 and 1999—supplemented in the 1999 federal budget—has four goals: to prevent premature death by suicide; to reduce rates of injury and self-harm; to reduce the incidence of suicidal ideation and behaviour; and to 'enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities'. The focus is on the public health model: even though it incorporates 'sensitivity to social and cultural context' by asserting that we need a 'variety of interventions and the involvement of multiple service sectors and government departments' is needed. A variety of professional training programs are under way. The Strategy embraces a 'community development approach', with two areas pinpointed for action: parenting skills programs and school-based 'mental health promotion programs'. The Strategy prefers 'mental health promotion' to the term 'primary prevention'.

The Strategy undertook a *National Stocktake of Youth Suicide Prevention Activities in 1997-98*. Of 919 programs in the *Stocktake*, only 75 were 'identified as belonging to the community development and support approach'. Of those 75, eight (including my study), related to Aborigines and Torres Strait Islanders; one (presumably my study) emanated from a university. It is important to note that New South Wales has in place, in addition to its 'We Can All Make a Difference: NSW Suicide Prevention Strategy', the development of suicide prevention programs for Aborigines in 1999.

(b) A specific Aboriginal emphasis

National and state strategies have to embrace specific Aboriginal 'wings' in all that they do.

A Strategy *Bulletin* quotes a Department of Family and Health Services publication listing of risk factors for suicide: among mental health problems, drug and sexual abuse, homelessness and unemployment, appears one other category: 'Aboriginality'![6] This may have been a shorthand, but it sits badly to have a national suicide body and a key government agency listing race as an inherent cause of its own self-harm.

What is meant by 'community development strategies' is too broad and ill-defined to apply to specific Aboriginal communities. The geography and demography of the Hunter-Reser study—one community which is physically separated from mainstream society and two island communities—cannot apply to the Aborigines in New South

Wales. There needs to be a separate Aboriginal strategy, and within that framework, a series of appropriate and region-specific strategies.

What has always bedevilled Aboriginal administration is the search for universal policies and practices, failing always because of the desire to implement simple and uniform solutions to complex problems.

Here is an opportunity to avoid repeating past failures, and to take the region-by-region, community-by-community approach, which is the long and difficult way round.

Key Messages:

- **Strategies for alleviation must have separate Aboriginal and non-Aboriginal 'wings'.**

- **There are no universal strategies which apply to all Aborigines, even within one state: the only path is the difficult one, region by region, sometimes community by community.**

4. Treatment practices

In contemporary suicidology concerning Amerindians, there is an expressed desire for euphemisms. Shore suggests calling prevention programs 'evaluation' programs, being a 'safer' term among people who feel stigmatised by the concept of 'prevention'. 'Fear of stigmatisation', he argues, 'has reinforced the avoidance of research for 20 years'. He presents an intelligent discussion about the hostility of Indians to research: 'in every Navajo *hogan*, there are grandparents, parents, children, maybe great-grandchildren and an anthropologist.' Said in jest, it nevertheless conveys a hostility not much different from that found in Aboriginal Australia. Maori claim they have been 'clip-boarded' and researched beyond endurance. Shore writes that most health professionals who want to undertake research in 'Indian country' encounter these feelings. His point is that if researchers are not prepared to deal with the hostility, they should not be there.

What does not make sense is Shore's—and Australia's bureaucracy's—failure to see that their already euphemistic label, 'mental health', is the greatest single creator of hostility in Aboriginal communities.

Mental health makes a great deal of sense to, and has an appeal to, the white middle-class: we live in an age of medicalised neurosis, one in which suffering is unhealthy and happiness is an inalienable human right. To be mentally healthy is to be happy.

To Aborigines, 'mental health' produces hostility and avoidance: a people who have suffered every conceivable label hardly need the ultimate categorisation of not

being mentally 'right'. Optimistic as it may seem to expect a dominant Anglo mainstream to relinquish terms they prefer, there is every reason to demand an appropriate use of language and nomenclatures when the services are for Aborigines.

The Maori propensity is for 'wellness'. It has the merit of not being an emotionally loaded noun. I have no particular term to offer, but have no doubt that the sooner that agencies abandon the present terminology, the more likely are those in need of treatment to avail themselves of clinical and support services.

Key Message:

- **Mainstream society may prefer to retain the phrase 'mental health' but this terminology is unacceptable to most Aborigines; if the services which come under that rubric wish to make progress in Aboriginal communities, another term, such as the Maori 'wellness', will have to be found.**

5. Aboriginal initiatives

(a) Empowering themselves

What does it mean when researchers and strategy-devisers talk of the need for 'indigenous' communities to 'empower themselves', or to 'engage in self-determination'? For example, a Strategy *Bulletin* states: 'It is crucial that Aboriginal and Torres Strait Islander communities are empowered to develop and implement their own ways of supporting and guiding their young people'. 'It will be a major challenge to find creative ways of ensuring self-determination for particular communities ...'[7] These are shibboleths and catchcries, phrases that sound good but are never accompanied by any specificity as to their meaning in theory or practice.

For close on 40 years now I have watched, alongside Aborigines, as policy slogans of this kind were invented, barely implemented, replaced, only to be discarded when a different slogan was suggested. We would do well to revisit Deloria's philosophies of 'leave-us-alone' and self-help, together with a commitment to respond promptly to calls for assistance, but only when asked.

(b) Corporation/incorporation power

By forming corporations or legal associations, Aborigines have a viable power base in mainstream society. The artificial legal *persona* of such bodies is a greater force than the separate legal personalities of the individuals who comprise them. These bodies have been the agencies through which governments have sought to achieve their aims and objectives; however, like Indian corporations in the United States and band councils in Canada, they are capable of proactive, even aggressive assertions of a local will. Land councils, legal aid corporations, housing

associations, and educational incorporations can band together to innovate, monitor, adjudicate, or ameliorate youth behaviour.

'Nothing happens in human affairs without the creation of new power or the redistribution of old power.' Denis Oliver, who helped establish a 'National Awareness Campaign' to reduce suicide among Western Samoan youth[8], based this premise on the helper's belief that 'the people in the villages could solve the problem and it was therefore their right and responsibility to dig for the causes and remedies'. The essence of the strategy was to

- 'inform the people that they had a problem',
- 'educate them of the facts of the problem',
- 'create a vacuum for them to move on the problem', and
- 'facilitate and encourage their action on the problem'.

It was, in large measure, successful.

Aborigines know only too well that they have a problem. Some groups need briefing on ostensible causes and related issues. What they lack—given their struggles for survival on budgets which are forever endangered or cut—is the space, the 'vacuum in which to move'. Corporations have the base not only to bring suicide 'in-house', but also to tackle such matters as institutional racism, discriminatory practices by real estate agents, unilateral dismissal of students from schools. The mechanism for adversarial action, both legal and political, is there: they have to find the best ways to act.

In sum, corporations may need some assistance in establishing the monitoring programs, but this has to be on Aboriginal terms.

(c) Domestic violence, sexual assaults, and the cannabis problem

Domestic violence has for long been the subject of anguish and attempted resolution in communities. Ernest Hunter believes that suicide is the 'flip-side of domestic violence'.[9] In the period between 1989–90 (when I did my earlier fieldwork in New South Wales) and the 1997–99 field research, I saw an increased willingness of women to report such violence to the police. In response, police promoted awareness of, and the need to report, domestic violence. Reporting is an important first stage: the next battle is to convince the women concerned to testify in court hearings against their abusers.

Much has been written, and nothing done, about community justice mechanisms. An outstanding report by the Australian Law Reform Commission in 1986, on the *Recognition of Aboriginal Customary Laws*, chaired initially by the Honourable Justice Michael Kirby and later by Professor James Crawford, dealt with such mechanisms.[10] That report has simply been ignored. It needs urgent resurrection.

It lies within the structural power inherent in the corporation to put an end to the now rampant sexual abuse of children. These abuses must be reported as police matters, and the consequences borne by both the offender and the affected family; or the behaviour can be dealt with in-house. Traditionally it was, and most severely. Deloria's concept of Indian revivalism could include this scenario.

Cannabis is a relatively new phenomenon in Aboriginal communities. As alcohol is celebrated in the Australian ethos, it can hardly be denied to Aborigines; cannabis is rampant in the non-Aboriginal society and well on the way to being decriminalised. However, 'educating people about the facts' must include a strong message that many Aboriginal youth suicides have had an obsessive association with the substance. There is a difference between 'light recreational party' use and leaving home to live on river banks where private plantations can be nurtured. Many of these harmful behaviours, as Hillman would argue, are interior to communities.

(d) Expansion of CDEP occupations

Few Aborigines have an independent source of income. The great majority live on the income generated by social service benefits, paid either directly to the recipients or worked for to the level of the CDEP benefit. The new federal budget allocations in 1999 for Aboriginal employment provide for more CDEP positions. My praise and criticism of CDEP has been given in earlier chapters.

(i) CDEP and suicide

One aspect of CDEP is that it does allow for important innovation in the context of suicide. Aboriginal corporations which run CDEP have few restrictions on the work undertaken. It ranges from sophisticated landscaping services in Forster, to vegetable-growing in Tingha, to house-building in Woodenbong and Narrabri. CDEP could well create positions, some of which would require special training and guidance in,

- remand cell visits,
- prison visits for those sentenced and, more important,
- being 'friend in court' when the youth appears in court.

Parents are often not around: possibly an end-of-the-road, had-a-gutful kind of reaction. Too often it is an abdication of parental responsibility. 'Court liaison officer' is an official category now: but only four Aborigines have been appointed in New South Wales! The presence of a friend in court, and friend at the cells, and friend as visitor, is an essential strategy for Aboriginal youth. North American literature reports on the lack of training and on the inability of custodial officers to handle at-risk youth. So, too, with their Australian counterparts.

(ii) Incarceration, places and processes

In New South Wales, the majority of police station cells have been decommissioned, even those with an A rating for surveillance. Youth are transported

great distances from home to towns with 'super' surveillance systems: cells where it is impossible to attach a cord or cloth; television cameras that run round the clock; sometimes small perspex cages, located so that desk staff can see the person at all times. These facilities were shown to us, with pride. In many centres, police have been replaced by custody officers from the Department of Corrective Services, who receive some training. It is important to separate policing duties from those of minder or carer. However, the basis for these procedures, is to ensure that there are no deaths in custody. Given the increasing incarceration of Aboriginal youth, even for petty offences, I question the logic of a system which daily increases the rates of arrest while taking more and more evasive action to avoid any further Royal Commission-type enquiry.

During my fieldwork in the Kimberley in 1990, at Fitzroy Crossing, the then officer-in-charge undertook to drive me around the town. Before leaving the police station, he told a number of young men, and several elders who were sitting in the grounds, at tables, under shade umbrellas, that they were not to go to town, and were to keep away from the local nearby hotel pub. He said he would be back shortly. I asked him who those people were. My prisoners, he explained. I asked why are were outdoors and unsupervised (knowing there was absolutely nowhere for anyone to abscond to). 'I'm buggered if any blackfella is going to kill himself in my cells', he replied, as the shadow of the Royal Commission loomed over everyone. (I endorsed his handling of his prisoners but had a lesser regard for *his* motive.)

(iii) The alternatives

Warrakoo is a large property about 85 km west of Wentworth, near the South Australian border. It is a two-hour drive from Mildura, the furthermost northern Victorian town, and is situated near Lake Victoria. Physically, it is a long walk to nowhere, and of the approximately 80 Aboriginal residents there since 1991, only one person has absconded. There are no walls and no restraints.

Warrakoo is an impressive, Aboriginal-run alternative to the juvenile and criminal justice system—preferable, in my view, to the 30-bed detention centres in Dubbo and Grafton. When an offender is brought before a magistrate, the legal aid service and/or the medical service can ask that the person be brought before the Warrakoo management board for assessment as to suitability for the 'straightening out' program. Instead of sentencing, the magistrate can remand for an assessment of suitability for the Warrakoo program. Following rehabilitation, the offender may be considered for release from criminal charge.

The place and the personnel are impressive. There is no sense of incarceration, no shadow of warders. The manager commands loyalty and respect. The chairman of the board is an Aborigine. On her assessing board is the former Dareton police sergeant who is committed to alternative systems of rehabilitation, particularly for those who appear to be at high risk of suicide. A recent assessment, in 1999, included a Wilcannia prisoner facing a long sentence in Geelong, Victoria. He believed that he had turned a corner and was assessed, by television link-up with the Warrakoo board, which

recommended his acceptance. He may now be able to complete part of his sentence in this program.

Warrakoo has enabled many youth, mostly in their 20s, to rehabilitate and to give up alcohol. The board sees alcohol, not drugs, as the key issue. Almost all of their residents have been sexually abused in childhood.

The Victorian institutions have been willing supporters of the program, but not the NSW Police. Most of the residents are South Australian and Victorian. A second large property, in northern Victoria, is being purchased, to be run as a cultural revival centre for, among others, Aboriginal youth at risk.

In earlier research, I observed similar schemes, especially the Wildman River camp in Arnhem Land in the Northern Territory, an open but much less free arrangement than Warrakoo. There had been a short-lived experiment in Western Australia in which youth were sent to their tribal elders in the Port Hedland region. Many of the youth emerged as 'changed people'.

The reality is that unless bureaucrats in police and corrective services begin to use, or even to help establish, such Aboriginal-run exercises, increasing numbers of Aboriginal youth will crowd the jails, uprisings will take place, as in Casuarina in Western Australia, and increasing suicides in custody will bedevil those in charge.

(e) Painting

The Hunter-Reser study includes nine examples of symbolic representations of suicide by hanging. While they may well be symptomatic of grief, or the pervasiveness of suicide 'ideation' in the three communities in their study, there could well be value in the deliberate encouragement of painting and sculpture as 'purgation' of suicidal feelings. The front cover of my report is an example of such art. In Nowra, health workers have been reasonably successful in suicide education by showing the paintings, or photographs of them, to young people at risk. Community organisations could consider a 'paint-your-feelings' program.

(f) Sport

Enough has been said to date about the role and value of sport in giving young people a sense of belonging, coherence, loyalty—and purpose in life.

What remains is for Aboriginal communities to make strong representations to sporting associations, and to national and State sport and recreation bodies,

- to allow Aborigines into competitions;
- to provide sports administrators in each community; and
- to fund teams for equipment and travel.

In other written pieces, I have shown that the Australian Sports Commission and the NSW Department of Sport and Recreation are overly concerned with sport at the elite level. No attention is paid to sport as therapy or as a physical or mental focus for youth, as a substitute for group cohesion, as 'medication' for circulatory and metabolic disease (such as diabetes), as an answer to boredom, as leisure and therefore as a possible alternative to the togetherness of the pub.

Of all 'group therapies' available, sport is the most logical in our armoury, and the one most likely to succeed.

Where Aborigines have been expelled, rejected or frozen out of competitions, or teams disbanded—as at Coomealla and Moree in the first instances, and Wilcannia and Menindee in the latter—corporations need to use their power to fight for

- inclusion,
- mediation of disputes,
- funds to travel and buy equipment, and
- capital grants to enhance what few playing fields they have, such as the grassing of ovals and the installation of lights.

(g) Mentors and enlightened witnesses

Throughout this study, discussion with Aborigines focused on the need for 'gurus', 'respect' figures, mentors, tutors, guides in the community, individuals to turn to when life betrays them. The American literature makes constant references to 'gatekeepers', almost always assuming they will be the tribal elders (of yore). Ideally, there should be someone within the community group, who becomes a first port of call for the youth at risk. There are different roles for those assuming real responsibility:

- a guru figure, seen as a voice of wisdom;
- a mentor, such as a sporting hero or role model;
- an enlightened witness, one who gives verity to what the individual has experienced and suffered and cannot talk about, thus enabling victims to retain some belief in themselves.

There are no training courses for such figures. It is a matter of personality, repute, what the Maori call *mana*. However, a starting point for consideration is that Aboriginal (and Maori) men and women train as grief counsellors. If they can be seen to mediate grief, they may well come to be seen as people who can counsel, or be able to refer the victim to more specialised personnel.

Aboriginal Community Liaison Officers (ACLOs) come closer than anyone else to performing this function, but their association with the police is often a barrier. However, ACLO training, to date informal and learned on the job, would benefit from formal training and from some specialised youth work, including an understanding of

the whole suicide canvas.

Key Messages:

Aboriginal initiatives are now increasingly possible within the new framework of corporations:

- **to introduce community justice mechanisms;**
- **to expand CDEP tasks to include positions as 'friends in court', court liaison officers and custody visitors;**
- **to work towards alternative juvenile facilities, such as the successful Warrakoo 'redirection' centre;**
- **to organise (cathartic) painting classes for youth at risk of suicide;**
- **to campaign for greater access to sport, and the provision of equipment and funding;**
- **to find, or 'produce', mentor figures to whom youth can turn for help.**

6. Programs to assist Aborigines

I discuss below ten programs which have the potential to alleviate suicide. All require input from non-Aboriginal sources. Two may require that Aboriginal community members visit New Zealand, or that New Zealand personnel tour Aboriginal communities.

(a) Aboriginal suicide 'AA'

In the United States, there are growing numbers of groups formed by relatives and friends of suicides. The 'survivors of suicide' hold promise for the possibility of some alleviation. Suicide avoidance can be modelled on Alcoholics Anonymous and Gambling Anonymous programs. Our limited observation (perhaps a dozen large group meetings) was that, within a group, individuals were keen to talk about their suicide attempts: it was a kind of revelation time. Regular 'suicide AA' meetings, in their own domains, may draw youth. The capacity for such a strategy is already there. In the initial period, external assistance may be needed for establishing protocols of do's and don'ts, handling such matters as anonymity and confidentiality.

(b) Smoke free/suicide free?

The Health Sponsorship Council in Wellington, New Zealand, has been quite successful in seeking sponsorships for sport, youth and Maori programs from other than tobacco companies. The Council provides, or raises, funds to replace tobacco sponsorship. One of many programs is SMOKEFREE, with a Maori subset called 'Smokefree Maori'—aiming at abandoning the habit. It is not the usual 'quit smoking' campaign, accompanied by terrifying pictures of damaged lungs. Rather, a reverse psychology is used: that it is 'cool' and 'with it' *not* to smoke. 'Cool' activities include dances, with large attendances. The non-smokers gather *en masse*; smokers are asked to smoke away from the group, at a distant, segregated space. The peer group pressure of the 'cool' ones seems to be prevailing.

Throughout, the accent is on positive change to a healthy lifestyle. Youth are asked to consider taking this experience to their homes and workplaces and, above all, to the *marae,* 'the last bastion of Maoritanga and lifestyle'. And the slogan is to stop smoking for the benefit of all Maori: to do it for your people.

In a sense, this is replacement rather than displacement innovation: learning to do something new, and is the germ of an important idea: that 'cool' kids don't commit suicide.

(c) 'Going-for-Goal' (GOAL)

Ken Hodge at the University of Otago and Steve Danish at Virginia Commonwealth University in the United States have established both pilot and ongoing life-skills programs: 'basic skills needed to achieve *across* [different] environments'. The project authors 'believe that sport provides an excellent metaphor for this message'. Adolescents aged 10 to 14 are taught to:

- identify positive life goals;
- focus on the process (not the outcome) of goal attainment;
- use a general problem-solving model;
- identify health-compromising behaviours which can facilitate goal attainment;
- seek and create social support; and
- transfer these skills from one life context to another, for example, sport to classroom, school to career.

The pilot study in Dunedin has been promising, especially given that New Zealand youth are so sports-conscious. GOAL has been established in 25 places in the United States.

There is every reason to believe that GOAL can not only be taught in Aboriginal societies, but that its premises, aims and methods are appropriate to suicide prevention, or rather, life-positive outlooks.

Dr Ken Hodge should be brought to Australia to teach us the GOAL system.

(d) Parenting and conflict resolution skills

Duclos *et al* examined suicidal behaviour among Indian adolescents in detention.[11] Factors involved were alcohol abuse and dependency, frequent run-ins with police, frequent interpersonal conflicts, chronic family instability and, above all, 'prolonged, unresolved grieving' and 'continued deprivation of parental caring', resulting in 'difficulties with the law'. The authors could as well have been writing about Aboriginal youth.

Parenting styles vary across cultures. There are many who deplore what they see as a laxity in Aboriginal child-rearing practices, at least in non-traditional domains. Certainly there is a difference in the degree of anxiety about life's dangers. Aboriginal parents often allow their children to see and experience risks, believing that 'once-burned-twice shy' will teach the young. The virtues of cultural systems are not in question in this context. What is problematic is why Aborigines are today failing as parents.

In all cultures, there is, at bottom, a 'being there' for one's children: loving and nurturing, guiding them through emotional and intellectual difficulties, setting boundaries for behaviour, disciplining when appropriate, assisting in decision-making, and the all-embracing obligation to provide food, shelter and clothing. There are many reasons why these skills can be missing, including child removal, parental absorption in grief, and family breakdown—all leading to the absence of role models. However, even where these skills are lacking, they can be taught—and learned.

If we are serious about reducing suicide, then we have to travel to the problem, not wait for the problem to come to the consulting room, by appointment. This applies to all the strategies suggested in this chapter. In the main, Aboriginal parents will not leave home to attend classes or workshops in a city, or in the next large town. They will not travel to environments in which they feel ill at ease, as in a university or TAFE (unless for pleasure, or escape from the kitchen, as is now common with painting classes). They avoid 'mental health units' at hospitals. Internets or websites are inappropriate tools, and Aborigines are unlikely to watch instructional video material.

In sum, classes will have to be facilitated by invitation, at Aboriginal places, and essentially on their terms.

Teaching parenting skills and grief counselling are, I believe, the most important skills in providing any alleviation.

Conflict resolution is another invaluable tool for defusing explosive situations. It also gives an insight into the individual's pain, frustration, needs and how to learn to express them without self-harm. It can be learned in a few sessions, and courses can be tailored to the needs of special interest groups.

(e) Grief counselling

No other cultural group in Australia is so exposed to death so frequently, especially early death. For many, grief is prolonged, constant and unresolved.

Grief counselling is crucial. I am told that for Aboriginal men and women to become counsellors, they must have a degree in psychology, preferably an Honours year, and then specialised training. A BA Hons (Psych) does not necessarily guarantee a good counsellor: specific short-term training could. There is need to explore the idea of bringing professional counsellors to Aboriginal centres for introductory lessons on what to do, or not to do, in the immediacy of death, especially by suicide. Even if these 'trainees' learn only how to recognise and refer to specialised professionals, that would be a start. I have every confidence in suitable Aborigines' fulfilling the role of grief counsellors. Those with a nursing background would be immediate candidates.

(f) Removed children

Grief counselling is usually conducted one-on-one or in a small group. A larger group could address whole communities in grief. Children and kin of the stolen generations need special therapy. *Every family* we met during this research had a strong or direct connection with the removal system, and its effects spill over across the entire Aboriginal population.

There is another kind of child removal: the large movement of Aboriginal youth to juvenile detention facilities. Most families have one or more children either in such a facility or who has recently been there. The removal is temporary and visits are possible. But the family member is absent and missed. It is a complex problem, but counselling could begin to address family structures.

(g) School programs

The United States and Canada consider school programs on suicide a virtue. For Canadian Indians, the issue is important because the discredited system of removing children to boarding schools still prevails—therefore special programs need to be included in the school syllabus.

There is American evidence that some programs were effective. Four high schools established programs for girls at high risk of suicide.[12] The girls were paid an hourly wage for attending two group meetings for one-and-a-half hours each week. The curriculum included parenting skills, the psychology of sexuality, decision-making, drug and alcohol matters, unwed pregnancies and even suicide 'presented by medicine men'. The program lasted two years, with dropouts and replacements. The outcome was: 10 per cent of girls became pregnant, as opposed to the earlier figure of 30 per cent; grades improved slightly; there was no police trouble in the group; and 90 per cent of the drinkers had cut down their intake. Only three of the girls attempted suicide. A similar program on a Zuni reservation also produced 'lowered scores on a measure

of suicide potential as compared to a control group who did not take the program'.

A contradictory North American report opposes these programs, suggesting that they 'enhance' the notion of suicide and give youth ideas they may not have entertained before.

Aboriginal youth at the suicide risk age—from 12 upwards—could not benefit from any school-based programs unless they were, indeed, still attending school: the programs would simply not reach them.

There is much more likelihood of success if classes were conducted by Aborigines, and by other respected helpers, outside of school hours, at Aboriginal medical services, legal services or on land council premises.

(h) Sport

The Australian Sports Commission and the NSW Departments of Sport and Recreation and of Health should initiate programs to bring rural and remote Aboriginal facilities closer to a 'level playing field'. More pertinent, they should help Aborigines towards any kind of playing field.

The GOAL program could be integrated into these initiatives. This is not merely a recommendation about money for travel, equipment and improved facilities; rather, it is that these agencies develop and implement sports policies that focus on life skills, early starts, suicidal and risk-taking behaviours, aggression, leisure in its true sense, recreation, anti-boredom, and specific activities aimed at therapy for diabetics.

(i) Police and Community Youth Clubs (PCYCs)

The NSW Police Service should rethink its role in Aboriginal life. Community policing is, or was, for long the ideal of the Service. Even if 'frontline policing' has replaced that policy, the community aspect remains a much-needed aspect of good policing.

Policemen and women interact with Aboriginal youth more than do any other non-Aborigines. They see and hear more than anyone else. They are present when everyone else is off duty. PCYC officers are in an even more advantageous position to be *assisting* police rather than *arresting* police. They offer Aborigines what no one else can: sport, computers, computer games, pool, preparation for driving licences, space, an outlet for energy, a meeting place, food, possibly an enlightened witness, a respite from home life. In the great majority of towns, including the towns which want curfews, caged shop windows, alcohol-free zones, boot camps and the like, these officers are the youth workers. The potential for suicide monitoring, and suicide and life- skills education are nowhere better than in refurbished premises, with uplifted and better-trained PCYC personnel.

(j) Ann Morrice's literacy program

Three to six hours of training is all that is required to train teachers to teach literacy to children. There is something of a 'magic bullet' available in Ann Morrice's language/literacy program, one demonstrated as being highly effective in at least 300 schools in Australia, including Aboriginal schools in South Australia and Western Australia. The technique is also effective with English-as-a-second-language students.

The philosophy is based on oral language development, linked to meaningful content and to the child's visual world. Speaking, listening, reading and writing are linked in meaningful contexts. Skill-based learning is included, and the written product is the focal point towards which lessons are directed. The process includes all the conventions of writing: phonemic awareness, phonics, conventional spelling, grammar, punctuation, syntax, reading skills, and comprehension. The technique can be taught at any venue and is not based on school-attendance. A key to the program is that it builds on the positives which exist for the child in his or her own environment. Ernabella, a remote South Australian Aboriginal community, has shown remarkable results from an approach that places a positive value on their own environment.

Examples of almost miraculous transformation in writing skills of young Aborigines are given in Appendix III. Material is presented from children aged 5 through to secondary pupils. At the sixth national conference on Suicide Prevention Australia in Melbourne in March 1999, Ms Morrice demonstrated her technique to an audience. (Demonstration is more effective than trying to describe the method.) Subsequently, several Aboriginal community representatives have invited Ann Morrice to visit and train local people.

The cost of her programs is minimal. The efficacy is beyond any doubt. The responses of Aboriginal youth border on the miraculous, especially in light of the disposition of conventional teachers dispositions to dismiss Aboriginal educability in general, or to cease bothering with children once they reach a certain age.

The federal government pledge to implement a literacy program is to be applauded. But, for reasons discussed throughout this report, much of the ensuing activity will not reach Aboriginal children. We cannot wait for standard school procedures, including special literacy projects, to become attractive to Aboriginal children. We can, however, teach Aboriginal children literacy, in a remarkably short time, outside of school, with the hope, or belief, that literacy skills will give them both the confidence and the incentive to return to, or to stay at, school.

Key Messages:

Non-Aborigines can make significant contributions to suicide alleviation by:

- **assisting Aborigines to establish suicide equivalents of Alcoholics Anonymous;**

- **sponsoring the equivalents of the New Zealand 'Goal-for-Goal' life-skills and the Maori Smoke-Free programs;**

- **sending trainers *to* Aboriginal communities to develop both training and operational parenting, grief counselling and conflict resolution skills;**

- **establishing programs modelled on the successful North American Indian school 'prevention' programs, *outside* of school hours and premises;**

- **offering counselling and advice to communities which have experienced the forcible removal of children;**

- **the NSW Department of Sport and Recreation, and the Australian Sports Commission, committing funds for increased sport, leisure and recreation programs in communities that have none;**

- **the NSW Education Department supporting the proliferation of Ann Morrice's literacy programs *within* and *without* the school curriculum;**

- **the NSW Police Service uplifting the training and promotion opportunities of PCYC officers, and encouraging them, after appropriate training, to engage in suicide alleviation projects.**

7. The coronial system

In chapter 4, I discussed at length the definitional problems of what is youth and what is suicide. It is also clear, as shown in chapter 9, that coronial under-reporting of suicide is common in New Zealand, the United States, Canada and elsewhere. I am disinclined to accept that the extremely low rates of male youth suicide reported in Spain, Portugal, Chile and Italy are due solely to Catholic inoculation against the behaviour.

It must be repeated that coronial bias is not obstructive. On the contrary, as I have explained, kindness, the avoidance of stigma and chagrin, caring for the families of the

bereaved, are a notable feature of small town life. However, if we are to focus on a specific problem of age, race, class or gender-related suicides, we have to demarcate those categories, and we have to do it within 'margins of error' to enable a greater breadth of perspectives about suicide than we have at present.

The movement towards a national database on youth suicide is laudable. But it will be a flawed resource if we perpetuate the current system which either allows or produces serious under-reporting.

There is urgent need to reintroduce the concept of a national, uniform coronial system, with minimal standards of education and professional training, especially in rural and remote areas.

There is need for in-service courses and 'refresher' seminars for those currently in office, including such topics as the goals and approaches of national and state suicide strategy bodies; the problems posed by youth suicide in general; youth suicide in other countries; and the matter of Aboriginal suicide.

There is a need to reconsider the prevailing attitude on the exclusion of a presumption of suicide. Britain, according to a High Court decision in June 1999, is now 'a foreign power'. British tradition about suicide verdicts may well have outworn its applicability in Australia in 1999. Coroners should be allowed the latitude of the three-verdict model: definite suicides, probable suicide and possible suicide, even if that classificatory system were not made public (to avoid undue distress) but were available as a guide to those engaged in research and strategy planning.

In addition to the making of physical findings at autopsy, there is an urgent need of a national system of 'socially profiling' suicide. Recording the social features surrounding a suicidal act is preferable to attempts at conducting a post-mortem 'psychiatric' analysis.

Police investigators have a special and important role in the Coroner's Office in Glebe. There are no specialist police officers in rural towns. In all domains, there is need of a team of assessors to work with the police to establish such social profiles. Assessors need to be appropriately trained people: they don't have to be psychiatrists or forensic anthropologists—but the latter should be included in any such assessment teams.

Key Messages:

- **Consideration should be given to a national, uniform coronial system, with appropriate (legal, medical and sociological) training for would-be coroners and those already in office.**

- **The British-inherited tradition that coroners may not presume suicide should be reconsidered.**

- **Coroners should be allowed the flexibility of designating suicide as being beyond reasonable doubt, probable suicide, and possible suicide, even if these broader categories are used only for policy formulation by research workers and 'alleviation' agencies.**

- **Assessment teams, including the [American-based] appointment of forensic anthropologists, should establish 'social profiles' of suicides rather than the proposed system of 'psychiatric autopsies'.**

8. The police and suicide

All police training procedures should include at least a ten-hour block of material on the phenomenon of suicide, including attention to Aboriginal suicide.

Although suicide is no longer a criminal act, the police are the first or, after a medical visit, the second to attend a body. It is the police who have to investigate the circumstances and report to a coroner.

The police are the custodians of the youth who threaten, or succeed in, suicide in detention. Clearly they are ill-equipped to deal with such matters. Caging a detainee inside a perspex box and looking at a television screen is hardly a 'treatment'. At best, it is preventing a media or investigative process into yet another death in custody. The police presumption, for the most part, is that custody itself gives rise to the suicide: yet police are given no insight into the events occurring outside of custody which lead to the suicide while in custody.

Given the extraordinary role that the police have had, and still have, in Aboriginal lives, there is every reason to have trainee and working police exposed to the suicidal aspects of Aboriginal life.

Police regional commands should emulate the model established at Hornsby Police Station, where a senior constable is the youth school liaison officer, giving lectures on suicide at schools and youth centres.

The NSW Education Department should consider allowing people from outside schools, such as these police liaison officers, to conduct lectures, or preferably, workshops for older high school pupils.

The Aboriginal Community Liaison Officers (ACLOs) are in the forefront of practically every facet of Aboriginal life. They warrant being formed into a professional category in the Police Service, with higher salaries, overtime (not paid in their 'package'), an ACLO union, their own vehicles, and in-service training, especially in suicide.

More Aborigines should be encouraged join the Police Service.

Key Messages:

The NSW Police Service can contribute a great deal to the alleviation of Aboriginal youth suicide:

- **by providing for a *professional* category, and appropriate salary, of Aboriginal Community Liaison Officers, the people who are most in daily contact with Aboriginal youth at risk;**

- **by establishing many more youth school liaison officers in rural and remote areas, on the Hornsby Police Station model—men and women capable of discussing suicide with high school pupils.**

9. Capacity-based workshops

The easiest path to new knowledge is to listen to attractively delivered material, preferably at times and places which suit the listener's professional or personal lifestyle. Reading and studying tend to be dismissed once one has graduated, trained or is on the job. Short, sharp workshops *in situ* have educational advantages: they can be styled as in-service training, advanced studies, professional training, and even certificated training. They also build on the capacities of the people attending: Aborigines, police, coroners, lawyers, mental health workers, and so on. The materials can be framed as new, supplementary or complementary, rather than suggesting 'a whole new ball game'. Several such workshops can be arranged, with minimal difficulty, and within reasonable costs, by the organisations concerned. Almost every agency has a component of in-service training and hence funding is not required. In most instances, the costs will be in terms of weekend rostering, travel to an equidistant, suitable venue, and the travel and/or fee costs of the presenters.

(a) Pharmacists

The medical and pharmaceutical professions are rightly concerned about 'non-compliance', that is, patients who are not taking what is prescribed for them. A NSW pharmacist who specialises in 'compliant packaging systems', informs me that non-compliance is not merely a problem with the aged and the confused, but with 'normal' people.

Throughout this study, we observed the standard dispensing of pharmaceutical drugs to people who cannot read the labels, the instructions and the manufacturer's micro-printed side-effects or contra-indications. During the research, I approached the NSW Pharmaceutical Association about seminars for regional pharmacists, with a view to their dispensing medication to illiterate people in blister packs for daily or weekly collection, or introducing medication-under-observation—as is the practice with methadone here or programs for the treatment of tuberculosis in several countries.

Several lectures and seminars were given to country town pharmacists: the responses are very positive in that Aborigines are now taking to the use of blister and directive packs.

There needs to be a regular series of regional workshops by staff from the NSW Pharmaceutical Association, Manrex Pty Ltd–Webstercare, and Medifrax (who specialise in medical awareness education), to pharmacists, doctors, nurses and Aboriginal parents.

Such instruction is as much about Aborigines taking medication for their diabetes, heart and kidney disease as it is about minimising the availability of lethal means of suicide, or attempted suicide. Blister-packing, or better still, 'daily-dosage' packing, could well mean that the young girl from Brewarrina, discussed in chapter 5, section 3, would not have had 50 Digesic tablets on which she fatally overdosed.

(b) Police

Regional workshops can be conducted with little effort. Several police officers, who had attended an in-service course on Aboriginal history and culture, were enamoured of the materials given to them. All claimed a better appreciation of their clients. The only *caveat* is that history and culture needs to be directed to the present rather than the past. There is a danger in many of these 'Aboriginal Studies' courses of the painting of an historic, romanticised and idealised picture of a people who, in the listener's experience, have no relationship whatever to the people they deal with in their daily lives. Often, these 'traditional' courses produce an antithetical effect: they make the contemporary population appear altogether removed from, or even 'deviant' from, their 'attractive' ancestors.

There is no shortage of Aboriginal and non-Aboriginal personnel to conduct such workshops. The focus, however, must be on suicidal behaviour, the possible causes, the warning signs (if any), the movements toward suicide, was of deflecting what look like destructive path choices, and so on.

(c) Coroners

We interviewed 31 New South Wales coroners in this study. Some are extremely competent and confident. Others are unsure in matters of suicide, and many are not *au fait* with Aboriginal societies. Several feel isolated, even though there is regular, helpful advice and service from the State Coroner and his staff.

Most were positive about wanting to attend a regional workshop on all coronial matters, including the suicide issue, at least once, if not twice a year. They see the coroners' association meetings as being for the 'real coroners' in Sydney and Melbourne. A few felt that they could not take off any time to attend training, as there was no locum and because they acted also as clerks of the court. I have no doubt that most would be willing to attend a workshop on the contents of this report.

(d) Custody officers

I have not inquired into the training of those officers who now form custodial units in rural police stations; nor do I know what training is given to corrective service officers in prisons in New South Wales. However, it would be surprising if the situation were markedly different from Canada and the United States, where the general conclusion is that such personnel are under-trained regarding prisoners at suicide risk. The NSW Corrective Services system does have psychologists who prepare screening tests for suicidal tendencies. However, screening on admission is not the same as knowledge on the part of the custodian as to what to look for, how to look for it, and what to do about it if something untoward manifests. Immediate referral to a prison hospital is neither the sole nor the whole answer.

Workshops should be conducted, in police stations and jails, to familiarise officers with the dimensions and pssible causal ingredients of the problem.

(e) Mental health workers, local doctors and nurses

Health personnel in every region would benefit from annual workshops. My experience is that they are always interested in how they are faring, new inputs, how other jurisdictions function, what makes Aborigines 'tick', what are the latest ideas on suicide. The most commonly expressed 'complaint' is that they 'don't know how to get through to Aborigines'. That, at the least, is true. The fault is not personal: research in North America has shown that mental health jargon is a barrier to communication and understanding, and therefore to therapy of any kind.

Such workshops would need to tackle the history of an Aboriginal experience that has resulted in antipathy to government institutions of the 'welfare' type. We all need to face this kind of history, and in facing it, there might be a breakthrough to a less hostile future.

(f) Psychiatrists and psychiatrists-in-training

A small group of psychiatrists in training at a major Sydney hospital, perhaps 20, has asked Ernest Hunter and me to address them. They claim that they lack confidence in how to handle youth suicide and ask whether there are any especial tools for handling Aboriginal youth. The Otago Medical School curriculum, discussed earlier, ensures that every graduate is taught whatever knowledge, however limited or speculative, is available. The National University Curriculum Project, established by the Hunter Institute of Mental Health in Newcastle, is currently preparing what can be called a 'suicide syllabus' for use in university curricula for doctors and nurses, among others.

Informal or formal university and/or hospital workshops for psychiatry residents would provide an ideal opportunity for the emergent practitioner to correlate, and possibly to integrate, the various approaches to youth suicide. It is not a matter of persuading them about choosing one or other of only two alternative approaches. Rather,

it is to overcome what appears to be a fear of intervening, or trespassing, into an 'Aboriginal territory' for which they have no training, no invitations and no culturally appropriate licence.

Key Messages:

A *series* of joint or separate capacity-based workshops should be established forthwith. They should be the forums for discussion and action by those involved, directly or indirectly, with Aboriginal youth suicide, including:

- **Aborigines who have lost children to suicide and who could form'suicide AA' programs;**
- **police in training at police academies and universities;**
- **remote and rural police officers in towns of known high suicide risk;**
- **pharmacists who need to appreciate the need for a different form of dispensing drugs to those who are illiterate;**
- **coroners who feel isolated, or who believe they need an understanding of Aboriginal issues generally;**
- **custody officers who, generally, have no training in either the causes or the signs of suicidal behaviour in youth;**
- **mental health and related professional workers who need to find ways of communicating with Aboriginal communities and whose language of training and operating currently cause antagonism to those who might need their services;**
- **psychiatrists and psychiatrists-in-training who want, and need, to know whether there are especial tools for dealing with Aboriginal suicide.**

The agenda for these workshops need to be discussed with the professions and people listed here. However, a starting point could be their analysis of the Hunter-Reser study of suicide in North Queensland communities, the Maori Suicide Review Group report, and this report.

Endnotes 10. Towards Alleviation

1. A renowned American essayist, critic, satirist and lexicographer. I do not recall the source for this quotation.

2. Lester, 1997, 174. My italics.

3. Ibid., chapter 9, 153-82.

4. *Calling from the Rim*, Synopsis, 250-55.

5. See, for example, *Youth Suicide Prevention Bulletin,* no 1, September 1998 and no 3, May 1999.

6. Ibid., September 1998, 14.

7. Ibid., 18.

8. Hezel, 74-82.

9. Personal communication.

10. Law Reform Commission, *Summary Report*, 133-57.

11. *Calling from the Rim*, 189-214, at 198.

12. Lester, 1997, 171-72.