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Review Article

Suicides in Aborigines; an analysis of the suicide prevention policies of Australia and New Zealand

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Abstract

The mounting suicide rates among the youths, specifically targeting the Aborigines have been a major health concern all over the world. Despite of having their suicide prevention policies in place, Australia and New Zealand face the same alarming problem of increasing suicide rates among indigenous people. This paper serves the primary purpose of comparing the suicide prevention policies for the Aborigines in New Zealand and Australia. Additionally, it also explains the reason behind this disproportionality/inclination of the suicidal deaths towards the indigenous people in these two countries which is less established in the existing research literature.

Walt and Gibson's Health Policy Triangle was applied to The New Zealand Suicide Prevention Action Plan 2013-16 and the Fifth National Mental Health and Suicide Prevention Plan of Australia. On demonstrating a paralleled picture of the two policies, it was found that Aborigines faced a common problem of cultural barrier in both the countries which was well displayed in their health sector as well. The inequities among the non-indigenous and the indigenous people led to the increasing scores of suicides among the latter. More importantly to overcome this problem, a more holistic approach which amalgamates different external sectors like finances, media and few others along with the health policy initiatives are required to bring a positive change in the health status of the Aborigines in both the countries.

Key words: Analysis of suicide prevention policies, health policy triangle, indigenous people, Thomas and Grindle's framework

Introduction

In recent years, the increasing rate of suicidal deaths amongst 15-29 years of age has raised global subject. Suicide, the act of deliberately killing oneself cannot be categorized under specific causes, as most of the suicides occur hastily with the interface of social, cultural and psychological factors. Approximately 8,04,000 suicide deaths occurred worldwide in 2012, demonstrating an annual global age-standardized suicide rate of 11.4 per 1,00,000 population, 15.0 for males and 8.0 for females[1]. Suicide is also witnessed reaching escalating proportions in the aboriginal populations worldwide[2]. Out of 195 countries, presently 28 countries have their national suicide prevention policies in place to tackle this crisis.[1] Australia and New Zealand (NZ) are the two countries, which have identified suicide prevention as one of their major health goals among them. In Australia, it is an important public issue, where it was also observed that suicide rates for the Aboriginal Torres Strait Islander people are twice as high as for the non-indigenous Australians[3]. Similarly, NZ also reveals some striking facts about suicides which displays that every-week on an average, 10 people die in NZ by suicide and the suicide rates of Maori are 50% more than the non-Maori[4]. The current Prime Minister of NZ also highlighted the plan of rebuilding the mental health services in the country[5]. Now, the question arises why the suicide rates among the indigenous and non-indigenous

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people are highly disproportionate among the two countries? To have a better understanding of this important public health issue, this paper instead of essay serves the primary purpose of analyzing and comparing the two most recent suicide prevention policies with regard to aborigines. The paper is structured in three sections. The first and the second sections of the policy describe the analysis of the suicide prevention policies of the two countries. The third section discusses the juxtaposition of the policies, leading to the final section of conclusion.

Methodology for analysis

In order to analyze the suicide prevention policies of NZ i.e. New Zealand Suicide Prevention Action Plan 2013-16 and the Fifth National Mental Health and Suicide Prevention Plan of Australia, Walt and Gibson's health policy triangle is applied to identify the content, various contextual factors, actors and the four stages of policy process i.e. problem identification, policy formulation, implementation, and evaluation. Content, concerns with the main constituent of the policy, while contextual factors refers to situational, structural, cultural and international/exogenous factors which help to identify the transitory situations, political and technological systems, the position of ethnic minorities or linguistic variances and the international engrossment in the policies respectively. Actors, present at the centre of this framework denotes the individuals/organizations/ groups and their actions that can affect the policy. The fourth part of this framework, describes the process by which the policy was initiated, formulated, communicated, implemented and evaluated. This framework was used as it covers the major aspects of the policy, which are to be analyzed and the simplicity of the framework helps to unravel the compound set of inter-relationships existing within the policies.

Further, to evaluate more on implementation part of the policy process, Thomas and Grindle's framework has also been applied to identify various political, managerial, technological and financial resources in the policy[6].

New Zealand Suicide Policy 2013-2016

Despite being one of the first countries to prepare a National Suicide Prevention Strategy, suicide is still a major issue that is of real concern to NZ communities. The long-term commitment to suicide prevention started in 2006, when the Government released the Suicide Prevention Strategy, subsequently followed by the Action Plan 2008-2012, to address the health inequalities in suicide rates of different populations[7]. The page 1 of the present policy focusses on the five objectives of supporting the aboriginal families, reducing the impact of suicides, providing support for people at high risk, using social media to prevent suicides and strengthening the infrastructure for suicide prevention, forming a part of the content of the policy.

Structural factors

To begin with, the contextual factors, describing the timeline of events; leading to the policy formation was facilitated by the Ministry of Health and coordinated with eight other governmental agencies under a unitary system. It was well established that the policy framework required multi-sectorial cooperation between the governmental, the non-governmental organizations and partnerships with the community. Along with the thirty actions in the policy, the government also continued with several other suicide prevention initiatives, for example, the Social Sector Trials, legislative-reviews including the Coroners Act 2006 and the Harassment Act 1997. In view of this strategy and the Action Plan coming to an end, a draft of the new strategy has been developed and was released for public consultation on 12 April 2017[4].

Cultural factors

Many cultural factors are also linked with Maori suicides, as it forms a stigmatized issue in the communities[7]. Health inequalities in terms of gender, ethnicity and socioeconomic factors like unemployment while compared to non-Maori's were also leading to this crisis. Also, some of the additional risk factors, attributed to suicide in such communities could be colonization, breakdown of traditional structures, westernization, lack of social

cohesion and values present in pre-Maori European society[8].

International factors

Following the national suicide prevention strategies' published guidelines by UN (1996); New Zealand was one of the first countries to develop their own strategy. Also, the Ministry of Health maintains close links with the WHO, the International Association for Suicide Prevention in monitoring international developments in suicide prevention and research[7].

Problem identification

According to the policy, suicide was the major problem among the aboriginal communities. Existing inequities in terms of accessing healthcare, a social disadvantage over the non-indigenous groups and lack of community awareness/ involvement in the prevention of suicides were some of the factors, responsible for this problem. Other risk factors contributing to it were lack of social cohesion, exposure to trauma and difficult economic circumstances. The policy also framed a number of actions to deal with such problems, for instance, the action-3 of the policy.

Policy formation

Further to tackle this complex problem, the policy was communicated at national and international level, as explained above. It was also established that no single initiative would reduce the rate of suicide in the communities. Thus, the action plan followed a multi-sectoral approach where various stakeholders such as the NGO's, Central Government including other Ministries along with the local government and NZ police were identified, whereas the Department of Corrections; professional organizations; community/families/individual-groups; and educational institutes constituted the interest groups[9, 10].

Policy implementation

Thus the policy suggests a top-down approach, which was responsible for the specific actions by lead agencies of the government under each objective. [6]

Political resources

It was also observed that the policy was coordinated by the Ministry of Health and eight government agencies which formed the main power responsible for implementation of actions in this Action Plan, with the main focus of decreasing the inequalities among the aboriginal communities. Implementation agencies met regularly through the Inter-Agency Committee on Suicide Prevention to coordinate and support implementation activities.

Managerial resources

Other agencies represented on the Committee included the Ministry of Pacific Island Affairs and Ministry for Women. However, for those who were not in contact with the governmental agencies, strong partnerships with the communities were considered as an important aspect of successful implementation.

Financial and Technological resources

Along with some parallel running cross governmental plans described before, the Government allocated $25 million over four years to implement the Action Plan. [3] Some parts of the policy also suggested a model of active cooperation where in order to protect the vulnerable people and to limit the harm done by social media; some restrictions on what can be made public about suicide were made. These are given under Section 71 of the Coroners Act 2006[4].

Evaluation

According to the policy, some ongoing actions were led by Ministry of social Development (CYF) and Department of Corrections along with the other action plans. Also, in September 2013, the Ministry of Health contracted the Commission to trial a suicide mortality review, which resulted in establishing the Suicide Mortality Review Committee. On page 53 of the Mental Health Annual Report 2016, the suicide rate for non-service users in 2014 among Māori was higher[11].

Australia Suicide Prevention policy (2017-2022)

The four previous National Mental Health Plans established the foundation of this policy. A timeline of events starting from 1993, a five-year document plan, renewed in 1998 and 2003 followed by the fourth

mental health plan in 2004, led to the formation of this policy. For the first time, this plan displayed a commitment of all governments to work together towards suicide prevention, not seen previously.

Structural factors

According to the policy, it was developed at the time of considerable change in social policy in Australia. The foundation of the National Disability Insurance Scheme has been of utmost importance. The development of this policy was built on the extensive dialogue undertaken by the National Mental Health Commission-2014, when they brought together the knowledge and experience of the people from various sectors. In addition to Primary Health Networks that have been established, several State Governments acknowledged Mental Health Commissions that focused on the government's approach to prevent suicide.

Cultural factors

Moreover, the main stressors among the Aboriginal people at personal, societal and institutional levels, leading to suicide are peaking levels of discrimination, exclusion, victimization, and racism at personal, societal and institutional levels. Many experiences by the indigenous and non-indigenous populations may/may not be similar, led to the path of equipping the non-indigenous clinicians reviewing the problem with regard to the cultural context of the aboriginals rather than viewing it from a medical perspective.

International factors

With regard to international context, Australia has promised the international community that it will protect and promote the human rights set out in the conventions (UN declaration on the Rights of Indigenous Peoples'). Australia also has reporting duties related to the WHO Plan 2013–2020.

Problem identification

According to the policy, suicide is considered as the major health policy issue. In Australia, the cultural barrier plays an essential role, where the accessibility to mental health services and professionals is compromised. The lack of cultural knowledge

and effective leadership in the overall system and services hindered the Aborigines to integrate into a culturally competent system of healthcare.

Policy formulation

To keep a track of events right from 2013 when Australian Health Ministers' Advisory Council (AHMAC) endorsed the National framework, to treat the aboriginals, to 2016, when Council of Australian Government (COAG) endorsed the Cultural Respect Framework for Aboriginal Health, formed important objectives of the plan.

The Mental Health Expert Reference Panel, the Aboriginal and Torres Strait Islander Mental Health, and Suicide Prevention Project Reference Group, the Suicide Prevention Project Reference Group, and the Australian/State/Territory-Government Health Departments were all identified as responsible stakeholders in this policy. In addition, Local Hospital Networks and Primary Health Networks, community managed sector, families, and carers formed the interest groups. With all these actors working for the plan, the policy is well communicated following a decentralized system.

Policy implementation

This policy also aims to work on five priority areas, two of which are dedicated to suicide prevention in the aboriginals. Implementation of the Fifth Plan progressed with reference to work committed to, under the National Drug Strategy 2017-2026. This policy follows a Bottom-up approach where AHMAC and other Principal Committees are responsible for the implementation[6].

Political resources

Following the Thomas-Grindle's Framework, many existing initiatives suggested a National approach such as the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

The stakeholders responsible for contributing to this policy included the Australian Government Department of Health, MHISSC, Mental Health Principal Committee, Primary Health Networks (PHNs), and State/Territory Government Health Departments.

Managerial resources

It was also recognized that the implementation should occur at the national and local level with active involvement from the Government and service providers; with each Common-wealth and State/Territory Government managing its own activities in their areas.

Financial and technological resources

The Australian and the State/Territory Government shared the responsibility of funding. Another innovation was the establishment of the Subcommittee of MHDAPC, which introduced the use of care navigators and single care plans to improve service integration[12].

Evaluation

The COAG Health Council holds the power for monitoring while the responsibility of evaluating this policy was of NHMC's. According to their report, an important achievement for both PHNs and State/Territory Governments was the introduction of dedicated positions for Aboriginal and Torres Strait Islander people in mental health services, as well as clinical positions in mental health to support the people[13].

Juxtaposition of the policies

The above analysis conveyed broad dimensions of comparison in NZ and Australia's policies. Although both countries recognized the need for mental health policies quite early, it took 11 more years for Australia to dedicate one specifically on suicide prevention. NZ observed a top-down approach of implementation, whereas Australia followed a bottom-up approach with different levels of government, managing their own activities. In addition, various cross governmental plans to tackle the complex problem of suicides were undertaken only by NZ. Along with such plans, NZ also managed to fund $25-million for the program, while lack of funding formed a major barrier in various sectors of a decentralized-system such as the Queensland-Department of Health.[13] Moreover, the involvement of police and limiting the role of media, in the action plan of NZ made it more robust.

Despite these, the policies also displayed various convergences in their frameworks. In both the policies, political commitment was ensured, focusing on the cultural barriers and health inequities faced by the Aborigines. Demonstrating international commitment, they also re-voted, the UN Declaration on the Rights of Indigenous People.

Conclusion

On the whole, this paper briefly describes the process of policy-making regarding suicides, reflecting various steps involved in the two countries. At this point, the cultural barriers, social disadvantages, and inequities in accessing healthcare formed the major causes of disproportionality in suicidal deaths among the indigenous populations of the two countries. Although, both the countries worked for promoting primordial and primary prevention, however, committed funding and integrating the cultural model into a health system, form a prerequisite for appreciable health outcomes among Aborigines in the coming future.

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