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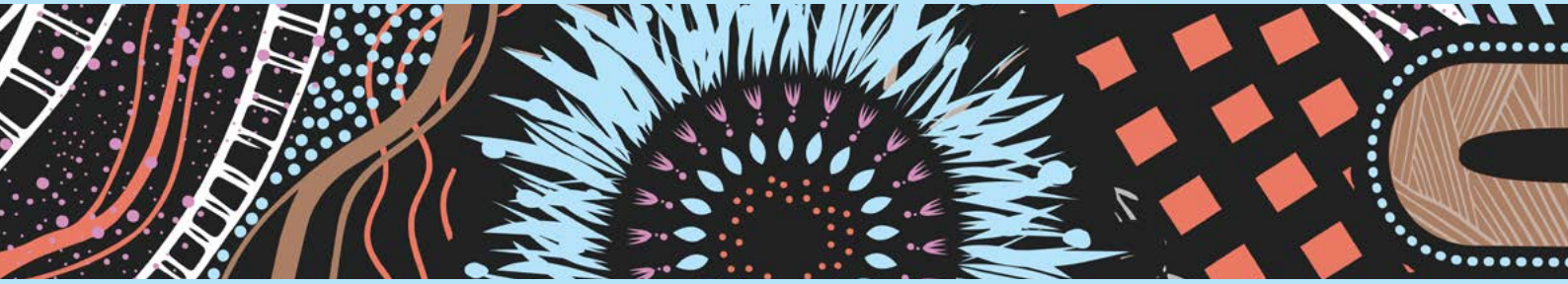

Harmful alcohol and other drug use and its implications for suicide risk and prevention for First Nations people: a companion paper

Julia Butt, Edward Wilkes, Jocelyn Jones, Emily Ripley and Annalee Stearne

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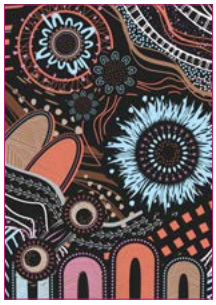

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Caution: Some people may find the content in this report confronting or distressing.

Please carefully consider your needs when reading the following information about Indigenous mental health and suicide prevention. If you are looking for help or crisis support, please contact:

13YARN (13 92 76), Lifeline (13 11 14) or Beyond Blue (1300 22 4636).

The AIHW acknowledges the Aboriginal and Torres Strait Islander individuals, families and communities that are affected by suicide each year. If you or your community has been affected by suicide and need support, please contact the **Indigenous Suicide Postvention Services on 1800 805 801.**

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe suicide and self-harm reporting. Please consider these guidelines when reporting on these topics.

Summary

What we know

- The harmful use of alcohol and other drugs (AOD) is a risk factor for suicide globally and among First Nations people. Alcohol has been identified in a significant percentage of deaths by suicide and emergency presentations for self-harm. Cannabis and methamphetamine use are also noted as concerning, with evidence linking these substances to increased suicidal behaviours. There is, however, a scarcity of recent and comprehensive data.
- First Nations men are more likely than First Nations women to die by suicide and are more likely to use AOD. Furthermore, they are less likely to access health services, making them a group at particular risk. It is important to note, though, that suicide is a leading cause of alcohol-related death among First Nations women.
- Specific groups, including young people, incarcerated individuals and those with co-occurring mental health issues, are at heightened risk for suicide when AOD use is present. The interplay of AOD use with factors like trauma, mental ill-health and social isolation is crucial in understanding and addressing suicide risk.
- The relationship between AOD use and suicide is complex; suicidal behaviour among First Nations people emerges from an intersection of individual, community and societal factors, including the ongoing effects of colonisation and the disruption of families and culture. Harmful AOD use shares common predictors with suicidal behaviour, such as factors already mentioned, as well as trauma and social dislocation.
- Acute AOD use (intoxication) is frequently present in suicide attempts. It can potentially exacerbate suicide risk through emotional instability, thus not only impairing decision-making and exacerbating impulsivity and interpersonal conflict but also destabilising existing mental health conditions and affecting access to support services.
- Chronic harmful AOD use can also compound existing vulnerabilities, leading to family and community destabilisation, mental ill-health, poor coping and distress tolerance, increased exposure to stressors (like violence and economic insecurity), stigma and reduced access to support services.
- Recognising that both acute and chronic AOD use, interpersonal conflict, family disconnection/disharmony and acute and post-traumatic stress are part of the AOD–suicide risk relationship has implications for practice.
- The absence of current First Nations-specific strategic frameworks for AOD is the most significant policy gap in reducing harms from AOD use and preventing suicide. This is followed closely by the need for effective implementation of existing policies. It could be argued that the lack of commitment by decision-makers at all levels to supporting First Nations communities is evident in the absence of any accountability or requirement for these policies to be implemented.
- With no group being responsible for implementing current (or expired) national First Nations-specific AOD frameworks, it is not possible to assess their effectiveness.
- There are clear cultural, community and family strengths that act as protective factors against suicide risk and harmful AOD use.

What works

- Developing and implementing strategic frameworks and policies both to reduce AOD harm and to support suicide prevention strategies in First Nations communities can be effective when they are codesigned with the affected communities. A place-based approach is necessary for these complex issues as factors influencing the implementation and sustainability of policies are locally influenced. Policy frameworks are effective only when implementation is resourced.
- In general, holistic approaches to both AOD harm and suicide prevention have efficacy. This includes strategies that are community and family focused, that are culturally centred, that target common risk and protective factors, and whose design is self-determined by First Nations communities.
- Within suicide prevention, AOD-related harm can be addressed within existing universal, selective and indicated prevention (as well as postvention services) and workforce strategies.
- Areas of opportunity include:
  - enhancing emergency department responses to include culturally sensitive assessments and care pathways for individuals with co-occurring AOD use and suicidal behaviour
  - expanding support service hours and capacity to manage co-occurring AOD, suicide and mental health conditions
  - providing support for those in crisis, especially during non-office hours
  - including AOD content in suicide prevention workforce and gatekeeper training programs and resources
  - increasing suicide prevention training in AOD settings
  - providing through care to those leaving custodial and residential treatment settings.
- Longitudinal, multi-component and multilayered programs tailored to community need – and with community ownership – are beneficial.
- Integrating AOD interventions with selective suicide prevention efforts has shown promise, especially when these programs are flexible and sustainable.
- Holistic residential treatment for AOD that provides not only AOD treatment but also mental health support, life skills and cultural connection is effective in reducing suicide risk post treatment.

What doesn't work?

- Strategic frameworks and policies both to reduce AOD harm and to support suicide prevention strategies are not effective if they:
  - are not implemented effectively
  - ignore the complexity and interrelated nature of the issues
  - are not updated and aligned with national-level strategies
  - focus on just one type of intervention; that is, treatment without supply reduction interventions.

- As highlighted in the primary paper *Harmful use of alcohol and other drugs and its relationship with the mental health and wellbeing of First Nations people: a review of the key issues, policy and practice approaches.* (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), the siloing of policy and practice for mental health and AOD-related harm persists, which has ramifications for the delivery of integrated services, including suicide prevention.
- The lack of availability of AOD and mental health services more broadly prevents effective suicide prevention work.
- While acknowledging that AOD-related harms, like suicide, are symptoms of broader issues, the lack of attention to both acute and chronic AOD use and harms within suicide prevention programs is concerning. There is a need to respond to both acute and chronic AOD harms within suicide prevention models. Existing clinical guidelines for suicide risk often fail to include comprehensive management of AOD use, reducing their applicability to people who use AOD and are at risk.
- Inflexible service delivery models are not suitable. This includes services without flexible delivery modes as well as those that cannot respond to changes in AOD use and suicidality.
- A shortage of culturally safe and positive service experiences prevents many First Nations people from seeking support for AOD, mental health and suicide crises, for themselves or their family.
- Insufficient postvention services following a death by suicide, or an attempt, leave families and communities without the necessary support, increasing the risk of suicide contagion and of AOD-related harms.

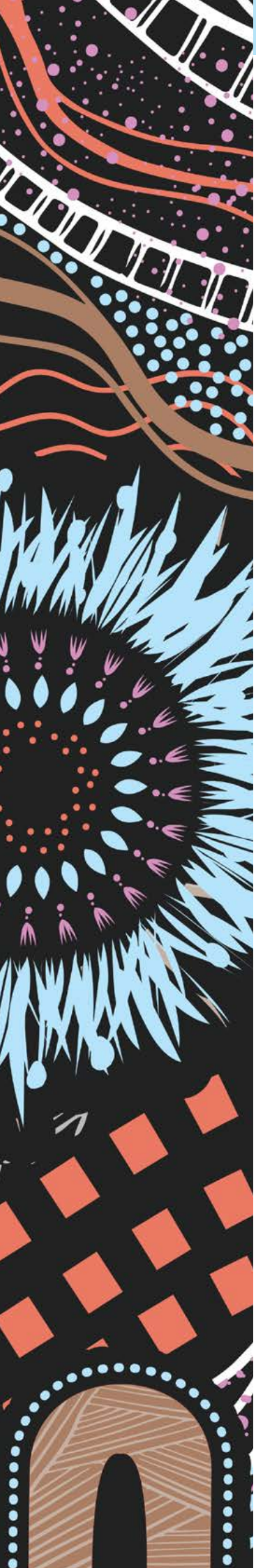
What we don't know

- Research on non-suicidal self-injury (NSSI), suicidal ideation, and attempts and deaths by suicide among First Nations people are significantly hindered by poor data quality and substantial gaps in available data. What we do not know includes:
  - community-level information on AOD use in relation to suicidal ideation and NSSI
  - detailed information on deaths by suicide outside Northern Australia
  - the role played by use of substances other than alcohol – such as cannabis, methamphetamines and polydrugs.
- There is a lack of recent data around NSSI, cannabis use in self-harm, suicide attempts and deaths by suicide, and general toxicology. Reviews often rely on outdated studies due to the limited number of papers available; ongoing, up-to-date research that considers community variations and the distinct experiences of First Nations people in different regions is needed. That said, comprehensive data may not be available in the short term, despite community reports consistently emphasising the significant role of AOD-related harms in suicide risk. There is nonetheless a need to respond while waiting for updated research.

Drivers of change

- Significant investment is needed in First Nations-led primary research that defines and increases understanding of NSSI and its risks and prevalence, and of AOD use and its intersection with suicidal behaviour.
- The recognition and resourcing of First Nations' leadership is vital to both the development and implementation of any policy framework and/or strategy; these issues are linked to the historical and ongoing traumas of colonisation and exclusion.
- First Nations peoples' right to self-determination is necessary to empower and develop a localised response for AOD, suicide and NSSI. There is no longer any body responsible, nor accountable, for advocating for First Nations-specific AOD priorities and policy. This means that there is no dedicated and resourced group advocating for the funding of prevention and treatment services; nor is there anyone to monitor actions related to the AOD strategies. Rectification of this national omission is an urgent necessity.
- Harmful AOD use is acknowledged as contributing to suicide; however, policy and strategy do not address this in detail. Preventing AOD-related harm needs strategically coordinated and resourced interventions under all pillars of the AOD harm minimisation framework.
- A systems-level approach is necessary to address the complexities of AOD and suicide prevention. Furthermore, given that the causes of suicide risk are systemic and long term, responses need also to be systemic and long term.
- Efforts to address AOD-related harms, and to prevent suicide and NSSI in First Nations communities, have been significantly underfunded and under-resourced; short-term projects with one-off funding dominate the landscape. However, these priorities are not one off; rather, there is a need for consistent and sustained resourcing of interventions.
- Suicide prevention and treatment should be multi-component and multilayered, and include interventions that can incorporate AOD and have the following features:
  - AOD-focused suicide prevention included in sustainable programs, with ongoing funding
  - services with the capacity to flexibly accommodate and respond to changes in AOD use and suicidality – as opposed to service termination when conditions fluctuate
  - increased opportunities for screening and identifying high-risk individuals in primary health care settings
  - gatekeeper training across sectors, particularly in AOD treatment services
  - AOD training across sectors, particularly in suicide prevention and intervention
  - recognition of the role of trauma in AOD and suicide risk presentations and of the need for increased training in trauma-informed and responsive care in AOD and suicide prevention services
  - clear aftercare pathways in high-risk contexts, including post AOD treatment, post hospitalisation and post incarceration.
- Clinical guidelines for suicide risk should include the assessment and management of AOD use.

- Emergency department responses should include not only suicide risk assessment and management of intoxication but also assessment more sensitive to the sociocultural contexts of psychosocial distress underpinning suicidal behaviour for First Nations people.
- Increasing the opening times that services are available is an opportunity to better support those with acute AOD use and experiencing crisis.
- Improved integrated AOD, mental health care and suicide responsiveness – a 'no wrong door' approach – needs:
  - culturally safe and secure screening and assessment that adequately identifies both AOD-related harm and suicide risk in culturally safe ways within mental health services
  - clinical pathways (including through care) that provide ongoing services to those at risk
  - recognition of the role of stigma in AOD presentations and of ensuring safe service delivery
  - recognition of the role of trauma and management of acute distress in presentations
  - innovative approaches and service delivery models that can support whole families and communities.
- New approaches need resourced implementation, including service delivery models, capacity building to identify and fill service gaps, workforce enhancement, remedies for siloing, prevention treatment, postvention, realistic timelines, accountability, monitoring and evaluation.



1

Introduction

1 Introduction

High rates of suicide persist among First Nations communities (AIHW 2023a); understanding, responding to and preventing suicide is a key national priority. The factors associated with suicide for First Nations people are varied and complex and include those unique to their experiences (Dudgeon et al. 2017; Martin et al. 2023; Westerman and Sheridan 2020). These factors are intertwined with social inequality and an ongoing legacy of colonisation, oppression and dispossession. Suicide prevention and responses need to encompass the diverse needs of First Nations people, including systemic change and support for individuals and communities at risk. 'One size fits all' approaches, and those that target single risk factors, are not recommended (Dudgeon et al. 2017; Martin et al. 2023; Westerman and Sheridan 2020). That said, consideration of some key risk and protective factors and clinical indicators can inform the development of prevention strategies and responses.

The harmful use of alcohol and other drugs (AOD) is a well-established risk factor for suicide internationally (Fisher et al. 2020; Rontziokos and Deane 2019) and there is compelling evidence that it is a risk factor of significance for First Nations people (AIHW 2022c). Despite this, there is a lack of focus or detailed research on harmful AOD use within the suicide prevention literature – beyond noting its role as a risk factor; furthermore, there is a lack of discussion in First Nations AOD literature about suicide risk.

AOD-related harms are experienced disproportionately by First Nations people (Butt et al. 2024; Gray and Wilkes 2010) and they are inexorably linked to individual and community mental health and wellbeing. However, despite decades of calls to action, there has been an ongoing siloing of AOD use and mental health policy and practice for First Nations people (Butt et al. 2024; Jebaraj 2015) – and, indeed, more broadly (Deady et al. 2014). This lack of integration between AOD use and mental health practice, policy and research adversely affects the capacity to respond effectively for those who experience both. Furthermore, this siloing persists into the prevention and management of suicide risk.

Understanding the impact of AOD use on suicide risk is necessary not only to address overlapping concerns, but also to minimise risk and provide integrated responses. As such, this paper builds on the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health) in exploring the role of harmful AOD use on suicide risk and in considering the implications for policy and practice.

Aims of the review

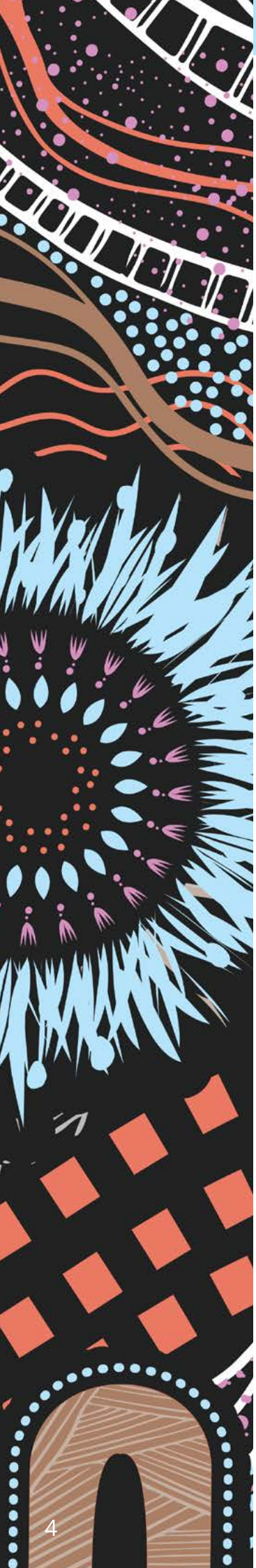
This review synthesises research relating to the co-occurrence of harmful AOD use and suicide risk, as well as policy and practice responses. Specifically, it aims to:

- examine the co-occurrence of, and relationship between, harmful AOD use and suicide risk and the interrelationship of alcohol use, suicide risk and mental ill-health
- analyse current policy approaches to harmful AOD use and suicide prevention, and identify effective policy responses
- examine current programs that integrate responses to AOD suicide prevention, response and postvention, and identify effective responses.

Limits of the discussion

The intersection of AOD-related harms and suicide (and mental health) is complex and wide ranging; hence, it is important to note the limits of the current review as was done for the initial primary paper.

- Tobacco and nicotine use, while prevalent and associated with a significant burden of disease (AIHW 2022a) and with implications for mental health (Colonna et al. 2020), is not considered in this review.
- The intersection of harmful AOD use, suicide risk and disability (including Fetal Alcohol Spectrum Disorder) is not covered specifically in this review. Neither is the relationship between harmful AOD use, suicide risk and neurodiversity.
- With respect to AOD policy, the current review does not discuss specific AOD strategies in depth. Of note, supply reduction policies do aim to reduce AOD-related harms, including suicide. At a population level, there is evidence that alcohol consumption is linked to suicide rates (Norström and Rossow 2016) and reducing consumption may result in lower suicide rates; however, there is a lack of data relevant to First Nations people and, furthermore, conclusions from existing research are clouded by confounding variables (Kõlves, Chitty et al. 2020). Supply reduction and, indeed, demand and harm reduction strategies are important facets of universal suicide prevention (for example, see Dudgeon et al. 2016); however, they are not stand-alone solutions.



2

Background

2 Background

Locating AOD-related harm and suicide risk within the social and emotional wellbeing framework

This review identifies the harmful use of AOD and suicidal behaviours within the broader conceptualisation of social and emotional wellbeing (SEWB); it recognises that they are consequences of disrupted SEWB. SEWB is a well-established and holistic concept encompassing 7 health and wellbeing domains: connection to Country; connection to spirit, spirituality and ancestors; connection to body; connection to mind and emotions; connection to family and kinship; connection to community; connection to culture (Gee et al. 2014). SEWB is distinct from individual centric models of mental health and wellbeing – a significant factor, given the focus of individual behaviour change inherent in most treatment modalities. A comprehensive discussion of SEWB is available in Gee at al. (2014) and in recent AIHW Clearinghouse publications (for example, Martin et al. 2023). Integral to the SEWB framework is a recognition that strengthening connections between SEWB domains is associated with better wellbeing, whereas disruptions result in poorer SEWB outcomes (Gee et al. 2014; Martin et al. 2023); furthermore, the model recognises the importance of cultural identity and expression on positive SEWB (Kickett-Tucker et al. 2015). Within this framework, harmful AOD use can be considered as both arising from disrupted SEWB and as a factor that disrupts SEWB at both the individual and community level.

Key concepts

AOD-related harm

A detailed definition and exploration of AOD-related harm is presented in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health); however, to ground the approach of this review, it is emphasised that not all AOD use is harmful. This review considers 'harm' through a public health lens – with 'harm' considered at the individual level, family level and community level. The definition of harmful use is not restricted to meeting the diagnostic criteria for a substance use disorder (American Psychiatric Association 2022) (and the associated terms of 'dependence', 'addiction' or 'use disorder') but incorporates the broader social, familial, economic, health and wellbeing implications of engaging in harmful AOD use.

As described in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), the harmful use of AOD is an impediment to the health and wellbeing of First Nations people. While data likely underestimate use, data from the *2018–19 National Aboriginal and Torres Strait Islander Health Survey* reported that 50% of First Nations people aged 15 and over drank alcohol above safe limits, and 28% used drugs in the previous year (AIHW 2023b). While the proportion of First Nations people who consume alcohol is less than that for the general population (AIHW 2023b), First Nations people experience a disproportionate amount of harm from AOD, with estimates suggesting that the harms experienced are 2.3 times greater than those for the broader population (James et al. 2020). Communities most often cite alcohol, cannabis and methamphetamine as the 3 substances causing harm; these are also the most common primary drugs of concern among

people receiving treatment (Butt et al. 2024). Importantly, there is a lack of detailed and nuanced data related to patterns of AOD use, in particular polysubstance use, and its interaction with markers of mental health, psychological distress, suicide and non-suicidal self-injury.

Suicidality

This review considers suicidal behaviour along a continuum of deaths by suicide, attempted suicide and suicidal ideation (Rontziokos and Deane 2019; Yuodelis-Flores and Ries 2015). Inherent in suicidal behaviour are thoughts about or intent to end life (however fleeting); this review does not consider non-suicidal self-injury (NSSI) (irrespective of whether it results in death) within the definition of suicide. It does recognise, however, that suicidal behaviour, like NSSI, is understood as an expression of profound distress, which may or may not correlate with a diagnosable mental health condition (Dudgeon et al. 2017; Martin et al. 2023). Data associated with suicide attempts and ideation are limited; most existing data come from information on deaths by suicide or hospital admissions for self-injury. Hospital admissions may include both NSSI and suicide attempts and can be described in the literature as 'self-harm' (for example, see McHugh et al. 2016). As such and as discussed elsewhere (see AIHW 2023a; Martin et al. 2023), detailed accurate data on suicidal behaviour are limited.

Despite data limitations, suicide is understood to be the fifth leading cause of death for First Nations people, being the second leading cause for First Nations men and the seventh for First Nations women (ABS 2022). There are varied patterns across demographic groups within the First Nations population; however, the rising rate is consistent across groups (Martin et al. 2023; McHugh et al. 2016; Tighe et al. 2015) with young First Nations men consistently identified as a priority population (Tighe et al. 2015). As well as the high rates of death by suicide, rates of suicidal ideation are also considered high; for example, First Nations men are twice as likely as non-Indigenous men to report recent suicidal thoughts (Armstrong et al. 2017). A recent AIHW Clearinghouse review (AIHW 2022c) comprehensively discusses risk and protective factors; this review builds on that, with a focus on the relationship between suicide and harmful AOD use.

Non-suicidal self-injury

NSSI is distinct from suicidality; it involves intentionally injuring the body, in the absence of suicidal intent, in a manner that is not socially or culturally accepted (American Psychiatric Association 2022). Broadly speaking, NSSI is understood as an expression of distress, and a way to cope with extreme distress (American Psychiatric Association 2022). Most data collected on suicidal behaviours and NSSI do not adequately distinguish between these 2 behaviours. That said, it is possible that self-harm is a predictor of suicide risk (De Leo et al. 2011; Kuipers et al. 2012; Leckning, Hirvonen et al. 2020), although this relationship is not robust and contrary evidence has since been found suggesting that self-harm may not predict suicide for First Nations people (Leckning et al. 2023). There is no recent prevalence data for First Nations people with respect to NSSI; however, previous research suggests that rates of self-harm among First Nations people do not differ from those among non-Indigenous Australians (Moore et al. 2015).

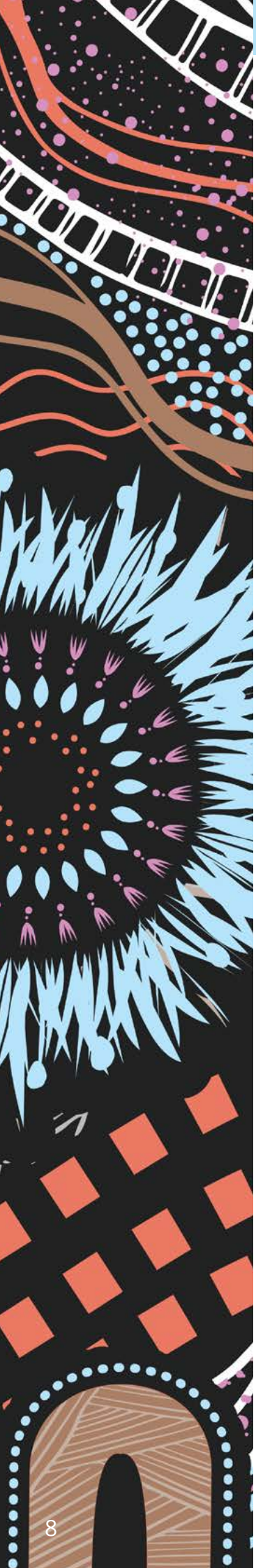
Importantly, the above definition of NSSI does not include culturally sanctioned behaviours. (Such behaviours may be captured as 'self-harm' in hospital presentations and misdiagnosed as NSSI.) As noted by Westerman (2021), culturally sanctioned self-harm behaviours exist among First Nations people and can be related to grief, tribal/lore markings and physical payback.

Cultural norms exist around these behaviours and as such they do not pose a significant risk of harm. Westerman (2021) emphasises the importance of differentiating between behaviours that represent deliberate self-harm and those that represent a culturally appropriate expression of grief, rite of passage or problem resolution process. Only with appropriate recognition and understanding of NSSI can appropriate prevalence data be examined, and appropriate service provision identified, if required. Nationally, there is a lack of data to distinguish between suicide and NSSI and between NSSI and self-harm related to cultural expression. Hence, discussion on NSSI and culturally sanctioned self-harm is limited in this review.

Key contextual factors regarding AOD use and suicide risk among First Nations people

High rates of both suicide and harmful AOD use occur within the broader context of the ongoing impacts of colonisation, oppression and racism experienced by First Nations people, and cannot be understood and successfully addressed without acknowledging and taking account of these issues. These broader issues are examined in detail in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health) and elsewhere (for example, Barry and Guerin 2024; Darwin et al. 2023; Dudgeon et al. 2016; Dudgeon et al. 2017; Martin et al. 2023).

Particularly important to the current discussion are the impacts of past and current policies that involve the removal of children from families, dispossession of land and language, exclusion from economic structures, systemic racism, and high rates of incarceration – all of which serve to disrupt family and community structures (Darwin et al. 2023; Dudgeon and Holland 2018; Dudgeon et al. 2017; Gray and Wilkes 2010); furthermore, alcohol and drug policy since colonisation has excluded and minimised the voice of First Nations people (Brady 2000; Butt et al. 2024; Stearne et al. 2021; Stearne et al. 2022). This scenario, coupled with broader social inequality, has led to high rates of adverse life experiences, homelessness, stress and trauma, which, alongside a lack of access to quality service, are drivers of distress and of both suicide risk and harmful AOD use. Against the backdrop of disadvantage, however, clear cultural, community and family strengths act as protective factors against suicide risk and harmful AOD use (Dudgeon et al. 2021); policies and practices that continue to enhance cultural and family strength provide a context for good SEWB and need ongoing investment (Dudgeon et al. 2016; Martin et al. 2023).



3

Method

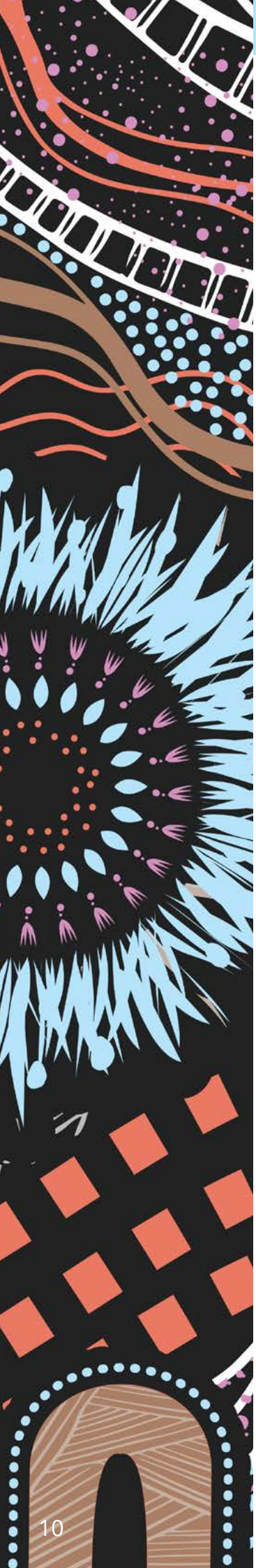
3 Method

Publications reviewed and used in the evidence synthesis in this paper were identified as part of the broader review into the relationship between harmful AOD use and mental health. Full details are provided in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health).

In summary, a scoping review methodology was employed (Munn et al. 2022) focused on iterative review, lines of inquiry were followed, and the review was expansive (rather than specific) in focus. This methodology was adopted due to the paucity of research directly on the topic. Both traditional academic papers and grey literature were searched. The initial literature was identified using the search terms included in Table 1 of the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health) as well as the following terms related to suicide, NSSI and self-harm: suicide, self-harm, non-suicidal self-injury, self-injury, suicide risk, suicide ideation, suicidal intent, suicidality, coroner, cause of death, gatekeeper, suicide cluster and contagion. Reviewed materials related to suicidality and AOD-related harm were reviewed separately to enable the relationship between harmful AOD use and suicide to be discussed in detail.

Due to the complexity of the field, the overlap across several research domains, and the changing policy landscape around AOD, the review limited searches to articles published in the previous 10 years (from 2013). Exceptions were made for critical works (Clough 2005; Davidson 2003; Gray and Wilkes 2010; Hanssens 2007, 2011; Hunter 1990; Kuipers 2012) – these include papers on cannabis use for which there is no recent research. Other aspects of the review methodology were that:

- papers on the search topics were not indiscriminately included
- First Nations voices and research were privileged within the review
- papers without clear links to community oversight and authorship were not included unless agreed by the full research team
- unless specified, the review did not include research on First Nations people from other nations.



4

Key issues

4 Key issues

Evidence for a relationship between harmful AOD use and suicide risk among First Nations people

Internationally, harmful AOD use is a well-established risk factor for suicidal ideation, attempts and deaths by suicide (Kennedy et al. 2015). Although there are limited data to fully explore the role of AOD in suicidal behaviour among First Nations people, it has been identified as a key risk factor (AIHW 2022a, 2022b; ATSISPEPS 2021) and highlighted by an Elders report into preventing suicide (People Culture Environment 2014). This review explores evidence for the relationship – and the nature of it – between harmful AOD use and suicide risk. This complex interrelationship is discussed in detail at the conclusion of this section; however, in brief, it is useful to hold 3 pathways in mind while reviewing the data:

- firstly, that harmful AOD use and suicidality share many common predictors (as described earlier, including both sociodemographic risks and mental ill-health)
- secondly, that chronic harmful use of AOD is related to suicidality, both directly and indirectly
- thirdly, that acute harmful use of AOD – in particular intoxication – increases suicide risk.

Suicide risk and harmful AOD use varies across communities and over time; therefore, examination of the research described below has been undertaken cautiously. Furthermore, as the AIHW noted (2022a), data quality issues must be considered; this includes the under-identification of First Nations people in deaths data, and difficulties in classifying deaths and self-harm. Of note, community and stakeholder concerns and reluctance in asking about suicide means questions pertaining to suicide (such as attempts and ideation) may not be asked or included in broader research that investigates SEWB factors more broadly (that is, McCalman et al. 2017). Consequently, there are limited data.

Internationally, heavy alcohol use is recognised as a significant predictor of deaths by suicide; furthermore, the relationship between alcohol use and suicide attempts is stronger than that for other substances, and predicts suicide attempts independent of other co-occurring drug use (Kennedy et al. 2015). Thus, alcohol is a significant focal point of research. Oft cited research by Hanssens (2009) examined Northern Territory coroners' data from 1996–2006 and identified that alcohol was present for 77% of deaths by suicide among First Nations people; although outside our review window and restricted to the Northern Territory, this research provides a valuable starting point in considering the role of alcohol. More recent studies also highlight the relationship between both acute and chronic alcohol use among First Nations people who have died by suicide:

- Kõlves, Koo and colleagues (2020) examined blood alcohol concentration among those who died by suicide from the Queensland Suicide Register between 2004–2015 and identified that 56.3% of First Nations people who died by suicide had positive blood alcohol readings at the time of death.
- Analysis by Gray and colleagues (2018) of alcohol attributable death data between 2011 and 2015 (from the Steering Committee for the Review of Government Service Provision 2016) in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory estimated that 40% of male suicides and 30% of female suicides were attributable to alcohol.

- The West Australian Government noted that suicide was the most common cause of alcohol-related deaths among Aboriginal men and the fourth most common cause among Aboriginal women.

Research also demonstrates a relationship between harmful alcohol use and suicidal behaviours and self-harm data from hospital and police records:

- McPhee and colleagues (2022) examined routinely collected self-harm data from the Kimberley District of the Western Australia Police Force (2014–2018) and local emergency department data (June 2017 to December 2018) and found that First Nations people, particularly young people and those affected by alcohol, were over-represented in the self-harm data. They identified that 80% of self-harm events recorded by police for individuals aged 25–50 involved alcohol. Furthermore, many of these self-harm incidents occurred in the evening and at night.
- Leckning, Borschmann and colleagues (2020) examined emergency department data from the Northern Territory and identified that among self-harm presentations for First Nations people there were high levels of associated substance use disorders (75%). Furthermore, although co-occurring mental health diagnoses were not described, 40% of people had had previous contact with mental health services (which suggests mental ill-health at some point in their life).

Other than the study by Leckning, Borschmann and colleagues (2020), there are few studies looking at substances other than alcohol, and at studies in a community setting. Pandeya et al. (2021) noted that drug use was related to recent thoughts of suicide or self-harm among First Nations primary health care consumers completing health checks at an urban Community Controlled Health Service. Drugs such as cannabis and methamphetamine are important to consider in relation to suicide. As described in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), high levels of cannabis use are a health concern for First Nations communities. Internationally, cannabis use is considered a risk factor for deaths by suicide (Campeny et al. 2020) and suicidal ideation (Carvalho et al. 2019); however, a clear causal pathway has not been established. Outside our review window, though, previous research identified that cannabis was formally detected in 31% of First Nations people who had died by suicide, and noted as a factor in a further 17% of case reports (Kuipers et al. 2012). Similarly, research in the Northern Territory in 2003 found that 50% of 'near hangings' treated within an emergency department were positive for cannabis during toxicology (Davidson 2003). Hanssens (2007) reported a link between cannabis and hanging among young First Nations deaths by suicide in the Northern Territory (25% of hangings were in the context of cannabis use) and suggested that cannabis contributed to impulsivity during intoxication, withdrawal, and drug seeking. A number of authors have concluded that, much like for alcohol, high cannabis use is associated with increased suicidal behaviours among First Nations communities (Clough et al. 2005; Kuipers et al. 2012; Lee et al. 2007). More recent research is needed.

Methamphetamine use is a topic of concern for First Nations communities and related to significant harms (MacLean et al. 2017; Reilly et al. 2020; Snijder et al. 2019), but there is a lack of data relating to suicide risk. A review of the Australian National Coronial Information System found that between 2009 and 2015 there were 1,649 cases where methamphetamine had been recorded as contributing to death; 18% of these were deaths by suicide (Darke et al. 2019). Although data related specifically to First Nations people are not available, it is likely that a relationship between suicide risk and methamphetamine use (including chronic use), intoxication and withdrawal may exist. Qualitative research with First Nations people who use methamphetamine and their families by MacLean and colleagues (2017) highlights the complexity associated with the use of this drug,

including the disconnection and alienation from community and family that users experience – which are known risk factors for suicide. They also noted that involvement in the drug trade for some methamphetamine users was implicated in descriptions of suicidal ideation.

For a number of years through the 1980s to the early 2000s, volatile substance use (VSU) and its associated harms were publicised and targeted in research and prevention; over the last decade, however, far less attention has been paid to VSU than to other drugs, and current levels of use and harms are unknown. That said, it has been identified as a risk for suicide, particularly among young people (d'Abbs and Shaw 2016; Marel et al. 2022), and ongoing monitoring of VSU is important.

In summary, the existing data show support for a link between harmful AOD use (both chronic and acute use), deaths by suicide, and self-harm within the hospital context. Generally, data are lacking outside of Northern Australia, in community research and for drugs other than alcohol.

Suicide risk in AOD research

Considering the relationship between harmful AOD use and suicide risk, people in AOD treatment settings with suicidal ideation are a potentially high-risk group who may require intensive services (Rontziokos and Deane 2019). In reviewing Australian research of suicidal behaviour in AOD treatment, these researchers found no studies of reported rates of suicidal behaviour for First Nations people; as they concluded, this highlights a significant gap in the literature. Since Rontziokos and Deane's (2019) review, we have identified 2 recent pieces of research that do demonstrate suicide risk among First Nations AOD treatment seekers:

- Davis and colleagues (2022) investigated the impact of psychiatric comorbidity on outcomes following detoxification among a treatment cohort that included both First Nations and non-Indigenous patients; they identified suicidality among 29% of the cohort, noting that 61% of participants had a co-occurring mental health condition. Despite the research including both First Nations people and non-Indigenous Australians, the result highlights that those in treatment for harmful AOD use, and those with AOD and mental health comorbidities, are a high-risk group for suicidality.
- Nathan and colleagues (2020) reviewed suicide and self-harm among First Nations young people in residential rehabilitation in New South Wales. At intake, they identified that 20% of young people had previously attempted suicide, and 30% had reported previous self-harm. These figures are higher than those for other reported prevalence of suicidal ideation and self-harm among First Nations young people and confirm that those seeking rehabilitation for AOD-related harms are a high-risk cohort.

Despite the limited evidence, there are sufficient data to suggest that those seeking treatment for AOD use are at risk of suicidality. International research also highlights the importance of suicide risk following discharge from AOD treatment; however, a recent Australian study looking at suicide attempts post discharge from AOD treatment using data linkage (Tisdale et al. 2024) identified that First Nations people were less likely than non-Indigenous Australians to have suicide-related presentations. This highlights the potential ongoing value of residential treatment; however, as noted by the authors, findings may be attributable to non-treatment factors – as such, they emphasise the importance of 'after care' or 'through care' post discharge to support those exiting residential AOD treatment (Tisdale et al. 2024).

There is a lack of research among those who use AOD outside the treatment environment. As noted earlier, researchers and communities can be reluctant to address suicide for a range of reasons: discomfort, concerns that questions may cause harm to participants or those conducting research (Heard et al. 2022; McCalman et al. 2017), and suicide falling outside the priority areas of some research. While further research is necessary, it should proceed cautiously.

Harmful AOD use among those specific suicide risk factors

Communities with high suicide prevalence – echoes and contagion

Suicide echoes, sometimes referred to as clusters, have been documented in some regional and remote First Nations communities (Hanssens 2011). Suicide echoes are deeply complex phenomena whereby multiple suicides occur within a short period of time (Silburn et al. 2014). They are related to a range of historical, social, economic and cultural dislocation factors. There is concern that high levels of community-wide alcohol use may increase the risk of suicide echoes, and that alcohol use can have an impact on high-risk communities (see, for example, Hanssens 2007, 2011; Parliament of Western Australia 2016). One review concluded that among First Nations communities where there were suicide echoes, impacted people were reported to either be intoxicated or in severe withdrawal at the time of their attempt or death by suicide (Silburn et al. 2014). Westerman and Sheridan (2020) also described the role of harmful AOD use in suicide echoes suggesting that intoxication exacerbates impulsivity and creates a high-risk environment, which affects contagion of suicidal behaviour. Similarly, high levels of alcohol use in communities and families creates social disruption which can then have an impact on the risk of suicide (see, for example, Fogliani 2019). Community-level harmful AOD use, in particular alcohol harm, has an impact on suicide risk in high-risk communities.

People with co-occurring harmful AOD use and mental ill-health

Harmful AOD use can destabilise individuals with co-occurring mental health disorders and consequently increase suicide risk (Fisher et al. 2020; Handley et al. 2018). International research has identified a relationship between AOD use disorders and comorbid psychosis, bipolar affective disorder, depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and suicide risk (Fisher et al. 2020). As described in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), there is a lack of data on comorbidity among First Nations people, and this lack of detail persists in suicide prevention research. However, limited evidence within the treatment sector (Davis et al. 2022) and within emergency department data (Leckning, Borschmann et al. 2020; Leckning et al. 2023) highlights that First Nations people with co-occurring AOD and mental ill-health are at heightened risk of death by suicide. Consistent with the primary paper, it is important to highlight the potential role of trauma, acute stress and PTSD in understanding comorbidity and suicide risk. Limited data exist; however, Shepard and colleagues (2018) noted that people who used AOD and had PTSD were more likely to have suicidal ideation in custody than those without PTSD.

Young people

Among First Nations young people, rates of both harmful AOD use and suicide are disproportionately high (Hill et al. 2022). The suicide rate for young people aged under 18 is 3 times that for the broader youth population; for children aged under 15, the rate is 12 times that for the broader age-matched population (Gibson et al. 2021). Research suggests that harmful AOD use is a risk factor for suicide for First Nations young people:

- Recently published data from the Westerman Aboriginal Symptom Checklist – Youth (WASC–Y) (a comprehensive culturally appropriate youth mental health assessment) (Westerman and Dear 2024) provide compelling evidence. From their analysis of a data set of over 1,000 young people who had completed the WASC–Y within mental health services between 2007–2022, Westerman and Dear (2024) report that 41% of respondents had experienced suicidal ideation and, of those, 25% had previously attempted suicide. In relation to AOD, multiple regression modelling of suicide risk identified that AOD was a significant predictor of suicide risk among young people in mental health settings (alongside depression, anxiety, impulsivity, gender [woman] and lower cultural resilience). These findings emphasise co-occurring AOD, suicide risk and mental health among young people.
- Leckning and colleagues (2023) analysed data from first admissions to a Northern Territory emergency department and identified that First Nations young people were more likely to be diagnosed with comorbid substance use and have a prior admission for alcohol use than non-Indigenous young people.
- Analysis of child deaths in Queensland identified that 33% of First Nations children (aged 10–14) who died by suicide had consumed alcohol before their death by suicide and 30% had a lifetime history of drug use, with the majority of these being the use of cannabis (Soole et al. 2014).
- A systematic review of NSSI among First Nations people and New Zealand youth identified alcohol use as a predictor of NSSI (Black and Kisely 2018).
- A systematic review of antecedents to deaths by suicide among First Nations young people (Dickson et al. 2019) cited equivocal findings in respect to harmful AOD use and deaths by suicide; they concluded that harmful AOD use was not related to ideation but may be related to suicide attempts. Of note, the majority of research in Dickson and colleagues' review occurred outside our review window. Additional current research that investigates the differing role of AOD in suicide attempts and ideation for young people is important.
- In the inquest undertaken by the Western Australian Coroner into the deaths by suicide of 13 First Nations children and young people in the Kimberley region, harmful AOD use was co-occurrent with a significant number of the investigated deaths by suicide and highlighted as a risk factor (Fogliani 2019).

Older adults

Shen and colleagues (2018) noted that an increase in life expectancy means there is a growing cohort of older First Nations people, a population that has received scant attention in the mental health and AOD research area. In this study, Shen and colleagues investigated the impact of various sociodemographic risk factors in older adults with depression and suicidal behaviour.

They noted risky alcohol use and cannabis use within their sample, but neither significantly predict suicidality (Shen et al. 2018). That said, and mindful that this is an under-researched cohort, further research is warranted among older adults.

Men

First Nations men are more likely than First Nations women to die by suicide (AIHW 2024; Martin et al. 2023), use more lethal methods during suicide attempts (AIHW 2022c; Martin et al. 2023), and are more likely to use AOD (Butt et al. 2024; Nasir et al. 2018); furthermore, they are less likely to access health services (KAHPF 2016), making them a group at particular risk. There is a lack of specific data related to men outside the justice context; however, suicide has been reported as the most common cause of alcohol-related death among First Nations men (Berry et al. 2022; Haregu et al. 2022).

Women

There is a lack of detailed research on First Nations women and their experiences with AOD-related harm and suicidality in community settings; however, suicide is a leading cause of alcohol-related death among First Nations women (Berry et al. 2022). Furthermore, recent work by Westerman and Dear (2024) highlights the importance of gender differences in the predictors of suicidal behaviour. Therefore ongoing research should consider the differing role that harmful AOD use may play for men and women.

LGBTQIASB+ people

There is little published research specific to interactions between suicidal behaviour and harmful AOD use among First Nations LGBTQIASB+ people. Nationally, suicide rates are higher among the LGBTQIASB+ community, which is identified as a priority community in the *National Drug Strategy 2017–2026* (Lea et al. 2021). This research gap is highlighted and discussed in a recent Clearinghouse review alongside risk and protective factors specific to suicide among First Nations LGBTQIASB+ people (Day et al. 2023). Recent research investigating SEWB among First Nations LGBTQIASB+ young people has reported high rates of suicidal ideation, with 57% of participants reporting ideation but low levels of AOD-related harm (Liddelow-Hunt et al. 2023). There was no relationship between AOD use and suicide variables. Thus, it is not clear if and how AOD-related harms are related to suicidal behaviour among young LGBTQIASB+ people.

People involved in criminal justice

Suicide rates are higher among incarcerated people than among the general population, with suicide being the leading cause of death of incarcerated people (Shepherd et al. 2018). Furthermore, people released from custody remain at increased risk (Borschmann et al. 2017). Considering the over-representation of First Nations people in the justice system, the role of AOD among this high-risk cohort is important to consider. Research looking at suicide risk among incarcerated First Nations men found that lifetime experience of an AOD use disorder was among the highest correlates of suicidal behaviour and was *the* highest correlate (other than suicidal ideation) of having attempted suicide (Shepherd et al. 2018). Similarly, in a Queensland study of incarcerated adults (men and women), Young and colleagues (2018) noted that mental illness, lifetime experiences of

suicidal ideation, and previous suicide attempts were more common among those with an AOD use disorder than among those without it – highlighting the co-occurring impacts of not only harmful AOD use but also co-occurring harmful AOD and mental ill-health. Further research has noted that young people in custody, particularly young women, are at a higher risk of suicide (Moore et al. 2015). Whether First Nations people have higher suicidal ideation and suicide attempts than non-Indigenous people in custodial settings is not clear, with results across the research being mixed (see Dickson et al. 2019 and D'Antoine et al. 2022 for a discussion); this research is largely related to measurement concerns and the lack of appropriate assessment tools, and to the potential for a ceiling effect related to the sheer number of risk factors experienced by those in custody. Irrespective, historical and current AOD use among those in the criminal justice system is a risk factor for suicide.

Understanding the relationship between harmful AOD use and suicide risk

The data presented earlier in this section, although limited, confirm that harmful AOD use is a risk factor for deaths by suicide among First Nations people. Understanding the relationship between harmful AOD use and suicide risk, however, is complex. Suicide is influenced by interacting factors, which can include harmful AOD use as well as mental ill-health, and historical, social and cultural circumstances (AIHW 2022c). A single dimension 'causal pathway' to suicidal behaviour is not supported by evidence; rather, the evidence suggests that a complex intersection of individual, community and societal factors creates the conditions in which suicidal behaviour occurs.

Three interacting pathways in which harmful AOD use may have an impact on suicide risk are discussed below:

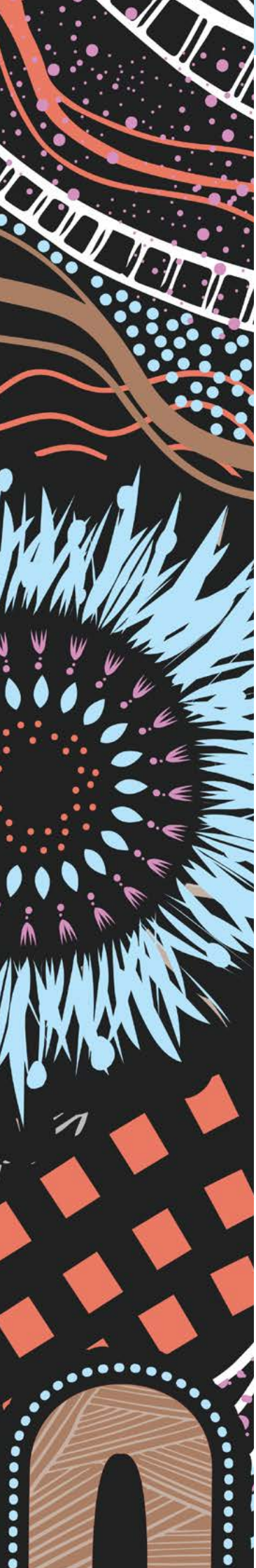
- **Harmful AOD use and suicidal behaviour share common predictors:** For First Nations people, the historic and ongoing disruption of families, culture and community due to colonisation and oppression are central to the conditions in which suicidal behaviour occurs (Dudgeon et al. 2018; Hunter and Milroy 2006; Silburn et al. 2014) and in which harmful AOD use develops (Hunter et al. 2001). The Kimberly Aboriginal Suicide Prevention Plan (Kimberley Aboriginal Medical Service 2021), for example, emphasises that AOD harms are a symptom and consequence of colonisation and trauma. Indeed, experiences of trauma are related to higher rates of self-harm (Leckning et al. 2021) and AOD use (Nadew 2012; Butt et al. 2024), as well as being noted in the custodial setting as a predictor of suicidal behaviours (D'Antoine et al. 2022). Thus, harmful AOD use can be thought of as part of the context in which suicidality occurs, sharing many of the same predictors. While this is fundamental, limiting consideration of AOD harm to suicide risk only through shared common factors may result in missed prevention opportunities.
- **Chronic harmful AOD use as a risk factor for suicide:** Chronic harmful AOD use can disrupt and destabilise social factors associated with suicide risk, such as homelessness, exposure to violence, economic insecurity, family and relationships. Thus, it can compound existing risk factors. Furthermore, there is an interplay between chronic harmful AOD use and other psychological and SEWB factors:
  - It can, as described above, destabilise mental health conditions such as psychosis, depression and PTSD, thus having an impact on suicide risk.

- It can affect frontal executive functioning which, in turn, can affect decision-making over the short and long term (Witt and Lubman 2018).
- It is related to poor coping skills and low distress tolerance skills which, when combined with high levels of psychosocial stress (such as racism, homelessness, incarceration, family disconnection and violence) (Shepard et al. 2018), increase suicide risk.
- It has an impact on family functioning, which can create psychological distress and affect belongingness and availability of social support in the short and long term.
- As noted in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), due to a range of factors (including systemic factors and stigma), harmful AOD use can prevent and/or complicate access to services. This lack of service and support may also increase suicide risk and minimise opportunities for suicide prevention and intervention.
- Anecdotal evidence noted in a report by Elders (People Culture Environment 2014) suggests that engagement in harmful AOD use prevents engagement with cultural activities, thus limiting contact with protective factors.

- **Acute AOD use (intoxication) is a risk factor for suicide attempts:** Findings from emergency department (Leckning, Borschmann et al. 2020; Leckning et al. 2023), emergency response (McPhee et al. 2022) and coroner (Kõlves, Koo et al. 2020) contexts suggest that intoxication is common among those who attempt and die by suicide. This is consistent with international evidence; for example, meta-analysis confirms that acute use of alcohol, particularly at high doses, is associated with the increased likelihood of a suicide attempt (Borges et al. 2017). While acknowledging that the cause of acute AOD use is complex (that is, why someone chooses to become intoxicated), AOD intoxication can affect both mood and impulsivity in the short term, increasing the risk that a person might act on suicidal ideation and potentially the lethality of method. The Kimberley Aboriginal Health Forum (KAHPF 2016) cited and reviewed unpublished data by Bala (2015), emphasising that suicidal behaviours were often impulsive and emotionally heightened responses to triggers. Consistent with this, national-level research has highlighted that recent interpersonal disputes predicted suicide in those with alcohol use disorders (Kõlves et al. 2017); while this has not been replicated in First Nations-specific research, it does align with community evidence that emphasises the triggering role played by relationship difficulties and family conflict in a suicidal crisis (KAHPF 2016; People Culture Environment 2014). Interpersonal crisis, heightened distress and impulsivity are clearly escalated by AOD intoxication, particularly alcohol.

Inherent in this discussion is the discrepancy between suicide attempts (which may be impulsive) and suicidal ideation. There is a lack of recent research that looks at acute AOD use and suicidal ideation. Interestingly, international research suggests that AOD-related harm is more related to suicide attempts than to ideation (Nock 2008, 2009); this was also suggested by Dickson and colleagues (2019) for First Nations young people – namely that suicide interventions that target only harmful AOD use will not reduce ideation. As surmised by the KAHPF (2016), alcohol use is best understood as part of coping, rather than as the cause of suicidal thinking.

Taken together, the above findings highlight that although much is unknown about the role of harmful AOD use in suicidal behaviour – and the role of AOD in NSSI is almost completely unknown for First Nations peoples – acute and chronic AOD use can play a significant role in suicidal behaviour – in particular, in suicide attempts.



5

Policy approaches to co-occurring AOD and mental health and suicide prevention

5 Policy approaches to co-occurring AOD and mental health and suicide prevention

As highlighted in the primary paper and summarised in Appendix B to that paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), AOD-related strategies, both nationally and specific to First Nations people, barely mention suicide as a consequence or consideration when addressing harmful substance use (Butt et al. 2024; Department of Health 2014, 2017a, 2017b, 2019; Department of the Prime Minister and Cabinet 2015). Furthermore, national and local strategies and policies relating to AOD have different foci and do not necessarily intersect (Butt et al. 2024). The National Drug Strategy is founded on the principle of harm minimisation, which has 3 pillars – reduction of supply, reduction of demand, and reduction of harms. Strategies to address the harms from the use of AOD should do so for *all* the pillars – both for the individuals and communities affected by the other's AOD use, as well as for those who experience AOD-related harms themselves (Gray et al. 2018). Efforts outlined in these policies should not only focus on the individual and intervention at a AOD treatment level, but also on workforce factors.

Suicide prevention policy sits within mental health and wellbeing policy, as evidenced in *The Fifth National Mental Health and Suicide Prevention Plan* and its Implementation Plan (Department of Health 2017c) and the *National Mental Health and Suicide Prevention Agreement* (Agreement) – agreed in 2022 between the Commonwealth of Australia and the states and territories (see https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf). There are also 2 suicide-specific strategies that focus on suicide prevention at a national level: the *National Suicide Prevention Strategy for Australia's Health System: 2020–2023* (Department of Health 2020) and the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (Department of Health and Ageing 2013). Despite this latter strategy having been released more than 10 years ago, all 3 frameworks still recommend implementation, but to date provide no detail for this implementation (Butt et al. 2024; Department of Health and Ageing 2013). While these strategies recognise the role of harmful AOD use as a contributing factor, none of them detail how to strategically respond to it in the context of suicide prevention.

The above-mentioned Agreement, which detailed a commitment by the Australian Government and state and territory governments, outlined a whole-of-government response to address mental health and suicide prevention (see https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf) – with First Nations people being a priority group. Yet the lack of consideration of AOD factors may limit its efficacy. This occurs at a state/territory level as well.

The Western Australian Government has committed to a whole-of-government approach. In responding to the Western Australian Coronial Inquest into 13 deaths by suicide of First Nations children and young people in the Kimberley region (Fogliani 2019), the state government issued a statement of intent (Western Australian Department of the Premier and Cabinet 2019). Though well intentioned, the focus of the government response, from the perspective of AOD, was to recognise the possible role of fetal alcohol spectrum disorder in the lives of these young people; there was no acknowledgement of the broader ways in which harmful AOD use is related to suicide risk. The section in the statement of intent on 'Increased government leadership, co-ordination and accountability' failed to acknowledge that the

Western Australian Mental Health Commission also funds and manages AOD prevention and treatment services. Such an arrangement could be extremely strategic in its approach to ensuring the workforce and services provided recognise all the factors at play. While there has been some action – such as the establishment of a metropolitan Specialist Aboriginal Mental Health service – the needs of residents in the regional and remote areas of the state are not supported.

What is needed

Harmful AOD use is acknowledged as contributing to suicide; however, policy and strategy do not address it in detail. Preventing AOD-related harms requires strategically coordinated interventions under all 3 pillars of the AOD harm minimisation framework, not just under the harm reduction (treatment) pillar. As with mental health and AOD, the frameworks focus on the training and development of the AOD workforce, providing treatment services in mental health and suicide prevention as a way to implement this. Such a focus is simplistic and ignores the social and structural contributors to AOD use, suicide and NSSI. A systems-level approach is necessary to address the complexities of AOD and suicide prevention. Furthermore, given that the causes of suicide risk are systemic, long-term responses are needed.

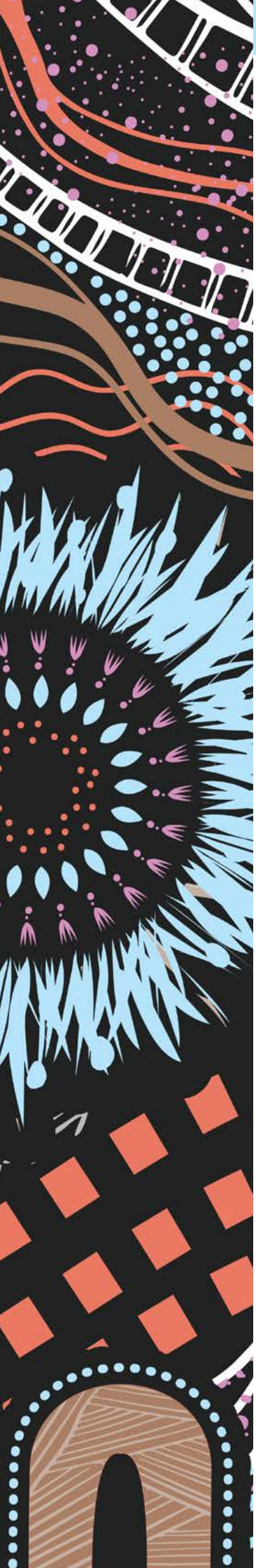
Efforts to reduce AOD-related harms and prevent suicide and NSSI among First Nations communities have been significantly underfunded and under-resourced. The strategies and frameworks do not come with specific and ongoing funding. These are not one-off priorities – consistent and sustained resourcing of interventions is needed. While First Nations people are a priority population group in national-level policies, the First Nations-specific frameworks have not been updated since (for more information, see https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-5/nmh_suicide_prevention_agreement.pdf also see Appendix B of the primary paper, https://www.indigenousmhspc.gov.au/publications/aod-mental-health). Furthermore, the national-level strategies have continued to recommend implementing the First Nations-specific strategies. There is clearly a failure of, or a barrier to, implementation. The care systems that exist are operating independently, even when structurally they are not independent.

The Western Australian Government statement of intent is a prime example. The Mental Health Commission in Western Australia is responsible for both AOD treatment and prevention, and mental health services in the state; however, internally, these systems operate independently of each other. As evidenced by the strategies, although there is overlap, these areas are treated independently; this is reflected in the funding of services and programs. For example, the Agreement refers to funding and resourcing of Aboriginal Community Controlled Health Services (ACCHSs). This recommendation ignores the relationship and role of both First Nations-community controlled and non-Indigenous services that provide AOD-related treatment. Not all ACCHSs are resourced or skilled to provide AOD treatment interventions. Furthermore, many AOD treatment programs or services are not provided or linked to ACCHSs (Gray and Wilkes 2010). Such an approach does not acknowledge the existing structure of the systems that are in place to respond to AOD-related harms in Australia.

As well as being dated, most of the frameworks and strategies mentioned in this section have been developed by departments of the Australian Government. The leadership of First Nations people in developing policy is vital to improving the health and wellbeing of First Nations people (Green et al. 2012). First Nations people's understanding of health and wellbeing is much broader than that described in non-Indigenous definitions (Gee et al. 2014). As discussed in the primary paper

(https://www.indigenousmhspc.gov.au/publications/aod-mental-health), First Nations people's right to self-determination is necessary to empower and develop a localised response for AOD, suicide and NSSI. As also already noted in this review, there is no longer any body responsible, or accountable, for advocating for First Nations-specific AOD priorities and policy. This means, by extension, that there is no group advocating for the funding of prevention and treatment services, nor is there anyone to monitor the actions related to the AOD strategies.

First Nations AOD and suicide prevention strategies need to be updated by setting up First Nations leadership. Further to this, such updated policies should be informed by applied knowledge and by significant investment in First Nations-led research that defines and increases an understanding of NSSI, its risks and its prevalence.



6

Responding to AOD-related harms and suicide risk

6 Responding to AOD-related harms and suicide risk

The evidence presented indicates a need, on the one hand, to respond to suicide risk among First Nations people who use AOD, and, on the other, for AOD use and harms to be considered in the prevention, assessment and management (and postvention) of suicide risk for individuals, families and communities. Consistent with the policy discussion in Section 5, to date there has been scant explicit focus on preventing and managing AOD-related harms in suicide prevention and intervention approaches for First Nations people. Indeed, beyond broad-based recommendations that risk factors (such as harmful AOD use) be addressed, there are no guidelines for First Nations people that cover AOD-related factors in detail. Among the suicide prevention and intervention approaches reviewed for this review, most did not recognise AOD or include direct strategies to manage or remediate harmful use (for example, ATSISPEP 2021; Clifford et al. 2013; Kimberley Aboriginal Medical Service 2021). This finding is consistent with those of previous reviews; Ridani and colleagues (2015) undertook a comprehensive review of Aboriginal suicide prevention programs in 2015 – only 11 of 67 articles reviewed included contents specifically on AOD. This lack of attention is consistent with commentary on the positioning of AOD within the broader national suicide prevention context (Chong et al. 2020; Fisher et al. 2022; Ridani et al. 2015; Witt and Lubman 2018), with commentators arguing that AOD-related suicide risk should be a key priority in comprehensive suicide prevention strategies. Similarly, there is a lack of First Nations research on suicide risk and prevention in AOD settings (Rontziokos and Deane 2019) and a lack of suicide risk outcomes described in AOD treatment research (Nathan et al. 2020; Ross et al. 2012). This is not to say that co-occurring harmful AOD use and suicide risk are not mentioned, but rather that there is a lack of detail on how they are responded to and the outcomes achieved.

As reviewed elsewhere (Clifford et al. 2013; Dudgeon et al. 2016; Martin et al. 2023; Ridani et al. 2015; Westerman and Sheridan 2020), due to a variety of systemic factors, there is not a strong evidence base for First Nations suicide prevention programs and responses. However, there are a range of well-established best practice and promising practice approaches, principles and exemplar programs (Clifford et al. 2013; Dudgeon et al. 2016; Martin et al. 2023). This is the case, too, for AOD interventions for First Nations people and is presented in detail elsewhere (Butt et al. 2022; Butt et al. 2024; Gray and Wilkes 2010; Gray et al. 2018; Snijder et al. 2020). Despite the lack of a traditional evidence base (Dudgeon et al. 2021), there are opportunities to better respond to the intersection of AOD-related harms (both acute and chronic) and suicide risk.

Summarised below are:

- the key components of suicide prevention for First Nations people
- a summary of recommendations from broader literature on AOD-focused responses in suicide prevention
- the opportunities and barriers identified for intervention and an outline of exemplar programs that address both AOD and suicide risk for First Nations people.

Note that specific approaches to NSSI are not reviewed in the section that follows due to a lack of evidence and research.

Approaches to suicide prevention among First Nations communities

To address the extreme distress behind the high rates of suicide among First Nations communities is a clearly identified (and advocated for) need to reduce inequalities in the social determinants of health, build on existing cultural resilience and establish a national commitment to ending the racism experienced by First Nations people. This, however, has yet to be achieved. Detailed reviews of suicide prevention are provided elsewhere (for example, Clifford et al. 2013; Dudgeon et al. 2016; Martin et al. 2023; Ridani et al. 2015). These reviews identify that strategies should be community wide and:

- target common risk and protective factors (including belongingness, health factors and family factors)
- target known clinical pathways to suicidal behaviour
- be designed and implemented with self-determination by First Nations communities (which incorporate culture, knowledge and decolonising approaches)
- be adequately and sustainably resourced (Clifford et al. 2013; Sjoblom et al. 2022; Westerman and Sheridan 2020).

Suicide intervention approaches include:

- universal prevention: broad-based prevention and health promotion programs
- selective prevention: community-based suicide prevention programs (including gatekeeper programs)
- indicated prevention: targeted intervention programs for those at risk within communities
- acute responses/crisis responses to those at risk, with pathways for ongoing care
- postvention services
- workforce development.

A checklist for undertaking First Nations suicide prevention activities summarised by the ATSISPEPS (2021).

In undertaking any suicide prevention or AOD harm reduction activities, principles such as those outlined in the *Gayaa Dhuwi (Proud Spirit) Declaration* (National Aboriginal and Torres Strait Islander Leadership in Mental Health 2015), and the 9 guiding principles in the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing (*NIAA 2017) should be abided by. As well as these, the *Kimberley Aboriginal Suicide Prevention Plan* (Kimberley Aboriginal Medical Service 2021) describes 4 principles to underpin suicide prevention activities:

1. Prioritise culture and healing
2. Community self-determination
3. Place-based strategies
4. Sustainable funding and resourcing.

These principles clearly articulate the grounding on which effective interventions can be built.

General recommendations for interventions addressing harmful AOD use and suicide risk

A recent Australian evidence check of the role of AOD in suicidal behaviour and of effective interventions (Fisher et al. 2020) concluded that suicide prevention and treatment should be multi-component, multilayered and include interventions with an AOD focus. In highlighting a range of opportunities in which suicide prevention and intervention can include AOD-related risk factors, the authors recommended:

- AOD-focused suicide prevention as part of sustainable programs with ongoing funding
- services with the capacity to flexibly accommodate and respond to changes in AOD use and suicidality – as opposed to service termination when conditions fluctuate
- increased opportunities for screening and identifying high-risk individuals in primary health care settings
- gatekeeper training across sectors, particularly in AOD treatment services
- AOD training across sectors, particularly in suicide prevention and intervention
- clear aftercare pathways in high-risk contexts, including post AOD treatment, post hospitalisation and post incarceration (Fisher et al. 2020).

As well, Witt and Lubman (2018) emphasised the need for clinical guidelines for suicide risk to include the management of AOD use, noting that this was currently lacking. They also noted limitations within the existing evidence base, whereby research investigating treatment approaches to suicide risk tended to exclude those with AOD conditions (Witt and Lubman 2018), thereby limiting the applicability of the treatment evidence base.

Opportunities to address the impact of AOD on suicide risk for First Nations people

Considering the findings presented in this review, the broader recommendations above, and existing AOD and suicide prevention literature, there are opportunities to better address suicide risk in the context of harmful AOD use (including responding to both acute and chronic AOD harms). These are described below:

- **Enhance existing responses in emergency department settings:** Although only a small number of suicide attempts and NSSIs result in hospital attendance, presentation to an emergency department is an opportunity for engaging high-risk individuals (Shand et al. 2018), for quality assessment and empathic listening, and for referral pathways for people with suicidal behaviour and for whom harmful AOD use is indicated (Shand et al. 2018). Leckning, Borschmann et al. (2020) highlighted the need for emergency department responses to include not only suicide risk assessment and management of intoxication but also assessment that was more sensitive to the sociocultural contexts of psychosocial distress underpinning suicidal behaviour for First Nations people.
- **Increase service availability and flexibility**:
  - *Increase the time services are available:* This is an opportunity to better support those with acute AOD use who are experiencing crisis. Data analysed by McPhee and colleagues (2022) noted that suicide and NSSI co-occurring with alcohol use tended to happen outside regular office hours – in the evening and at night. Hence, there is a need to provide service options (other than police and emergency department resources) during these hours.

  - *Increase the capacity to respond to co-occurring AOD and mental health conditions:* As discussed in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), integrated responses to co-occurring conditions need to be improved. These include, as also highlighted by Fisher and colleagues (2020), services that can respond flexibly to changes in conditions (for example, increase in suicidality or AOD use) without discontinuing treatment.
  - *Increase the system-wide capacity to respond to chronic AOD-related harm:* As noted by the Western Australian Coroner (Fogliani 2019) and the ATSIPEP guidelines (Dudgeon et al. 2016), AOD services need to be generally increased in the community to reduce suicide risk and increase distress tolerance and coping among those with chronic AOD harms.
  - *Improve the capacity for services to respond to intoxication and distress:* Given the relationship between alcohol intoxication and suicide behaviours (attempts and deaths by suicide), a need for services to be able to manage acute distress with intoxication is indicated.
  - *Increase family-based services:* Suicidal risk behaviour and AOD occurs within family systems and has an impact on whole family systems – opportunities to work with family systems can address multiple risk factors (see also the primary paper – https://www.indigenousmhspc.gov.au/publications/aod-mental-health).

- **Initiate workforce interventions:** Support for the AOD and suicide prevention workforce is indicated, as is support for the mental health and other workforces that engage with people at high risk (for example, child protection, justice and homelessness services). This support may include clinical supervision, development of reflective practice, mentoring, reduction in client–contact hours for those managing complex cases, and regular training. Previous research conducted outside of our review window (Ross et al. 2012) identified a lack of policy and training for suicide risk management in residential AOD settings. There is also a lack of recent data on the capacity of AOD services to respond to suicide risk (Rontziokos and Deane 2019); however, ongoing support of the AOD sector to deal with suicide risk and management is important. Also important, is increasing the capacity of the suicide prevention workforce to ask about AOD and related harms.
- **Develop community approaches:** The need for whole-of-community responses that target risk factors, protective factors and causal pathways at the community level in AOD harm reduction (Gray and Wilkes 2010) and suicide prevention (Westerman and Sheridan 2020) has been highlighted in a range of previous reviews. Whole-of-community responses can flexibly respond to the needs of community. Numerous reports that document community engagement and lived experience highlight that AOD is regarded as a significant impediment to community wellbeing (ATSISPEPS 2021; People Culture Environment 2014); community members and Elders regard AOD harms as a critical driver of death by suicide (People Culture Environment 2014).
- **Provide postvention services:** Deaths by suicide, and indeed attempts, are associated with significant grief and distress for the family and communities of those bereaved. This presents a risk for suicide echoes as well as distress, which can affect mental health and AOD use. As such postvention services (described in more detail below) are critical and can provide opportunities to prevent both the AOD-related harm and contagion, and to support adaptive coping and grief.
- **Improve integrated AOD, mental health care and suicide prevention:** Consistent with the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), integrated treatment needs to be provided for those who need it; taking a 'no wrong door' approach, this needs:

- culturally safe and secure screening process and procedures that adequately identify both AOD-related harm and suicide risk in culturally safe ways within mental health services
- clinical pathways (including through care) that provide ongoing services to those at risk
- recognition of the role of stigma in AOD presentations and in ensuring safe service delivery.

As well as the above opportunities, this review notes that, in the ATSISPEP review (Dudgeon et al. 2016), there is ongoing mention of AOD-related harm. The document highlights the need to target AOD use as part of universal prevention, and at a community level when identified by the community; furthermore, the authors recommend the assessment of AOD and related harms as being integral to addressing outcomes (Dudgeon et al. 2016).

Barriers to responding to AOD and suicide risk

There are a number of barriers to improving suicide risk assessment and management in AOD settings, and to increasing the focus on AOD in suicide prevention initiatives highlighted in the literature that are worthy of consideration:

- **Silence around suicide:** A reluctance and discomfort to talk about suicide is a significant barrier to suicide prevention within the AOD space. Heard and colleagues (2022) highlighted the challenges associated with discussing suicide among First Nations people. They identified that despite participants voicing strong beliefs about the importance of discussing suicide it did not routinely occur. They further identified barriers of fear and shame as contributing to the silence. Participants in the study reported feeling 'silenced' and unable to reach out for help when in a suicide crisis or when grieving over the loss of a loved one to suicide, as well as not knowing what to say to others who were struggling. Participants also felt reluctant to discuss suicide and related trauma as they recognised that their family and community had already experienced enough trauma and feared causing them further harm (Heard et al. 2022). This final concern is consistent with the findings of McCalman and colleagues (2017) who noted the needs of workers and potential trauma for those with lived experience in asking about, and responding to, questions about suicide risk within research and practice. This silence and trauma, related both to suicide and to discussing suicide, is critical to acknowledge. While it speaks to the value of gatekeepers, it also highlights that developing and implementing any responses requires careful cultural oversight and community control to prevent unintended harm.
- **Avoidance of AOD in suicide prevention responses:** As noted earlier, there is scant attention paid to AOD within a number of suicide prevention frameworks and intervention strategies. While it is important to acknowledge that AOD harms are a symptom of colonisation and trauma (for example, as highlighted by the Kimberley Aboriginal Medical Service 2021), it is also important to acknowledge that directly assessing and responding to AOD-related harms are a part of the suicide prevention and intervention mix. Including AOD-related strategies and outcomes in suicide prevention strategies will provide more holistic responses.
- **Lack of appropriate services:** A lack of culturally safe services and a lack of positive experiences in accessing services are significant barriers for people who seek support for harmful AOD use, mental health and distress (Culbong et al. 2023; Heard et al. 2022; McCalman et al. 2017). Not knowing what crisis intervention services might be like is also a barrier for some young people (Wilson et al. 2019).

- **Siloed funding and planning:** As described in the primary paper, siloed funding and planning of AOD services for mental health and suicide prevention creates a barrier in developing integrated services and pathways (https://www.indigenousmhspc.gov.au/publications/aod-mental-health).
- **Lack of funding, lack of sustained funding:** See the primary paper for a full discussion (Butt et al. 2024).
- **Workforce barriers:** See the primary paper for a full discussion (https://www.indigenousmhspc.gov.au/publications/aod-mental-health).

Exemplar programs for co-occurring AOD-related harm and suicide risk

This review has identified a small number of programs that target both AOD harms and suicide risk. The following section provides a brief overview of workforce and gatekeeper training programs and broadbased health promotion/prevention programs that show promise. Exemplar programs in community-based suicide prevention, targeted suicide prevention, and suicide prevention in residential AOD settings are also summarised. A summary of reviewed interventions that deal with AOD and mental health and/or suicide is presented in Table C, Appendix C of the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health).

Workforce and gatekeeper suicide prevention programs

A number of workforce development and gatekeeper programs exist that aim to upskill workers and community members in responding to suicide. Three programs of note are:

- Indigenous Network Suicide Intervention Skills Training (INSIST) (Brown et al. 2020; Nasir et al. 2017)
- We Yarn Aboriginal Mental Health Suicide Prevention (Davies et al. 2017; Davies et al. 2020)
- Aboriginal mental health first aid (Armstrong et al. 2020).

These programs are worthy of mention as they have strong community-based development and implementation and promising outcomes; nonetheless, there is a lack of detail on if, and how, they include AOD and if they have been delivered within AOD services. Most importantly, these programs do not include details on how they may support people to manage intoxication and associated risks. Nonetheless, they are promising programs, which may have future application in better mitigating the impact of AOD on suicidal behaviour, particularly for those gatekeepers at the frontline of AOD-related harm.

Assessment protocols and management guidelines for suicide risk and AOD-related harm

Evidence presented in the current review suggests that individual suicide risk assessment and management protocols include AOD screening, and the management of suicide risks and triggers. Several protocols for suicide assessment are available (for example, the Suicide Assessment Kit – Deady et al. 2015); they are not reviewed here other than to comment that there is a need to continually develop and refine these approaches so that they are not only developed but also delivered in culturally safe ways and cater for both acute and chronic AOD. Similarly, there is not

scope in the current review to examine the assessment of suicide in the AOD sector; however, the assessment of suicide risk is a component of initial assessment in most AOD settings, and general guidelines for AOD treatment include suicide risk assessment and prevention (for example, Stone et al. 2021). Although outside the review window, the guidelines for workers in *Handbook for Aboriginal alcohol and drug work* (Lee et al. 2012) extensively cover suicide risk and prevention and effectively bring together AOD risk and suicide risk. As well, *Alcohol and other drugs treatment guideline for working with Aboriginal and Torres Strait Islander people in a non-Aboriginal setting* (Wallace and Allen 2019) does refer to suicide risk and response in the context of AOD harms. Culturally safe and validated assessment of AOD, mental health and suicide risk is an area of ongoing development and reviewed elsewhere (Butt et al. 2024; Schlesinger et al. 2007; Westerman and Dear 2023, 2024). Such assessment, using culturally developed and validated measures (such as the WASC–Y, which includes mental health, AOD use and suicide), are clearly needed in practice (Westerman and Dear 2024).

Universal prevention: health promotion and broad-based suicide prevention programs

Health promotion and prevention programs aim to target risk and protective factors holistically at the community level and may also provide information and skills to individuals. These tend to be delivered either universally to a whole community (for example, to all children at a school or to all local community members) or targeted at high-risk individuals and groups. Programs of note that target broad risk and protective factors were examined in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health) and details of reviewed prevention programs (and their inclusion of AOD- and suicide-related content) are summarised in Table C, Appendix C of the primary paper and elsewhere (Martin et al. 2023).

Exemplar selective prevention: community-based prevention programs

Whole-of-community approaches to suicide prevention target the known risk and protective factors, including mental health conditions, psychological distress and harmful AOD use. Only a small number of evaluated community-driven suicide prevention programs have been described in the literature and there is generally a lack of discussion about AOD in these; 2 of these programs, summarised below, show some evidence of covering AOD.

Community-developed suicide prevention program

Isaacs and Sutton (2016) describe a targeted prevention program developed and delivered by an Aboriginal Community Controlled Health Organisation that included 3 streams aimed at increasing resilience, early intervention and postvention. The resilience stream included the locally developed 'Bullroarer program', which aimed to increase resilience among young men during a series of 2-hour workshops. Due to community concerns around methamphetamine use, the program included health promotion on methamphetamine to young people deemed at risk. No outcomes of the program are available; however, the structure and development process shows the importance of tailoring suicide prevention to community need and community risks, which may include harmful AOD use. Further research into the outcomes of the program in addressing suicide and the risk factors associated with suicide is an important next step.

Whole-of-community forums to support First Nations youth

Westerman and Sheridan (2020) describe the outcomes of a whole-of-community suicide prevention initiative for remote communities with identified high levels of suicide risk. The program aims to increase individual and community capacity to respond to suicide risk, through providing workshops for young people, community members (families and caregivers) and service providers – with each group receiving tailored content. Thus, the model provides education and a shared language across the community in responding to suicide risk and protection factors, as well as skills development (Westerman and Sheridan 2020). The workshops were conducted in 3 phases: introduction, skills development and a consolidation. This longitudinal design was considered necessary for capacity building and adequate skills development.

All participants completed pre- and post-workshop questionnaires at the first workshop and then immediately after the skills consolidation workshop. The questionnaires assessed self-reported skills and knowledge. Results were positive and identified enduring change in participants' knowledge and skills, but it was emphasised that ongoing work was needed with young people to support their capacity for distress tolerance (Westerman and Sheridan 2020). Outcomes beyond self-report were not reported in the research. Of note, the research does not describe in detail the content of material presented (it was largely tailored to specific community need); thus, it is not clear how harmful AOD use was covered in the content. Outcomes measures did not include content on AOD – but did include material on depression and other mental health conditions. Potential areas for the program's improvement could be a stronger inclusion of AOD. The results demonstrate that longitudinal approaches that can cater for both individual and community capacity in managing suicide risk alongside risk factors – and are embedded in cultural ways of knowing and doing – provide an exciting avenue for programs; however, as mentioned, they may be further improved by explicit reference to and measurement of AOD-related harms.

Exemplar indicated prevention program

Targeted prevention programs support those identified to be at high risk and can provide early intervention; one recent targeted program is highlighted below.

U-Help suicide prevention program for First Nations youth

The U-Help targeted prevention program (Skerrett et al. 2018) was developed within an ACCHS in partnership with a non-Indigenous organisation; it included the input of youth and Elders. The approach comprised 4 one-hour psychoeducation sessions delivered to participants in a group format. The program reported a decrease in suicidal ideation and deaths by suicide, although it is not clear if and what AOD content was included. Data on AOD use were not reported; however, the qualitative outcome indicators collected (using the discussions of focus groups) reported useful findings. At intake, very few groups were able to describe coping strategies – indeed, some groups noted AOD use as a coping strategy – and groups had difficulty identifying health-harming behaviours. At follow-up, all focus groups were able to identify the importance of health-harming behaviours, which included harmful AOD use, and could describe a range of adaptive coping and support strategies. This approach shows the importance of considering the role of AOD as an unhealthy coping strategy and addressing this through strength-based approaches.

Targeting suicide risk in AOD treatment settings

Residential rehabilitation for harmful AOD use to reduce suicide risk

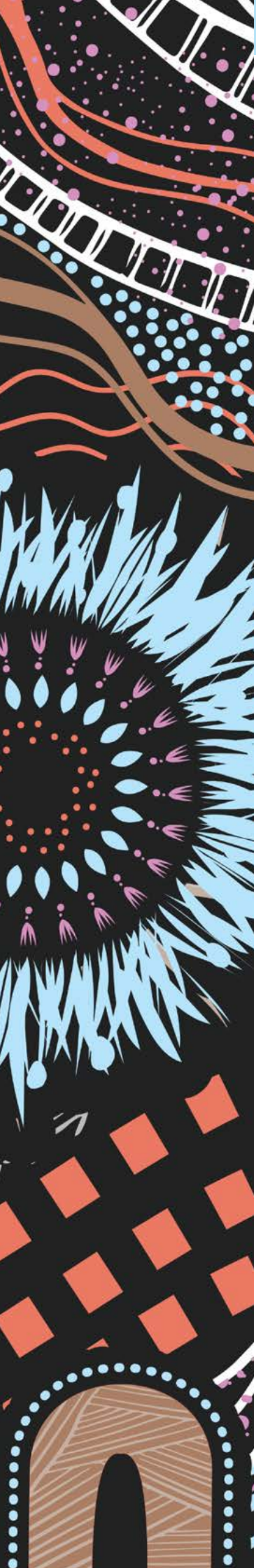
Given the impact of AOD use on suicide risk, the role of AOD services in targeting suicide is important to note. This said, some AOD service providers may initially decline services to those expressing suicidal intention. It is, however, important for AOD services to respond to suicide risk, and for pathways to treatment that can remediate both AOD and suicidality to be clearly delineated for clients. A recent research paper (Nathan et al. 2020) demonstrated improvements in suicide risk among First Nations young people in a residential treatment program for harmful AOD use; it highlights the importance of acknowledging suicide risk in AOD treatment and the potential success that AOD treatment can have in reducing suicide risk. The rehabilitation program targets AOD, mental health, education/employment, accommodation, social/community and family life within a strong cultural resilience framework. The program provided ongoing care after discharge for up to 3 years. This continuing care approach aimed to ensure that young people had ongoing support in achieving wellbeing.

Nathan et al. (2020) examined the outcomes of this program, including AOD use and suicide risk and attempts for 89 First Nations young people measured at 3 months after discharge; the sample included only those who had stayed in the program for a minimum of 30 days. Results identified that not only had participants reduced their AOD use but also there was a significant reduction in suicide attempts at follow-up. The results showed that a holistic treatment program for harmful AOD use can reduce suicide risk.

Postvention programs

There is a lack of postvention services in Australia in general and particularly for First Nations people (Isaacs and Sutton 2016). Postvention programs support those (individuals and communities) bereaved by suicide and in so doing can minimise the risk of contagion or cluster suicides.

Thrilli (https://thirrili.com.au/), an Aboriginal Community Controlled Organisation, is a national provider of postvention support and assistance for First Nations people. It has a number of services, including counselling and capacity building, as well as recent partnerships to provide diverse services (including recent partnerships to support the development of online yarning spaces and facilitated discussion groups). There is no detail on AOD-related harm in published materials (Thirrili 2023); however, due to the community focus and the centrality of individual community needs and self-determination, harmful AOD use may well be dealt with as part of the support provided to individuals and individual communities. As a relatively new program, there is no outcome data currently available, but the importance of programs such as this cannot be overstated.



7

Gaps, limitations and recommendations

7 Gaps, limitations and recommendations

Gaps and limitations

Research

Research is significantly limited by data quality and a lack of data in general about NSSI and suicidal ideation. The key gaps that need attention are:

- lack of community-level data on AOD use and suicidal ideation
- lack of community-level data on AOD use and NSSI
- lack of research outside Northern Australia
- lack of research on substances other than alcohol – with a particular need for updated research on cannabis use, methamphetamine use and polydrug use that can distinguish between acute and chronic use to examine its role in suicidal behaviour and NSSI
- lack of research on the relationship between AOD and suicide (other than co-occurrence)
- important need for ongoing research. At present, much of the published material in this area is systematic reviews and syntheses of findings. Due to the limited number of papers, older research is cited, which, due to change over time, may not be currently relevant.

It is important to recognise community variation and the differing needs and experiences of First Nations people living in urban, regional and remote locations – meaning that extrapolating research findings is challenging. Research into both suicide and AOD can also be challenging for researchers and participants; thus, it must proceed cautiously and carefully. It is unlikely in the short term that comprehensive data will become available – but community wisdom in the area is clear. Numerous reports have highlighted community concern and observation about the role of AOD-related harms in suicide risk (Dudgeon et al. 2016; People Culture Environment 2014), suggesting an increased focus on addressing the impact of AOD harms on suicide risk before further data is collected.

Policy

While there are national-level policies and strategy frameworks that cover AOD and suicide prevention, there are some significant limitations:

- Firstly, these are national-level strategies; they do not provide a pathway to implementation at a regional level. These issues need to be place-based responses.
- Secondly there is no group, committee or council that is responsible for the First Nations-specific strategies; thus, there is no accountability for implementation, nor continued development.
- Thirdly, the Indigenous-specific strategies (Department of Health 2014; Department of the Prime Minister and Cabinet 2015) are more than 10 years old, and not aligned with existing national population-wide strategies (Department of Health 2017a, 2019). The recent national population-wide strategies recommend implementing the First Nations-specific strategies, highlighting the continued inaction.

- Fourthly, the complexity of the relationship between AOD and suicide prevention strategies means that suggestions to respond to one in the context of the other (for example, suicide prevention in the context of AOD interventions) is almost tokenistic and not considered across the 3 pillars of the AOD harm minimisation strategy.
- Fifthly, the siloing of funding and the separation of responsibilities at a government department level is a significant limitation. Funding for First Nations-specific programs and services is managed differently (that is, by the Australian Government) from population-wide funding (by state and territory governments). While there is possibly some specialised knowledge, it means that similar programs and services are not necessarily funded by the same government department, creating significant gaps.

Practice

The evidence shows that AOD-related harms are not sufficiently integrated into First Nations suicide prevention efforts, with few guidelines explicitly addressing these factors. Previous reviews and existing suicide prevention programs largely overlook the role of AOD in suicide risk, reflecting a broader national context where AOD-related suicide risk is under-emphasised. This gap extends to research on suicide risk within AOD settings and the inclusion of suicide risk outcomes in AOD treatment studies. While co-occurring harmful AOD use and suicide risk are acknowledged, there is little detail on how these issues are addressed in practice, and the outcomes achieved. As well, and as described in the primary paper (https://www.indigenousmhspc.gov.au/publications/aod-mental-health), there is a general lack of AOD and mental health services for First Nations people.

Recommendations

Research

AOD-related harm is related to suicidal behaviours; however, the relationship is complex and poorly understood (Fisher et al. 2020). Research is needed that not only describes the co-occurrence of AOD-related harms and suicide but also explores the relationship between them – and it must include nuanced data that explore a range of substances, acute and chronic AOD use, suicide ideation as well as suicidal attempts and deaths, and NSSI. Research that focuses on these issues, and the gaps listed in the section in this review headed 'Limitations' is indicated. Furthermore, evaluation research is clearly needed to aid the ongoing development of practice in the AOD and suicide prevention space. Given the complexity of these topics, it is imperative that the research is undertaken with self-determination.

Policy

The absence of current strategic frameworks that are specific to First Nations people is the most significant policy gap in reducing harms from AOD use and in preventing suicide. This is followed closely by the need for policy for their implementation. The absence of any accountability or requirement for these frameworks to be implemented shows a lack of commitment by decision-makers at all levels to supporting First Nations communities. While there are current national population-wide strategies for minimising AOD harm and preventing suicide, these strategies approach these 2 issues

from a specific base, with each ignoring the evidence base for the other. A specific implementation strategy is needed to inform and guide efforts specifically to deal with the impacts of both. Recognising First Nations' leadership is vital to developing and implementing any strategy, as these issues both stem from the historical and ongoing traumas of colonisation and exclusion. First Nations people have the right to self-determination and should be leading the development and implementation of such strategies. The reformation of national level advisory and advocacy groups is also vital for effective prevention strategies.

Practice

There is sufficient evidence of the need for suicide prevention and interventions to recognise and respond to the complexity of AOD use in suicidality. Despite the lack of a strong evidence base for suicide prevention programs for First Nations people, there are established best practices and promising approaches, particularly those that prioritise culture, community self-determination, and sustainable funding.

There are opportunities to better target the intersection of AOD-related harms and suicide risk, such as by enhancing responses in emergency departments, increasing service availability and flexibility, and improving workforce capacity for mitigating the impact of acute AOD use on suicide risk. To better respond to the impact of chronic AOD on suicide risk, the integration of screening, assessment and treatment for AOD use can be enhanced through existing suicide prevention services (including but not limited to psychosocial interventions, aftercare/through care and postvention). Conversely, the management of suicide risk can be enhanced with AOD responses. An overall increase in the availability of AOD treatment services for First Nations people, in particular young people, is indicated. However, barriers do remain, including the silence around suicide, avoidance of AOD use in suicide prevention, a lack of culturally safe services, and the siloing of mental health and AOD use. Overcoming these challenges will require integrated, culturally informed approaches that consider the unique needs of First Nations communities.

Conclusions

High rates of suicide among First Nations people indicate experiences of distress; suicidal behaviours are complex and multi-determined. Chronic and acute harmful use of alcohol and other drugs has an impact on suicidal behaviour – yet there is a dearth of research that emphasises the co-occurrence of AOD use and suicide at the individual and community level (a finding consistent with the voices of Elders and the community). Despite this, acute and chronic AOD-related harms are not well integrated into suicide prevention policies and practical responses. A clear opportunity exists to enhance policy and practice by better integrating and responding to the co-occurrence of AOD-related harm and suicide risk across the AOD, suicide prevention and mental health sectors in an integrated and culturally secure way.

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Abbreviations

ACCHS	Aboriginal Community Controlled Health Service
AOD	alcohol and other drugs
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Project
KAHPF	Kimberley Aboriginal Health Planning Forum
LGBTQIASB+	lesbian, gay, bisexual, transgender, queer, intersex, asexual, sistergirl, brotherboy; the '+' indicates there may be other terms that should be included
NSSI	non-suicidal self-injury
PTSD	post-traumatic stress disorder
SEWB	social and emotional wellbeing
VSU	volatile substance use
WASC–Y	Westerman Aboriginal Symptom Checklist – Youth

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This paper synthesises research on alcohol and other drug (AOD)-related harms and suicide risk among First Nations communities. It examines their co-occurrence, relationship and potential points of intervention and reviews existing policy and practice responses. The paper notes that systems-level approaches are needed, with self-determination, community ownership, accountability and long-term investment.

AIHW

Stronger evidence,
better decisions,
improved health and welfare