Issues in suicide prevention for young people from non-English speaking backgrounds living in Australia

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A rise in suicide among young people, especially young men, has been a growing and alarming trend in Australia. Although the overall rate of suicide in Australia has remained constant for 100 years, the rate of suicide for young men has tripled since 1960 (Australian Bureau of Statistics, 2000). Deaths from suicide now exceed those from motor vehicle accidents, with suicide currently being the leading cause of death in young people in Australia (ABS, 2000; Baume, 1996). Whilst most young people successfully negotiate the transition from adolescence to become well-adjusted adults, a general decline has been noted in the wellbeing of young people in the last 30 to 40 years, as indicated by increases in depression, self-injury, illicit drug and alcohol use, excessive dieting and eating disorders and a decline in employment opportunities (Victorian Suicide Prevention Task Force, 1997).

However, in terms of suicide among non-English speaking background (NESB) young people, ‘little research has been done in this area’ (Cantor, Neulinger, Roth & Spinks, 2000). Consequently, the Transcultural Mental Health Centre (TMHC) and the NSW Health Department, Centre for Mental Health, jointly funded a project to address the needs of NESB communities under the NSW Suicide Prevention Strategy (NSW Health Department, 1999). This NSW NESB Communities Suicide Prevention Project adopted a ‘whole of life’ approach.

This chapter reports on some of the findings of the NSW NESB Communities Suicide Prevention Project and highlights issues that need to be considered in the development of suicide prevention initiatives targeting NESB young people (Dusevic & Baume, 2000). The term ‘NESB young people’, as used throughout this chapter, refers to those aged 15–24 who are born in a non-English speaking country, as well as the Australian-born children of immigrants born in NES countries. Whilst the latter principally refers to the second generation, it is also inclusive of the third generation and beyond who speak a language other than English at home.
In order to appreciate contemporary issues facing NESB populations the chapter will present the currently available information on suicide behaviour among NESB young people. Firstly, an analysis of NSW suicide and suicide attempts by McDonald and Steel (1997) indicates the diversity in suicide rates among different groups of NESB young people and cautions against assumptions of homogeneity. Secondly, the factors potentially impacting on suicide behaviour among NESB communities will be discussed, such as: immigration, acculturation and divergent sociocultural beliefs and practices. Particular attention will be paid to the divergence in beliefs and practices between NESB people and the Australian-born population and their implications for the development of accessible and equitable suicide prevention activities. An exploration of the potential risk and protective factors that may be operating within the NESB population highlights innovative areas for future research and suicide prevention. Thirdly, possible strategies that may be utilised in a suicide prevention program targeting NESB young people will be considered by presenting information from three sources: the views of key stakeholders, consulted as part of the NSW NESB Communities Suicide Prevention Project; an international literature review exploring the effectiveness of suicide prevention initiatives targeting this population; and an exploration of initiatives targeting NESB young people in Australia, particularly NSW. The final concluding remarks place the available evidence in context and advocates for research into suicide behaviour among NESB populations as an opportunity to further elucidate factors impacting on suicide generally.

Suicide Behaviour Among NESB Young People:
An Incomplete Picture

Whilst there has been some research on immigrant suicide in Australia, most of it principally occurred during the 1960s and 1970s (e.g. Burvill, McCall, Stenhouse & Reid, 1973; Whitlock, 1971). However, both the pattern of immigration and suicide has changed dramatically since then. Whereas earlier immigrants came from the United Kingdom and Western Europe, during the last two decades there has been a greater diversity of immigrants. For instance, there has been an increased influx of Asian immigrants, such as Indo-Chinese refugees, thereby contributing to greater cultural and linguistic diversity within Australia (Burvill, 1998). During the past 15 years in particular there has also been a marked shift in the profile of people who have died from suicide in Australia. While rates have generally declined for older people, rates have risen dramatically among young men (ABS, 2000; Baume, Cantor & McTaggart, 1998; Cantor & Baume, 1998). In response to these concerns, McDonald and Steel (1997) examined suicide deaths and attempts data in NSW in order to obtain a more comprehensive, quantitative profile on suicide among the NESB population.
**NESB immigrant suicide deaths data**

At a national level, analysis of suicide deaths indicates that 25 per cent of suicides are among the immigrant population, with 60 per cent being from NESB (Cantor, Neulinger, Roth & Spinks, 2000; Hassan, 1995; Kyrios, 1994). At a NSW state level, nearly 27 per cent of suicide deaths are among the immigrant population, with 57 per cent being from NESB (McDonald & Steel, 1997).

In terms of suicide risk for different immigrant populations, a great diversity was noted by McDonald and Steel (1997). They reported that in general the NESB population in NSW had a similar or lower rate than the state average, whilst after the age of 65 the immigrant population had a significantly higher rate. Figure 7.1 and Table 7.1 depict McDonald and Steel’s (1997) findings on age-specific suicide rates by people of NESB. It is important to note that the nature of coroners’ data means that suicide data on second generation (and beyond) immigrants is not included in the statistics on NESB immigrant populations. Deaths data are only collected on ‘country of birth’, meaning that there is no data on suicide among the Australian-born children of immigrants (Kyrios, 1994). Consequently, current deaths data do not provide an accurate picture of suicide among NESB young people beyond the first generation of overseas-born.

**Figure 7.1: Age-specific rates of suicide by NESB NSW residents (1979 to 1992)**

![Age-specific rates of suicide by NESB NSW residents (1979 to 1992)](image)

Overall, McDonald and Steel (1997) found that overseas-born NESB young people in the 15–24 age range had lower rates of suicide than the state average, the Australian-born and those born in English speaking countries. In terms of gender effects they found that NESB males aged 15–24 had a lower rate of suicide than the
average rate for males in that age range. Females, on the other hand, had similar rates to the average female rate in that age range. NESB males had a higher suicide rate than NESB females.

Table 7.1: Mean Age-Specific Rates of Suicide per 100 000 in NSW by Region of Birth (1979 to 1992) and in Selected Countries of Birth

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>Age group (years)</th>
<th>Ratio of rates for 75+ years to 15-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-24</td>
<td>65-74</td>
</tr>
<tr>
<td>Rates in NSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALL</td>
<td>12.79</td>
<td>16.53</td>
</tr>
<tr>
<td>Australia</td>
<td>12.98</td>
<td>15.56</td>
</tr>
<tr>
<td>English speaking countries</td>
<td>15.66</td>
<td>14.43</td>
</tr>
<tr>
<td>Non-English speaking countries</td>
<td>9.42</td>
<td>24.13</td>
</tr>
<tr>
<td>Southern Europe</td>
<td>7.69</td>
<td>25.13</td>
</tr>
<tr>
<td>Western Europe</td>
<td>19.58</td>
<td>22.77</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>24.64</td>
<td>44.83</td>
</tr>
<tr>
<td>Middle East incl. Egypt</td>
<td>5.87</td>
<td>15.64</td>
</tr>
<tr>
<td>Southeast Asia</td>
<td>8.65</td>
<td>9.06</td>
</tr>
<tr>
<td>Northeast Asia</td>
<td>6.80</td>
<td>23.47</td>
</tr>
</tbody>
</table>

| Rates in Country of Origin   |        |        |        |                                    |
| New Zealand                  | 19.28  | 13.68  | 26.81  | 1.39                               |
| England/Wales                | 5.77   | 11.54  | 11.35  | 1.97                               |
| Scotland                     | 9.36   | 10.76  | 10.79  | 1.15                               |
| Italy                        | 3.26   | 17.67  | 24.50  | 7.51                               |
| Greece                       | 3.74   | 6.86   | 11.25  | 3.00                               |
| Former Yugoslavia            | 8.96   | 41.28  | 62.30  | 6.95                               |
| Former Democratic Rep. of Germany | 10.32 | 47.17 | 94.80 | 9.18                               |
| Austria                      | 16.21  | 36.23  | 54.49  | 3.36                               |
| Former Czechoslovakia        | 8.50   | 33.60  | 53.36  | 6.27                               |
| Hungary                      | 17.52  | 81.86  | 110.66 | 6.31                               |
| Poland                       | 10.57  | 16.63  | 15.71  | 1.49                               |
| Hong Kong                    | 5.91   | 34.11  | 52.05  | 8.81                               |

Source: WHO World Statistics Annual
2. England and Wales combined because data is aggregated in WHO published figures

In terms of examining differences among specific NESB communities, small sample sizes precluded a detailed exploration of this issue. McDonald and Steel (1997) suggested that analysis of national suicide data would be required for this purpose. However, it may be reasonable to assume that 'some immigrant groups of young people have higher suicide rates than the Australian-born and others lower, as has been found for all ages' (Cantor et al., 2000, p.78). To compensate for small
sample sizes, an analysis of cultural differences was undertaken by grouping the data into regions, with the results depicted in Table 7.1. Young people from the Middle East, Northeast Asia, Southern Europe and Southeast Asia had lower suicide rates than the state average and the Australian-born population. However, young people from Western Europe and Eastern Europe had suicide rates that were higher than the state average and that of the Australian-born population (McDonald & Steel, 1997).

NESB immigrant suicide attempts data

Figure 7.2 depicts the age-specific rates of attempted suicide resulting in hospitalisation documented by McDonald and Steel (1997). In terms of attempted suicide among young people aged 15–24, NESB overseas-born females had lower rates than the average female rate in that age range. NESB overseas-born males had the lowest rates overall, in comparison to the average male and female rates in that age range. NESB females had a higher rate than NESB males.

Figure 7.2: Age-specific rates of attempted suicide resulting in hospitalisation (1988–89 to 1993–94)

Suicide attempts data, however, needs to be interpreted cautiously given the various methodological limitations (McDonald & Steel, 1997). Namely, those attending a hospital following a suicide attempt are only a relatively small proportion of those attempting suicide. It has been estimated in NSW that approximately
20 to 50 per cent of people who attempt suicide receive hospital treatment as a result of the attempt (Sayer, Stewart & Chipps, 1996). Whether there are ethnic differences in the proportion of all suicide attempts receiving hospital treatment is unknown. There is evidence documenting the underutilisation of health services, particularly mental health, by NESB populations (McDonald & Steel, 1997; Minas, 1991; Minas, Lambert, Kostov & Boranga, 1996). This has serious implications for analysis of immigrant suicide attempts data, with data being difficult to interpret due to ethnic differences in access to health facilities following an attempt (McDonald & Steel, 1997).

Given that prior suicide attempts are believed to be one of the best predictors of suicide (Diekstra, 1993; Gunnell & Frankel, 1994), limitations in immigrant suicide attempts data pose a number of challenges. Firstly, current information on immigrant suicide attempts may not give a complete picture of the extent of the problem. Secondly, the absence of accurate data poses a challenge to the development of initiatives targeting NESB young people at risk. These difficulties are compounded by deficiencies in the collection of ethnicity data by service providers (McDonald & Steel, 1997; Trauer, 1995).

**An Exploration of Factors Impacting on Suicide Behaviour Among NESB Young People**

The identification of risk and protective factors that may be impacting on NESB young people is crucial to the development of targeted suicide prevention initiatives (Beautrais, 2000; Patton & Burns, 2000). McDonald and Steel’s (1997) data on immigrant suicide behaviour indicates lower suicide rates among overseas-born young people in comparison to the average rate for that age group. Of particular note is the lower suicide rate of overseas-born NESB young males in comparison to the Australian-born. This indicates the potential value of exploring the protective factors contributing to the resilience of this population. Analysis of cultural differences, however, indicates diversity, with some NESB groups of overseas-born young people having higher than average rates (McDonald & Steel, 1997). The risk and protective factors that may be operating in these subgroups is unknown, with further research required to elucidate potential contributing factors. The finding of diversity in rates also cautions against assumptions of homogeneity among NESB young people and highlights the need for tailored approaches. In view of the limitations in available information on NESB young people, the remainder of the chapter will address the potential risk and protective factors that may be operating, including the role of immigration, acculturation and divergent sociocultural beliefs and practices.

In terms of risk factors operating among the general population, the available data suggests a strong relationship between mental illness and suicide (Baume et al., 1998; Beautrais, 2000; Goldney, 1991; Mason, 1990; Pirkis & Burgess, 1998; Tiller
et al., 1997). Unfortunately, there have been serious limitations in data exploring mental disorders in the immigrant population and the link between such disorders and suicide behaviour. The recent National Survey of Mental Health and Well Being (Andrews, Hall, Teeson & Henderson, 1999) reported that on average NESB participants had lower rates of mental health problems than the Australian-born population. However, participants with language difficulties were excluded from the study, limiting its generalisability.

Similar methodological issues limit the findings of studies exploring the mental health status of NESB young people. For example, the work of Klimidis, Stuart, Minas and Ata (1994) failed to find any difference in psychopathology in Australian-born adolescents with Australian-born parents, compared to NESB young people who were refugees, overseas-born or second generation. However, methodological issues limit the validity of conclusions that are drawn. Namely, subjects were volunteers, with an average age of 17, who were students at educational institutions and who were capable of completing self-administered questionnaires requiring a high level of English proficiency. It is likely that the study design may have excluded at-risk NESB young people who left school as a result of poor English skills, academic difficulties and factors such as marginalisation. Limitations in research on the mental health of NESB young people hampers an assessment of needs, the identification of those at heightened risk for suicide, the risk and protective factors that may be operating and the development of targeted interventions.

There is recognition, however, that suicide is a complex issue with multifactorial causation (Beautrais, 2000; Patton & Burns, 2000) and that risk factors other than mental illness also play a potential role, such as: alcohol and substance abuse, parental psychopathology, family history of suicidal behaviour, social disadvantage, personality factors, sexual orientation, unemployment, homelessness, custody and incarceration, physical illness and disability and other negative life events (Beautrais, 2000; Patton & Burns, 2000). The impact, and incidence, of these other risk factors on NESB young people has not been researched.

In addition to risk factors known to have a negative impact on all young people, NESB young people are also exposed to unique stressors brought about by immigration and its sequelae, such as acculturative stress. The following section will explore the potential impact of immigration on the mental health and suicide behaviour of NESB young people.

The impact of immigration

Migration has been suggested as a risk factor for developing psychiatric disorders and increases in suicidal behaviour (Harris & Barraclough, 1997). However, the reasons for immigration are varied including family reunion, pursuing a better education or economic environment, fleeing persecution and seeking religious freedom (Murphy, 1977; Minas et al., 1996). Consequently, there has been
speculation that factors prompting immigration may have divergent impacts on mental health status, with 'forced' immigration having more deleterious effects. In terms of NESB young immigrants, there appears to be a lack of research to either refute or confirm the view that they experience more mental health problems than their peers in their country of origin. Overall, studies examining the impact of immigration indicate that immigration per se is not associated with either an increase or decrease in mental health. Rather, it can be associated with exposure to a number of factors potentially associated with increased risk (Minas et al., 1996).

Some of the risk factors identified by the literature (Cooper & Sylph, 1973; Hassan, 1995; Kliewer & Ward, 1988; Kliewer, 1991; Minas et al., 1996) include:

- decrease in socioeconomic status;
- lack of recognition of overseas qualifications, including educational and employment experiences;
- low levels of English language learning and proficiency;
- separation from social, religious and cultural networks, particularly family and friends;
- social isolation and lack of support;
- prejudice and discrimination by the host population;
- traumatic experiences or prolonged stress prior to or during immigration;
- acculturative stress;
- language and cultural barriers to service access, including stigma about mental illness and lack of knowledge regarding available services;
- breakdown of traditional and family support structures, particularly family and relatives, with intercultural conflict being a major contributor.

Various researchers have explored the relationship between immigration and suicide risk, with some noting that immigration seems to increase suicide risk for some cultural groups (Burvill, Woodings, Stenhouse & McCall, 1982; Hassan, 1995; Kliewer & Ward, 1988). Some immigrant groups have higher suicide rates than their country of origin counterparts. For example, males and females from Poland and Greece, males from Austria, females from Finland, Czechoslovakia and Malta had an increased suicide rate with immigration to Australia, whilst for other groups there was a small decrease or no change (McDonald & Steel, 1997). However, caution was expressed in interpreting increases in suicide rates following immigration. It is difficult to conclude whether higher rates in the host country, in comparison to the country of origin, is due to stress and other factors associated with settlement, or a bias in the immigrant population towards those with a greater propensity to suicide.

In general, researchers have noted that those immigrant groups with high suicide rates in Australia also had high rates in their country of origin. Similarly, those with low rates in Australia also had low rates in their country of origin (Whitlock, 1971; Burvill et al., 1982; Burvill, McCall, Stenhouse & Reid, 1973; Hassan, 1995;
McDonald & Steel, 1997). These findings suggest that immigrant suicide rates reflect the rates in the country of origin more so than the country of settlement. The sociocultural factors that immigrants bring with them appear to be more salient determinants of suicide than factors operating within Australia (Whitlock, 1971), with these factors being potentially modifiable by immigration (Burvill et al., 1973; Burvill et al., 1982; Hassan, 1995; Kliewer & Ward, 1988).

The robustness of these sociocultural factors is further indicated by data on suicide methods. Generally, the choice of method is influenced by a number of factors including availability, convenience and social and cultural norms (Bille-Brahe & Jessen, 1994). Data available on immigrants suggests that methods used tend to be those traditionally associated with their culture of origin (Raleigh, Bulusu & Balarajan, 1990; Raleigh & Balarajan, 1992). Burvill and his colleagues (Burvill et al., 1982) explored the hypothesis that the longer the length of residence, the more method choice approached that of the Australian-born. The hypothesis was partially confirmed with males from Southern, Eastern and Western Europe and females from Eastern Europe and Asia. Overall, the convergence of methods towards the Australian-born was greatest in immigrants who came from countries that were most linguistically and culturally similar to Australia. This seems to suggest that the process of acculturation, mediated by English language proficiency, can impact on the suicide behaviour of immigrants.

There has also been some speculation that there is an interaction between age, time in Australia and suicide rate. Some researchers have suggested that the rates of those who are young on arrival may be closer to the rates of the Australian-born, regardless of whether they are young, middle aged or elderly at the time of suicide. It has been suggested that this particular subgroup may have more similar rates to the Australian-born, than those who are adult on arrival, due to greater acculturation and adoption of the customs and norms of Australian society (McDonald & Steel, 1997). Where adopted values are linked with lower suicide rates, acculturation is seen to have a potentially protective influence. Where adopted values are linked with higher suicide rates, acculturation is seen to pose potential risk. For instance, some researchers have noted an increase in drug and alcohol use as a result of acculturation, particularly among young males (Rissel & Rowling, 1991; Ritsner & Ponizovsky, 1998; Santamaria & Robinson, 1981). It has also been suggested that suicidal behaviour as an expression of distress may be a new ‘language’ acquired by immigrant young people from the host population (Ratzoni, Blumensohn, Apter & Tyano, 1991).

In summary, evidence for the involvement of sociocultural factors in immigrant suicide is provided by data suggesting a strong correlation between immigrant rates and those in their country of origin and the use of traditional suicide methods (McDonald & Steel, 1997). This suggests that culturally bound factors have a greater role in determining suicide behaviour than immigration factors. The absence of research in this area, perhaps due to the lack of reliable and valid measures of
culture, has resulted in a significant deficit in knowledge regarding the nature of the relationship between culture and suicide. The available literature will be explored later in the chapter, under the heading ‘the influence of sociocultural beliefs and practices’, to suggest potential links. Immigration, however, may also play a role in suicide behaviour through disruption of social ties (Hassan, 1995) and increased stress (Kliewer & Ward, 1988) following immigration. In particular, acculturative stress, caused by settlement difficulties following immigration, has been suggested as playing a role in mental disorders and suicide risk (Berry, 1991; Hovey, 1998; Merrill & Owens, 1986). Consequently, the following section will address the role of acculturative stress in the suicide behaviour of immigrant groups, especially NESB young people. Specific attention will be paid to the influence of acculturation on help-seeking behaviour.

The role of acculturation

Acculturative stress is seen to result from the tension within individuals and families over the retention of traditional cultural values versus adoption of the host culture’s values, following immigration. Some immigrant families are seen to close their boundaries to the host culture as a way of protecting their identity or integrity (Christie-Seely, 1984). This is particularly the case where the host culture espouses contrary values, mores and beliefs. Strategies used to close boundaries include refusing to learn the language or customs of the host culture and prohibiting children associating with outsiders. These boundaries are seen to dissipate as families slowly acculturate. Klimidis and Minas (1995) proposed that young people who have an optimal combination of the new and old culture are least likely to develop a mental illness.

Four levels of acculturation have been identified: assimilation, integration, separation and marginalisation (Minas et al., 1996):

- assimilation refers to the complete adoption of the culture of the host country;
- integration refers to the blending of elements of traditional culture with elements of the host culture;
- separation refers to the exclusive commitment to the culture of the country of origin, with very little affiliation with the host culture;
- marginalisation, where there is neither affiliation to the country of origin, nor the host culture.

A number of factors are seen to influence acculturation. Age at the time of immigration has been suggested as a determinant, with children and adolescents acculturating more quickly, and to a larger extent, than their parents (Klimidis & Minas, 1995). Differences in English language proficiency are seen to underlie this process influencing the speed and extent of acculturation. English proficiency seems to be a particular challenge for those immigrating after the age of ten (Storer,
1985, p.28) and those illiterate in their native language (Centrelink Report, 1997; Pauwels, 1995, p.120). This can sometimes result in unique communication difficulties with some NESB young people not being fluent in the language of their parents and parents not being fluent in English.

Characteristics of the immigrant community in the new country, such as size, resourcefulness, language proficiency and extent of acculturation, are seen to also have an impact on the acculturation of recently arrived immigrants (Kliwer, 1991; Pauwels, 1995; Centrelink Report, 1997). New arrivals to Australia can sometimes experience communication difficulties with more established members of their own communities, despite supposedly speaking the same language. This can be the result of a number of factors such as: longer stay immigrants not having kept up with language changes in their country of origin (Pauwels, 1995, p.123), and being caught in a 'time warp' often retaining the antiquated mores, practices and beliefs of their country of origin (Centrelink Report, 1997). These factors pose challenges to new arrivals' ability to create links with people from their own cultural background and thereby influence the degree of acculturation to the host culture. Lack of support from one's immigrant community following immigration has been linked to depressive symptoms (McKelvey & Webb, 1996) and highlights the role of host community response to the psychological wellbeing and acculturation of new immigrant arrivals.

The potential impact of acculturation on suicide risk may take a number of forms, some visible, others hidden and invisible. Where acculturation results in marginalisation, such NESB young people are postulated to be at heightened risk for suicide due to identity confusion, as well as loss of support (Berry, 1991). Klimidis and Minas (1995) suggested that marginalised young people may internalise the norms of the host culture, which may include negative stereotypes and prejudiced attitudes towards their own culture. Other NESB young people may cope with intercultural conflict by leading secret, double lives, espousing their parent's values at home, whilst living in accordance with the expectations of the host culture elsewhere (Storer, 1985, p.136). This can lead to lack of family support, either through ostracisation, or simply because the family may be unaware of the difficulties. Communication difficulties caused by differences in language proficiency may also contribute to lack of adequate support during times of crisis, when limited skills can be further compromised by stress (Pauwels, 1995, p.120). The absence of family cohesion, inadequate parenting and family conflict has been suggested as potential suicide risk factors for vulnerable young people (Patton & Burn, 2000; Pillay & Wassenaar, 1996). Consequently, the manifold threats to family cohesion and support posed by immigration and acculturation issues, creates potentially unique challenges for NESB young people.

Some researchers have suggested that second generation immigrants in particular may be at higher risk of suicide due to the negative impact of acculturation factors, intergenerational and cultural conflict (Hassan, 1995; Merrill & Owens, 1986;
Poole & Goodnow, 1990). Whitlock (1971) predicted greater disturbance in some second-generation immigrants where the strong cultural influences in their homes would conflict with the influence and expectations of the surrounding community. As stated previously, no data are available on suicide behaviour among the second generation of NESB young people in Australia. It is not possible to determine how the pattern of dramatic increase in youth suicide over time in the general population (ABS, 2000) compares to patterns within the second generation NESB population.

Other findings suggest that first and second generation females have heightened risk (Merrill & Owens, 1986; Poole & Goodnow, 1990). Kahn and Fau (1995) suggested that while young people caught between two cultures may be vulnerable, that it is perhaps those whose parents are confused and unsure of their ethnic identity that may be most at risk. Research indicates that intergenerational conflict is more common among females. Rosenthal, Ranieri and Klimidis (1996) found that the greater the difference between the extent of acculturation of Vietnamese girls and their parents, the higher the rate of intergenerational conflict over issues of independence. It appeared that Vietnamese girls were dissatisfied with the role played by females within the traditional Vietnamese family system. In contrast, boys did not experience this intergenerational conflict, as independence is probably expected and encouraged in males within the traditional Vietnamese family system.

This finding was further supported by the work of Merrill and Owens (1986). In their British study examining immigrant suicide attempts, for Asian people cultural conflict was seen as a common contributory factor. Cultural problems were identified as a significant issue for 60.7 per cent of the Asian female sample. The cultural conflict centred on family discord over Asian versus Western lifestyles and was particularly common among young unmarried girls.

An analysis of factors contributing to acculturative stress is therefore potentially important in the development of suicide prevention initiatives for NESB young people. Factors mediating positive acculturation, through optimal integration of traditional and host-culture beliefs and practices, can then be actively promoted. The following section examines the divergence in socioculturally based views and practices between NESB immigrant and Australian-born populations that may contribute to acculturation difficulties. An examination of these beliefs and practices also represents an opportunity to explore potential links between sociocultural factors and suicide behaviour documented earlier in this chapter. Given the absence of research exploring the nature of these links, the following section serves to highlight potentially innovative areas for research.

**The influence of sociocultural beliefs and practices**

Sociocultural beliefs and practices are important to consider in the context of suicide prevention, given their potential contribution to acculturative stress and roles as potential risk and protective factors for suicide. The degree of divergence
between traditional beliefs and the views of the host culture may influence the
degree of stress experienced by NESB young people and their families, the level of
available family and community support and the ability to engage in help-seeking
behaviour (Mumford, 1998). Disparate views among young people of NESB, their
families and mental health professionals may also limit the ability of at-risk young
people to enter suicide prevention services and programs provided by the host
culture. Cultural views can vary across multiple dimensions and those that will be
explored in the current context include: individualism versus collectivism, power
and role expectations in relationships, rules for social interaction, perception of
time, views of mental illness and suicide and views of health seeking and treatment.

Whilst these sociocultural views will be presented separately to streamline
discussion, they are interrelated. Likewise, while they are often presented as
dichotomous variables for ease of discussion, it is perhaps more accurate to view
them as existing on a continuum. As such, they represent a potentially more useful
way of exploring diversity and similarity among cultures, rather than relying on
rudimentary distinctions such as ‘country of birth’ or language groups.

**Individualism versus collectivism**

Cultures are seen to differ on a number of dimensions, one being the continuum
of individualism versus collectivism (see Minas, 1991; Minas et al., 1996;
Toukmanian & Brouwers, 1998). The following section will present the character-
istics of this continuum and explore their implications for suicide prevention for
NESB young people. Some authors have suggested a link between this continuum
and the suicide rates of different cultures (Minas, Read & Klimidis, 1999).
However, methodologically sound research has not been conducted on this issue. It
has been suggested that individualism, with its emphasis on individual rights,
personal goals and responsibility to the self alone, may cultivate isolation and
alienation and enhance suicide risk. Collectivism, on the other hand, is seen to
promote group integration, harmony and goals and potentially reduce suicide
risk (Minas et al., 1999). Adoption of more individualistic views as an outcome of
acculturation may consequently enhance the propensity for suicide among NESB
young people.

Within collectivist cultures an individual’s identity is more determined by their
family or community belonging, rather than individual achievements. Social
reputation is the major currency of collectivist societies, with gossip and the threat
of shame and marginalisation functioning as a form of social control (see Storer,
1985), and encouraging secrecy about stigmatised issues. Collectivist communities
typically highlight the obedience of children, with harmony being valued and
conflict avoided (Centrelink Report, 1997, e.g. appendix pp.41, 45, 55; Storer,
1985, p.63). There tends to be an acceptance of external forces, such as nature or
fate, with some problems seen to be beyond the power of people to solve.
Non-intervention and tolerance of difficulties is sometimes espoused. If problems are tackled, they tend to be tackled together, with the implications for others, such as family, being taken into account. Illness is considered a social event, with families expected to help the individual during this time. Individualistic cultures typically assume that problems are solvable, that individuals are capable of controlling their lives and that difficulties can be overcome with hard work. Achievements are seen to be the sign of individual effort and hard work. Conflict is accepted as part of this process. Illness is seen to be the responsibility of the individual, with families playing a peripheral or purely supportive role.

Australia can be seen to be principally individualistic in its orientation (Minas et al., 1996). NESB young people who immigrate from a collectivist culture to Australia can experience difficulties such as acculturative stress, family conflict, identity confusion and disruption to support networks caused by exposure to disparate views. Various sociocultural factors embedded in the post-migration environment may contribute to this phenomenon. Institutions, such as schools, may unintentionally contribute to intercultural conflict between parents and young people by espousing individualism, which can be at odds with the collectivist expectations of some parents (Storer, 1985, p.63). Additionally, mass media in the host country may espouse views contrary to traditional norms making it more difficult for NESB young people to maintain their ethnic subcultures. This may be particularly true for those living in rural and remote areas, where lack of critical mass may result in the absence of cultural supports and networks. The work of Morrell and colleagues (Morrell, Taylor, Slaytor & Ford, 1999) indicates that immigrants residing in rural areas are at heightened risk for suicide in comparison to the Australian-born and immigrants living in urban areas. Further research is required to determine the nature of the risk factors that may be operating, including the role of cultural supports and networks and acculturation difficulties.

Moreover, in an attempt to maintain cultural identity following immigration, misinformation is sometimes used by newly arrived immigrant parents to encourage the bonding of young people to their family or community. The host culture may be painted as bad and threatening with all good things reframed as originating from one's own family or community (Storer, 1985, pp 63, 71, 169). Under these circumstances, NESB young people may be encouraged to associate with their own cultural group, rely on word of mouth within their cultural network as an information source and distrust external sources of information (Centrelink Report, 1997). Distrust of the host culture can extend to health care providers as well, acting as a barrier to service access for NESB young people experiencing difficulties (Horowitz, 1998). These acculturation pressures may be more likely to occur where the host culture is seen to hold contrary views incompatible with collectivism and where there is insistence on change and assimilation.

Consequently, whilst collectivism has been suggested as a sociocultural protective factor in suicide, following immigration to an individualistic culture, NESB
young people may experience enhanced stress resulting from attempts to reconcile divergent views. Differences in acculturation between NESB parents and young people may contribute to conflict and lack of support and diminish the potentially protective effect of a collectivist approach. Therefore, after immigration collectivism may act as a risk factor when the family is the source of the problem, or is unable to solve the problem, whilst discouraging the individual from seeking outside help (Horowitz, 1998; Storer, 1985). Subsequently, there is a need to conduct research exploring the impact of cultural views and practices, such as collectivism and individualism, on resilience and the suicide behaviour of NESB young people. Interventions targeting acculturation issues and encouraging and supporting collectivist practices may also have a place in suicide prevention. For instance, family involvement at all stages of suicide prevention, including the therapeutic process, may serve to enhance NESB young people’s access to suicide prevention services and programs.

**Power and role expectations in relationships**

Cultures also vary in terms of the balance of power in relationships and the acceptance of hierarchical structures in relationships, dictated by dominance and status, as a natural and necessary part of life (see Minas et al., 1996; Minas et al., 1999; Storer, 1985). This power can vary across different contexts. In some cultures power is related to age, gender and educational attainment. In collectivist cultures typically power is associated with increasing age, being male and being educated. Individualistic cultures are typically more youth orientated and espouse greater equality between the sexes. Philosophically, as compared to actuality, people are also said to be equal irrespective of educational achievements within individualistic cultures. Cultures can also vary in terms of their perceptions of the roles of men and women, children and parents. This tends to focus on differences between nurturance and protection versus achievement and provision. In collectivist cultures, females are typically seen to be the former and males the latter. Men are assumed to be the providers and protectors, having authority over wives and children. The importance of examining power in the suicide prevention context is highlighted by suggestions that the absence of hierarchies and power structures, that is individualism, is associated with higher suicide rates (Minas et al., 1999). This seems to indicate the potential protective impact of collectivist approaches and highlights the importance of research in this area.

Another reason for examining these factors is that migratory movements from collectivist to individualistic cultures can cause stress on young people and their families as a result of profound changes in power and role expectations. As young immigrants tend to learn a new language more rapidly than their parents, they may have to assume a more parental role following immigration (Bashir, 1993). In cultures where children normally assume a subordinate role (Storer, 1985), this shift
in power can create conflict and stress within the family. Additionally, extra responsibilities such as interpreting, filling in forms, childcare and so on for members of their family can place stress on an NESB young person, compounding difficulties caused by shifts in family dynamics. This indicates the importance of the provision of information, language and bilingual support services to the integrity of NESB families following immigration.

Immigrant parents may also place pressure on young people to achieve academically, in the belief that educational attainment will ensure success, authority and family status (Bashir, 1993; Centrelink Report, 1997). In reviewing the available data, Minas and colleagues (Minas et al., 1996), noted differences in school participation and tertiary attendance rates between the Australian-born, English speaking background (ESB) immigrants and those from NESB. School participation rates in Australia are seen to be higher among teenagers born in NESB countries in comparison to the other two groups. Likewise, 1.7 overseas-born 15 to 24-year-olds attended university for every Australian-born person in the same age group attending university. This seems to indicate a positive picture of post-migration resilience. However, there may be a subgroup of NESB young people for whom academic pressures may act as a risk factor. There is the possibility that in the absence of appropriate academic support, some vulnerable young people may not be able to meet academic demands and be at increased risk for suicide.

In addition to the direct impact of immigration on NESB young people, some may be indirectly impacted by the negative immigration sequelae experienced by their parents. Given the importance of fulfilling role expectations on self-identity and self-esteem, difficulties in this area may influence parental mental health. Research has indicated that mental health difficulties experienced by parents can have a negative impact on the mental health and suicide risk of young people (Beautrais, 2000; Patton & Burns, 2000). Consequently, consideration of parental mental health difficulties following immigration needs to be an integral component of suicide prevention initiatives targeting NESB young people.

The work of Morrell, Taylor, Quine and Kerr (1993), for instance, has demonstrated a link between unemployment and suicide risk. The unemployment rate for immigrants is generally higher than for people born in Australia (Minas et al., 1996). Immigrants also tend to stay unemployed for a longer period of time than people who are born in Australia and in comparison to people who come from an English speaking background. Minas and his colleagues (Minas et al., 1996) attributed these higher rates to poor English language skills, recent date of arrival and non-recognition of qualifications. Additionally, the proportion of immigrants receiving financial assistance for unemployment is said to be less than their Australian-born counterparts (Minas et al., 1996, p.17). Consequently, factors such as unemployment can impact on an immigrant’s ability to obtain opportunities to fulfil traditional role and power expectations in Australia and thereby contribute to acculturative stress.
Marriages may also be threatened by challenges to previous roles present in individualistic cultures, such as greater power and opportunities for women (Bashir, 1993; Centrelink Report, 1997, appendix p.24 and p.34). Collectivist cultures are hypothesised to have a protective role through the availability of family support (Minas et al., 1999). Generally, researchers have highlighted that overseas-born people are more likely to be married or in a de facto relationship than are the Australian-born (Minas et al., 1996, p.14). Whilst these differences may be due to age and sex profile differences, they are perhaps also related to differential attitudes to family and marriage, and age of marriage, inherent in collectivist cultures (Minas et al., 1996, p.14). Immigration may potentially contribute to relationship break-ups, undermining the resilience of NESB families and young people.

Given the links between relationship difficulties and suicide, the potential negative impact of immigration on family relationships, via disruption to power and role expectations, is a viable target for suicide prevention. Researchers have indicated that marital status is associated with the lowest suicide rates, with relationship break-ups increasing suicide risk among vulnerable individuals (Baume et al., 1998). Separation from family and kin-based social support systems may be a compounding factor for family difficulties, particularly for women, resulting in isolation and lack of support (Minas et al., 1996). Consequently, the availability of relationship support and counselling services for NESB families, as well as initiatives enhancing community links, have a place in suicide prevention.

**Rules for social interaction**

Typically, collectivist cultures are also characterised by social rules and expectations. Authority is respected, with strong proscriptions regarding appropriate and inappropriate behaviour, especially in public and with strangers. There are distinct rules regarding emotional expression. Some cultures place high value on emotional control, seeing this as a reflection of maturity. Others expect greater emotional expression in certain social contexts with ability to abide by these rules having implications for marriage. Some cultures see marriage as being only for the able bodied, often backing this up by legal requirements (Storer, 1985, p.205); consequently, attempts may be made to hide mental illness and other disabilities. Individualistic cultures are seen to be looser, with greater ambiguity about social rules, and within which challenges to authority are seen to be acceptable. In individualistic cultures marriage is principally limited by age restrictions.

Social support has consistently been viewed as a protective factor in the relationship between immigration, mental disorders and suicide (Cheung & Spears, 1995; Hovey, 1999). Consequently, the ability to adopt the host culture’s rules for social interaction can have ramifications for obtaining appropriate support following immigration. For instance, the literature indicates that lack of sensitivity on the
part of the host culture’s mental health service providers to cultural differences in social interaction, can contribute to non-attendance, non-compliance, incorrect diagnosis and poor treatment outcomes for immigrants (Flaskerud, 1986; Kaiser, Katz & Shaw, 1998; Minas et al., 1996; Sue & Morishima, 1982 cited in Sue, Akutsu & Higashi, 1987; Toukmanian & Brouwers, 1998). This highlights the importance of cross-cultural education for professionals involved in suicide prevention services and programs, to ensure effective service provision for NESB young people and their families.

**Perceptions of time**

Time is highly valued by individualistic cultures. The future has particular importance in this context, as individualistic cultures are very goal-orientated. Some other cultures place more emphasis on the past — for example, ancestor worship by some Asian cultures. Others are very much focused on the present, seeing the future as being ‘out of their hands’. This is especially true for refugees and abuse survivors, who as a result of post-traumatic stress disorder, have a foreshortened sense of the future (American Psychiatric Association, 1994). The role of time perception in suicide behaviour has yet to be explored.

Australia may be seen as principally an individualistic, youth-focused culture, with a goal-directed, future orientation. Lack of sensitivity to cultural differences in time perception may have negative consequences in a suicide prevention context, contributing to non-attendance, non-compliance, inaccurate assessment and poor treatment outcomes for immigrants (Flaskerud, 1986; Sue & Morishima, 1982 cited in Sue, Akutsu & Higashi, 1987). In identifying components of culturally appropriate service provision, Flaskerud (1986) highlighted the importance of time perception and the use of brief, solution-focused approaches in working with NESB immigrants.

**Views of mental illness and suicide**

There is evidence that while the major mental illnesses have similar presentations across cultures (Draguns, 1987), different cultures have varying views of mental illness. There is variation in beliefs as to causation of the illness, its treatment and its ability to be treated. Some cultures view mental illness as being incurable (Cheung & Snowden, 1990). Not all cultures have the mind–body dualism or organic theories of causation which dominate Western approaches (see Minas et al., 1996). Some cultures see no difference between the mind and the body, often expressing psychological states in physical ways. They tend to have holistic approaches to intervention, sometimes going to the one ‘healer’ for all their complaints.
Some cultures view focusing on negative thoughts, expression of negative emotions, such as conflict, and disclosure to strangers as causative of mental health problems (Sue & Zane, 1987; Sue & Sue, 1990). Some believe that silence, meditation and acceptance, are the keys to mental health (Leininger, 1987). Likewise, some cultures believe that behaviour is predetermined before birth and are therefore unlikely to seek intervention for problems experienced. Some do not see behavioural problems in mental health terms, especially among children, nor do they see these problems as treatable (Cheung & Snowden, 1990).

In terms of suicide, differences in cultural beliefs and attitudes towards suicide have been documented, with these cultural beliefs hypothesised to influence rates and choice of methods (Diekstra & Kerkhof, 1989; Farberow, 1975). These suicide attitudes have changed over time ranging from its condemnation as a crime, to being perceived as a sin, to its perceived link with mental illness. Some cultures see suicide as an acceptable means of resolving ‘loss of face’, as atonement for wrong-doing, as a way of preserving honour, to avoid pain, to express bereavement from loss of a loved one, or as a political statement (Farberow, 1975). Others have strong religious and cultural prohibitions against suicide, with the possibility that such stigma may have a protective effect. As attitudes to suicide have changed, so have the attitudes towards the bereaved. For example, its link with mental illness has resulted in secrecy in some communities due to the negative impact on the status of the bereaved.

The major challenge for NESB people experiencing mental health difficulties following immigration is the ability to obtain effective and appropriate treatment. For example, in exploring the factors contributing to underutilisation of mental health services by people of NESB, researchers have identified the following: lack of knowledge about services, language and cultural barriers, stigma, lack of cultural sensitivity on the part of service providers, insufficient availability of interpreters and bilingual staff and fears of confidentiality breaches (Flaskerud, 1986; Gottesfeld, 1995; Minas et al., 1996; Mitchell, Malak & Small, 1996; Sue & Sue, 1990). The views of mental illness and suicide held by some NESB communities may be at variance with those of the Australian-born population and service providers (Minas et al., 1996). The gulf between traditional views of mental illness, suicide and the provision of mental health and suicide prevention services and programs, may act as a significant barrier to suicide prevention among NESB young people. Consequently, knowledge of the views held by NESB families and their young people facilitates the development of effective and targeted initiatives.

**Views of help seeking and intervention options**

Collectivist cultures emphasise the role of family and community resources in the resolution of problems (Storer, 1985). There may be socially sanctioned means of seeking assistance. The advice and support of extended family members may be
sought for marital difficulties and other issues. The nature of the problem often
determines how help is sought. Mental illness is often highly stigmatised, resulting
in secrecy and lack of external help seeking, especially with strangers (Sue & Sue,
1990, p.40). For these reasons, some people may not seek assistance for fear of
bringing shame upon their family. External help seeking may be seen as a failure by
the family to meet the needs of its own members (Centrelink Report, 1997 e.g.
Appendix pp.48, 49; Storer, 1985, p.219; Sue & Sue, 1990). This sometimes leads
to a distrust of strangers and reluctance to disclose personal details (Storer, 1985).
Similarly, gender issues are often important in the help-seeking context, with
women often seeking the support of other, sometimes older women, whilst men turn
to men.

In collectivist cultures families are expected to provide assistance to the ill
person, with evidence suggesting that immigrant families are more involved in the
care of mentally ill members than ‘caucasians’ (Cheung, 1989; cited in Horowitz,
1998). In a study of family involvement in the management of schizophrenia,
Cheung indicated that 69 per cent of Asian patients had at least one family member
and 46 per cent had multiple family members accompany them to sessions, versus
12 per cent and 8 per cent respectively for ‘caucasians’. It was concluded that
non-cultural factors such as language difficulties and problems with transportation
are not the principal reasons for this difference. This has a number of implications
for suicide prevention among NESB young people. Firstly, collectivist approaches
emphasising family support may be protective for vulnerable, mentally ill young
people. Secondly, reliance on family support may act as a barrier to service access
with the burden of care residing principally with the family. This reliance may con-
tribute to delayed pathways to mental health services, with negative consequences
for both the sufferer and family (Ell & Castaneda, 1998). Thirdly, initiatives
enhancing access by NESB young people and their families to support services
should be an essential component of suicide prevention initiatives.

Underutilisation of services due to the greater burden of care adopted by NESB
families contributes to an inaccurate picture of the incidence of mental disorders
among NESB young people and its role in suicide. Likewise, reliance on families
may ironically hamper access to appropriate suicide prevention services to NESB
young people at risk. The views of appropriate support and help-seeking held by
some NESB people may be at variance with those of the Australian population and
service providers. Consequently, the provision of suicide prevention programs and
services targeting NESB young people and their families needs to consider
traditional help-seeking pathways to ensure their effectiveness. The incorporation
of traditional help seeking pathways and carers valued by collectivist cultures, such
as clergy and healers, is seen to be crucial to successful intervention (Flaskerud,
1986). In order to better inform the development of targeted suicide prevention
programs, research is also required into the relationship between attitudes towards
mental illness and suicide, help-seeking and suicide behaviour.
Issues for Consideration in the Development of a Suicide Prevention Program for NESB Young People

Information on suicide behaviour among NESB young people was presented to indicate the patterns that may be present. Such information can assist the identification of possible groups at heightened risk. However, limitations in databases were seen to result in an inaccurate picture of suicide behaviour among NESB young people and potentially confound this process. In particular, limited information was available on suicide behaviour among the second generation of NESB young people. Literature on the role of immigration and the impact of culturally diverse views on acculturation and suicide risk were then examined to come to a better understanding of the risk and protective factors that may be impacting on the suicide behaviour of NESB young people. The absence of research in these areas, however, restricted the statements that could be made about the risk and protective factors that may be operating in the Australian context.

Nevertheless the available information highlighted issues that needed to be considered in the development of a suicide prevention program for NESB young people. For instance, the literature, although limited, suggests that acculturative stress, caused by differences between family-held views and those of the host culture, may potentially increase propensity to suicide among vulnerable NESB young people by reducing family support, causing disturbances in identity and support network formation. Likewise, disparate views among young people of NESB, their families and mental health professionals may potentially limit the ability of at-risk young people to enter suicide prevention activities provided by the host culture. As a result of these considerations a number of potential targets for a suicide prevention program can be identified:

1. programs addressing acculturation issues, particularly its contribution to family conflict and breakdown;
2. provision of information on English language and bilingual welfare support services;
3. provision of academic support to NESB young people experiencing language proficiency difficulties;
4. provision of services supporting NESB families caring for vulnerable people suffering from mental illness;
5. provision of relationship and family counselling to NESB families;
6. initiatives enhancing community links and cohesiveness;
7. professional training options in cross-cultural issues to enhance skills in the assessment and management of NESB young people at risk of suicide;
8. review of suicide prevention and mental health service delivery models to enhance their cultural and linguistic appropriateness; and
9. further research into factors impacting on suicide behaviour among NESB young people.
The views of key stakeholders

As part of the NSW NESB Communities Suicide Prevention Project, statewide focus group consultations with key stakeholders were conducted to collect information on how the issue of suicide in NESB communities was perceived and possible strategies that could be used to prevent it. The identification of key stakeholders was guided by the principles outlined in the NSW Suicide Prevention Strategy (NSW Health Department, 1999). The Strategy highlighted the integral involvement of all strata of society in suicide prevention, such as NESB communities and mainstream, ethnospecific and multicultural government and non-government organisations. The results of these consultations will be briefly presented, with a more comprehensive account available (Dusevic & Baume, 2000). The information presented reflects the views and perceptions of participating key stakeholders and does not include an examination of the accuracy of these perceptions. The aim of presenting this information is to complement the findings of McDonald and Steel (1997) and the literature review, and thereby assist in identifying the scope of evidence available to guide suicide prevention initiatives for this population.

Twenty-two focus group consultations were conducted with a total of 236 individuals representing a broad range of organisations and NESB communities; 60 per cent of participants were overseas-born, with a further 30 per cent being second-generation immigrants. Fourteen groups were conducted in the Sydney Metropolitan area and the remainder of the groups was run in regional and rural areas.

In terms of their perceptions of at-risk groups, 77 per cent of focus groups identified NESB young people as an at-risk group. The majority of focus groups highlighted the need to consider families and their resilience in suicide prevention initiatives targeting NESB young people, as family support was identified by 82 per cent of groups as a protective factor, with its absence seen as a risk factor by 82 per cent of groups. Issues to be targeted within this context were: stigma regarding seeking help outside the family (91 per cent); cultural conflict between parents and young people (41 per cent); language difficulties between parents and young people (27 per cent) and marital difficulties between parents (23 per cent). Examples of suggested strategies for addressing these issues were:

• education for parents (46 per cent);
• provision of English language classes (41 per cent);
• provision of relationship and family counselling (23 per cent);
• review of policies and legislation impacting on immigrants (18 per cent); and
• promotion of positive NESB role models among NESB young people (9 per cent).

A total of 46 per cent of focus groups indicated their belief that schools were best placed to provide resilience-enhancing initiatives to NESB young people and their families. A number of reasons were offered for this including the perception that
NESB parents afforded a great deal of trust to schools, being more likely to attend school-based programs and initiatives than those occurring in other settings. Caution was voiced by a number of focus groups in terms of school-based initiatives, namely, that school-based approaches should be universal in their focus (9 per cent), with concern that selective and indicated prevention approaches may further stigmatisé vulnerable NESB young people. Likewise, 9 per cent of groups cautioned against use of the word ‘suicide’ in school-based education approaches due to concern that this may normalise suicide and, paradoxically, enhance suicide risk.

The importance of developing community-based initiatives was also emphasised, with 86 per cent of focus groups indicating the need for NESB community ‘gatekeeper’ training. Training was seen to fulfil multiple purposes such as:

- promoting identification of at-risk NESB people and information on available services (59 per cent);
- minimising the likelihood of vulnerable NESB people and their families being marginalised within the community (46 per cent); and
- promoting ‘word of mouth’ information dissemination (36 per cent).

Issues to be targeted within this context were: stigma regarding mental illness and suicide (73 per cent); information regarding the confidentiality of services (73 per cent); poor knowledge of services (64 per cent); belief that suicide is not due to mental illness (36 per cent) and stigma regarding hospitalisation in a psychiatric facility (18 per cent).

Examples of suggested strategies for addressing these issues were: using existing NESB community networks, such as community venues and community leaders (59 per cent); using ethnic media (55 per cent); using ethnic radio (41 per cent); providing information in people’s own language (32 per cent); using ethnic newspapers (18 per cent); using pamphlets to provide service information (9 per cent) and using the internet to directly target NESB young people (5 per cent).

Various other considerations were raised by participants regarding community based education initiatives: need to be sensitive to settlement and acculturation issues (50 per cent); need to encourage health promotion approaches (41 per cent); several strategies are required for effectiveness, with NESB initiatives needing to be conducted in parallel with mainstream initiatives to avoid stigmatisation (32 per cent); there is no need to mention ‘suicide’, given the possibility that stigma may act as a protective factor (23 per cent); need to develop an information dissemination plan (14 per cent); and need to adopt a mental health focus, rather than mental illness (9 per cent). In addition to education initiatives, 64 per cent of focus groups also highlighted the importance of developing initiatives that linked vulnerable, marginalised NESB people with community networks and social structures.

In terms of suicide prevention services and programs, participants emphasised the important role of mental health services in meeting the suicide prevention needs
of NESB young people. Participants, however, discussed various factors that acted as barriers to access of services: stigma regarding seeking help outside the family (91 per cent); poor links between services and NESB communities (82 per cent); fears regarding confidentiality breaches (73 per cent); stigma regarding mental illness and suicide (73 per cent); poor knowledge of services (64 per cent); inadequate numbers of bilingual counsellors (46 per cent); lack of culturally appropriate services (41 per cent); inadequate numbers of interpreters (27 per cent); lack of interpreter use by staff (27 per cent); gaps in services (27 per cent); lack of continuity in care (23 per cent) and rigid referral criteria emphasising serious mental illness (14 per cent). Community-based education strategies were seen to be one means of addressing these barriers (86 per cent).

Another strategy was seen to be community outreach, with service providers establishing links with NESB communities and engaging at-risk NESB people utilising existing NESB community networks (82 per cent). Examples of other suggested strategies were: the provision of training for service providers on cross-cultural suicide prevention (73 per cent); development of collaborative partnerships and networks between mental health services, NESB communities and other key organisations (73 per cent); obtaining NESB community input into service delivery models (55 per cent); provision of, and support for, family based initiatives (50 per cent); enhancing the availability of bilingual counsellors (46 per cent); provision of, and support for, facilitated referral of at-risk NESB people (36 per cent); development of resources, such as an information booklet outlining suicide prevention services (36 per cent); provision of resources to address service gaps (27 per cent); enhancing availability of interpreters (27 per cent); promoting interpreter use by service providers (27 per cent); developing standards and protocols to enhance continuity of care (23 per cent); and facilitating the adoption of more flexible referral criteria, particularly for at-risk individuals not experiencing serious mental illness (14 per cent).

Another area addressed by 23 per cent of focus groups was the need for the development of evidence bases to guide suicide prevention initiatives, particularly in view of gaps in knowledge about NESB people and their suicide behaviour. A further 14 per cent highlighted the need to conduct evaluation studies to determine the effectiveness of suicide prevention strategies for NESB people. This was seen to include a review of service provider adherence to policy guidelines, as well as the adequacy of data collection. Nine per cent of groups also highlighted the importance of providing service providers with data, such as demographic information, to assist them in the development of local initiatives.

In summary, focus group participants highlighted the importance of including family and community-based resilience initiatives in the development of a suicide prevention program for NESB young people. This was in acknowledgement of the collectivist approaches of many NESB communities and the perceived role of collectivism in reducing propensity to suicide. As such the views of key stake-
holders seemed to parallel the information documented in the international literature. In terms of access to suicide prevention services and programs, the development of collaborative partnerships and networks between NESB communities and key organisations was seen to be crucial to the provision of efficient and effective suicide prevention. Particular recognition was given to the important and integral role played by mental health services in suicide prevention, with participants highlighting the need for cross-cultural training initiatives to support services in fulfilling this role. The need to guide and support suicide prevention initiatives through the development of evidence bases also featured prominently in the recommendations of focus group participants.

The use of effective suicide prevention strategies: An examination of the evidence

The development of suicide prevention initiatives for NESB young people rests on the availability of data to assist the identification of at-risk groups, the (modifiable) risk and protective factors that may be operating and the availability of effective suicide prevention strategies. In reviewing the international literature, very few immigrant suicide prevention initiatives are documented. In particular, no research appears to address the effectiveness of suicide prevention initiatives targeting immigrant populations. Consequently, the following discussion will focus on the effectiveness of general suicide prevention initiatives, with particular attention being paid to suicide prevention initiatives targeting young people. The aim of such a discussion is to highlight effective strategies that could be incorporated into a suicide prevention program for NESB young people. The review of available evidence is not intended to be exhaustive, but is an indication of the scope of strategies used and some indication of their effectiveness.

The challenges of demonstrating the effectiveness of suicide prevention initiatives have been discussed by numerous authors (Gunnell & Frankel, 1994; McNamee & Offord, 1990; Taylor, Kingdom & Jenkins, 1997). In general, experts have highlighted the need for a range of programs including primary, secondary and tertiary prevention for maximum effectiveness (Gunnell & Frankel, 1994; Lester, 1993; Mrazek & Haggerty, 1994). The need for these to be accompanied by evaluation is seen to be crucial given the potential negative effects of suicide prevention programs (International Association for Suicide Prevention, 1997; Kerkhof & Diekstra, 1995; Lester, 1992). For example, student participation in school-based suicide prevention programs has been shown to be detrimental, with some programs appearing to discourage suicidal students from seeking help (Garland, Shaffer & Whittle, 1989; Lester, 1992). Although some researchers are optimistic about the effectiveness of suicide prevention approaches (e.g. Ezersdorfer & Sonneck, 1998; Goldney, 1998), others report on the lack of effectiveness of existing approaches (Meakenin & Wasserman, 1997). The latter saw the stability of country ranking of
suicide rates, as well as overall increases in countries’ rates, as indirect evidence for the lack of truly effective mass-preventive measures.

Primary prevention approaches, such as those aimed at enhancing parental skills, family cohesion and reducing conflict, have not been adequately assessed in the context of suicide prevention (Patton & Burns, 2000). There appears to be some evidence for improvements on indices of family functioning and in terms of the behaviour and mental health of young people; however, demonstrated effectiveness in terms of suicide prevention is not reported. On an optimistic note, media guidelines on the portrayal of suicide were seen to be linked to reductions in suicide (Etzersdorfer & Sonneck, 1998). In terms of the effectiveness of primary prevention strategies, De Leo, Carollo and Dello Buono (1995) reported on the effectiveness of a telephone service in reducing suicide among older people in Italy. The telephone service had two components, one was an alarm system that the client could activate to call for help, and the other involved the client being contacted about twice a week for assessment of needs and for emotional support.

With reference to early intervention approaches, there have been studies exploring the role of general practitioners in suicide prevention. Studies have shown that many of those who suicide have had contact with their general practitioner shortly before death (Hawton, O’Grady, Osborn & Cole, 1982; Barracough, Bunch, Nelson & Sainsbury, 1974; Murphy, 1975). Consequently, successful suicide prevention was seen to depend on the skills of the family doctor, with evidence suggesting that doctors have a low rate of detection of psychiatric disorders and suicide risk (Murphy, 1975). There have been demonstrated changes in doctor knowledge (Michel & Valach, 1992) and ability to reduce suicide (Rutz, von Knorring & Walinder, 1989) after training. However, the findings of the later study have been criticised on methodological grounds (MacDonald, 1992). In terms of immigrant communities there is evidence suggesting that their contact with doctors is similar to that of the Australian-born (Stuart, Minas, Klimidis & O’Connell, 1996), with 80 per cent of patients with poor English skills consulting general practitioners (GPs) who speak their native language. However, there have not been any documented studies assessing the role and ability of bilingual general practitioners in immigrant suicide prevention.

There has also been an examination of the potential involvement of general practitioners (GPs) in the identification and management of young people at risk (Appleby, Amos, Doyle, Tomenson & Woodman, 1996). Review of GP records of suicides by young people indicated that: there were no gender differences in attendance; the majority of final visits were for psychological reasons; and there was a striking lack of evidence of risk assessment. The study concluded that there was a place for GP involvement in suicide prevention among young people, with training in recognition and assessment of risk being essential. However, given that young people’s contact with GPs prior to suicide is infrequent (Vassilas & Morgan, 1993), targeting of other professionals and services was said to be crucial to effective suicide prevention.
The impact of training initiatives on the identification of at-risk young people by allied health professionals has reportedly been very positive (Rotheram-Borus & Bradley, 1991). Intake assessments were compared before and after the implementation of training and management protocols. Assessments of suicidal ideation, depression, previous suicide attempts and family history of suicide occurred at significantly higher levels after the implementation of initiatives. Community education initiatives assisting in the identification of, and support for, at-risk young people have also been examined with positive results being reported, however evaluation data was not provided (McArt, Shulman & Gajary, 1999). Consequently, the conclusion cannot be supported on methodological grounds.

In terms of the effectiveness of medical treatment in suicide prevention, most studies have focused on the management of depression and the management of individuals with a prior history of suicide attempts. One study reported that psychiatric counselling following a suicide attempt resulted in fewer subsequent suicide attempts in comparison to a control group not receiving such counselling (Greer & Bagley, 1971). Pharmacological intervention with depression was also reported to reduce suicidal behaviour (Beasley et al., 1991; Montgomery, Bullock, Baldwin & Montgomery, 1992; Schou & Weeke, 1988). However, other studies have failed to find a statistically significant effect with intervention (Allard, Marshall, & Plante, 1992; House, Owens & Storer, 1992; Waterhouse & Platt, 1990). Of studies to date, none has apparently shown a statistically significant benefit of psychosocial intervention in reducing suicide attempts. However, the majority of these studies were seen to have methodological limitations (McNamee & Offord, 1994). Likewise, no data was seen to be available on the effectiveness of involuntary hospitalisation in reducing the risk of suicide (Wise & Berlin, 1987). No data could be found on the effectiveness of treatments in the management of immigrant suicide behaviour. The lack of such data is especially concerning given that numerous researchers have documented the unique challenges facing immigrants accessing mental health services (Minas, 1991; Minas et al., 1996; McDonald & Steel, 1997).

In reviewing the literature on young people, it has been noted that no treatment program to date has demonstrated reduced re-attempt rates in adolescent attempters (Greenhill & Waslick, 1997). One of the reasons for this may be that young people with a history of suicide attempts are difficult to engage in follow up interventions (Rudd, Joiner & Rajab, 1995). The other is that few therapeutic interventions have been developed specifically for suicidal adolescents (Rotheram-Borus, Piacentini, Miller, Graae & Castro-Blanco, 1994). In terms of pharmacological interventions, there is evidence indicating that the symptoms of affective disorders in adolescents are essentially identical to that seen in adults (see Greenhill & Waslick, 1997). However, the efficacy of antidepressant medications found in adult populations has apparently not been demonstrated in treatment studies of adolescents. Physiological and hormonal factors in adolescents are seen to be responsible for the reduced efficacy of pharmacological interventions, particularly among male adolescents.
In terms of psychosocial interventions targeting at-risk young people, limited effectiveness has been demonstrated (Burgess, Hawton & Loveday, 1998). The major reported benefit has been in the greater retention of at-risk individuals in comparison to routine follow up approaches (Rotheram-Borus et al., 1999; Rudd et al., 1996). Family therapy approaches have demonstrated effectiveness for some subgroups of at-risk young people, with greater compliance, reductions in psychiatric symptoms and suicidal ideation (Harrington et al., 1998; Harrington et al., 2000). However, benefits were principally observable in the subgroups not suffering from major depression, limiting the clinical significance of this result (Harrington et al., 1998). With family-based education approaches, positive benefits were noted. Namely, family education had a positive impact on greater compliance with follow up of at-risk individuals (Rotheram-Borus et al., 1996). In evaluations of family education about injury prevention, a greater restriction of access to means was noted in comparison to families not receiving such education (Krueci et al., 1999; McManus et al., 1997).

In the literature addressing prevention approaches focused on reducing access to means, success has been reported, with authors discussing challenges in reducing deaths by the hanging method (Cantor, Turrell & Baume, 1996; Baume & Clinton, 1997; Cantor & Baume, 1998; Gunnell & Frankel, 1994; Skopec & Perkins, 1998; Baume & Skopec, 2000). For instance, legislation restricting the number of tablets or capsules available per prescription of sedatives and hypnotics was seen to contribute to a decline in suicide rates in the late 1960s and early 1970s (Oliver & Hetzel, 1972).

The effectiveness of postvention initiatives has not been demonstrated due to methodological limitations in studies exploring this issue (Patton & Burns, 2000). Potential negative impacts have been documented, with postvention in schools being linked with increased suicide talk, threats and attempts (Callahan, 1996). In terms of immigrant communities particular challenges have been noted in the area of postvention. Firstly, stigma regarding mental illness and suicide can act as barriers to accessing bereavement services (Dusevic & Baume, 2000; Young & Papadatou, 1997), with this being compounded by NESB people tending to have less awareness of bereavement services than the Australian-born (Ata, 1994, p.71). Other unique challenges further complicate the bereavement process for NESB immigrants, such as autopsy requirements following suicide being at odds with culturally appropriate bereavement practices. Similarly, the dilemma of burying the deceased here or in the country of origin is an added burden for families (Ata, 1994, p.18). Consequently, one can speculate that immigrant populations may require particular attention in the area of postvention. However, there is a suggestion that stigma and secrecy may function as a form of ‘postvention’ by limiting the possibility of ‘contagion’ and imitation and thereby contributing to reduced propensity to suicide among certain cultures (Morrell, 2000). Such hypotheses highlight both the complexity of postvention issues and the need for further research exploring the impact of diverse postvention practices (Morrell, 2000).
In reviewing the overall effectiveness of suicide prevention approaches the Canadian Task Force on Preventive Health Care (McNamee & Offord, 1994) reported the following: evidence was seen to be available to support the effectiveness of general practitioner education on suicide prevention; there was seen to be insufficient evidence to support school-based or community education initiatives for those with a prior history of attempts; and there was evidence to support the role of medical intervention in the treatment of suicidal ideation and depression.

In summary, there is some evidence supporting the effectiveness of suicide prevention approaches, including those targeting young people. However, research into the impact of mainstream suicide prevention initiatives on NESB populations, including young people, is a neglected area. Documentation of ineffective, and counterproductive, suicide prevention initiatives makes the need for such research seem both obvious and imperative, particularly in view of the limitations in knowledge about factors impacting on the suicide behaviour of NESB immigrants. Consequently, while the limited evidence has highlighted potential targets for suicide prevention among NESB young people, the lack of demonstrably effective strategies for this population affirms the need for caution. The ‘piloting’ of initiatives and the inclusion of process, impact and outcome evaluation measures may be means of integrating safeguards into the development of a suicide prevention program for NESB young people.

The scope of NESB youth suicide prevention in Australia

Given the data on the effectiveness of some suicide prevention initiatives, it is important to examine levels of initiatives targeting NESB young people and their outcomes in the Australian context. Likewise, by determining current levels of activity one assists the identification of gaps and possible future directions in suicide prevention for NESB young people. To facilitate these processes, a number of information sources will be examined. In the first National Stocktake of Youth Suicide Prevention Initiatives (Australian Institute of Family Studies, 1998) it was found that only 1.6 per cent of all projects focused on the NESB population (Mitchell, 1999). None of these projects, however, appeared to provide data on the effectiveness of these programs in meeting either the mental health or suicide prevention needs of their target groups. In the second National Stocktake on Youth Suicide Prevention (Australian Institute of Family Studies, 1999), six of the 674 (<1 per cent) National projects were seen to target NESB populations. Once again, no projects appeared to have evaluative data reporting on the initiative’s effectiveness. Likewise, projects also did not appear to be targeting at-risk NESB young people as identified by McDonald and Steel (1997) and only addressed a limited range of modifiable risk and protective factors identified by the available evidence, leaving further scope for activity in this area.
In the report *Suicide and Self-Harm Prevention Initiatives in New South Wales* (NSW Health Department, 1997), there were no specific initiatives targeting NESB young people. In the report *What Divisions are Doing About Depression: An Activity Scan* (Integration Support & Evaluation Unit, 1998a), no general practitioner training initiatives were noted for immigrant suicide prevention or depression. Mention was made of five training initiatives occurring between 1993–1995 that focused on cross-cultural issues. Two of these initiatives took place in NSW, however, further details were not available. In *Sharing Mental Health Care in New South Wales & ACT: Stakeholder Information Kit* (Integration Support & Evaluation Unit, 1998b), mental health projects undertaken by Divisions of General Practice between 1993–1997 were documented. There did not appear to be any mention of initiatives targeting NESB young people.

In the first *National Stocktake of Early Intervention Programs* (Davis, Martin, Kosky & O’Hanlon, 1998), four of the 119 (3.4 per cent) projects were said to have a NESB focus. Some of the other documented projects reported that their approach was inclusive of, not focused on, NESB young people. In the second *National Stocktake of Early Intervention Programs* (1999), indexing did not include NESB targets. The only program with an apparent NESB focus was the one reporting the work of STARTTS in NSW, which targeted refugee survivors of torture and trauma (0.5 per cent of all initiatives reported).

In summary, some projects have focused on suicide prevention among NESB young people. However, the percentage of projects targeting this population is minimal. The ABS Census (ABS, 1996) indicated that there were 408,289 young people between the ages of 15 and 24 living in Australia who spoke a language other than English. That is, NESB young people represented 15.9 per cent of the population within that age range: a significant percentage. In light of the presented information and the gaps in research on suicide behaviour among NESB young people, especially the second generation, there is scope to further explore the needs of this group. Sadly, the absence of evaluation data for those suicide prevention projects targeting, or inclusive of, NESB young people represents missed opportunities to gather valuable information on this population.

**Concluding Remarks**

The aim of this chapter was to address issues in suicide prevention for NESB young people living in Australia. The first issue that was examined was the currently available information on suicide behaviour among NESB young people. A review of the available evidence highlighted gaps that seriously impede informed discussion and action in the area of suicide prevention for this population. Firstly, there are significant limitations in data on suicide behaviour among NESB young people, with no data available on suicide among the Australian-born children of NESB immigrants. Consequently, current databases do not provide an accurate picture of
suicide beyond the first generation of overseas-born. The finding that NESB overseas-born young people in general have a lower rate of suicide than the Australian-born can therefore not be assumed to be true for all NESB young people. In fact, McDonald and Steel’s (1997) work indicates that there is diversity in rates even among the overseas-born, with some groups having higher, and others lower, rates than the state average and those of the Australian-born.

The second issue explored was the factors impacting on suicide behaviour among NESB young people. Data on the risk factors that may be operating among NESB young people, such as mental disorders, were shown to be lacking. Likewise, research into the protective factors contributing to lower suicide risk among groups of overseas-born NESB young people is negligible and represents a missed opportunity to potentially inform suicide prevention initiatives. This is particularly important given data indicating that suicide among overseas-born NESB young males appears to be lower than the state average. The work of McDonald and Steel (1997) and other researchers indicates the salient impact of sociocultural factors on the suicide behaviour of immigrants. The relationship between culture and suicide, however, has not been adequately researched and represents a potentially innovative area for exploration. In discussing the impact of factors such as immigration, acculturation and divergent sociocultural beliefs and practices, some possible areas for future research were highlighted. There is a need for appropriate research methodologies to be utilised before reliable and valid conclusions can be drawn about modifiable risk and protective factors operating in the Australian context. The implications of available findings for the development of suicide prevention initiatives was also discussed, with advocacy for initiatives to cautiously target the unique concerns of NESB young people.

The third issue targeted was the evidence available to guide the choice of strategies for suicide prevention initiatives targeting NESB young people. The views of key stakeholders on this issue, as well as evidence from the international literature on effective suicide prevention strategies, were presented. An overview of Australian-based suicide prevention initiatives targeting NESB young people was also provided, to indicate the scope of activities carried out to date and to help identify the remaining gaps. Despite the challenges of evaluating suicide prevention initiatives, the literature indicated that certain strategies had demonstrated effectiveness in reducing the incidence of suicide risk. In reviewing national, and particularly NSW-based initiatives, it was clear that some have focused on NESB young people. However, the absence of evidence bases to guide the development of initiatives may have resulted in the needs of at-risk NESB young people, as identified by the work of McDonald and Steel (1997), being neglected. Likewise, the absence of rigorous research into modifiable risk and protective factors may have resulted in only limited attention being paid to factors identified by the literature. Evaluations on the outcome of existing initiatives on the mental health or suicide risk of NESB young people needs to be explored more fully, with the potential
harvesting of valuable data. Given that the percentage of projects focused on NESB young people was minimal, one can state that scope remains for addressing the needs of this population. This recommendation appears to be in keeping with the views of key stakeholders, who have advocated for the development of comprehensive and tailored suicide prevention initiatives for NESB young people.

In conclusion, it is hoped that by highlighting suicide prevention issues that need to be considered for NESB young people, this chapter inspires thought on future directions that can be undertaken. The examination of existing evidence bases, as well as gaps, identifies opportunities for innovative and thought-provoking research in this area. In recognition of 'a whole of community' approach required for effective suicide prevention, any future initiatives that are developed need to be developed in collaboration with NESB young people themselves, as well as other key stakeholders such as local, State and Federal government, non-government and community organisations. It is only by addressing the needs of culturally and linguistically diverse communities that unified, equitable and effective suicide prevention for all of Australia’s young people can be ensured.

References


Integration Support and Evaluation Unit (1998a) *What divisions are doing about depression: An activity scan. Preliminary report to the National Depression Action Plan Steering Group and the National Health Priority Area First Annual Report.* Sydney: Centre for GP Integration Studies, School of Community Medicine UNSW.

Integration Support and Evaluation Unit (1998b) *Sharing mental health care in New South Wales & ACT. Stakeholder information kit. Mental health & drug and alcohol initiatives of divisions of general practice.* Sydney: Centre for GP Integration Studies, School of Community Medicine UNSW.


NSW Health Department (1997) *Suicide and self-harm prevention initiatives in NSW.* Sydney: NSW Health Department.

NSW Health Department (1999) *Suicide: We can all make a difference. NSW Suicide Prevention Strategy: Whole of Government approach.* Sydney: NSW Health Department.


Diversity and Mental Health in Challenging Times

A prospective study of completed and attempted suicides in Victoria. Melbourne: 
University of Melbourne and Australian Rotary Health Research.

psychotherapy. In S. S. Kazarian & D.R Evans (Eds) Cultural clinical psychology: 

Trauer, T. (1995) Ethnic differences in utilisation and psychiatric services in an area of 
suburban Melbourne. Australian and New Zealand Journal of Psychiatry, 
29 (4), 615–623.

Vassilas, C. A. & Morgan, H. G. (1993) General practitioners’ contact with victims of 

Victorian Suicide Prevention Task Force (1997) Suicide prevention: Victorian task force 

Waterhouse, J. & Platt, S. (1990) General hospital admission in the management of para-

840–848.

consultation-liaison psychiatrist. General Hospital Psychiatry, 9, 40–44.

C.M. Parkes, P. Laungani & B. Young (Eds) Death and bereavement across cultures 