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Front-Line Worker Perspectives on Indigenous Youth Suicide in Central Australia: Contributors and Prevention Strategies

Melissa A Lindeman^{1,3*}, Pim Kuipers², Laurencia Grant³

¹Centre for Remote Health, a joint centre of Flinders University and Charles Darwin University, Alice Springs, Australia

²Centre for Functioning and Health Research, Metro South Health and School of Human Services, Griffith University, Brisbane, Australia

³Centre for Research Excellence in Rural and Remote Primary Health Care, Alice Springs, Australia

ABSTRACT: *This paper presents the perspectives of Central Australian workers in relation to Aboriginal youth suicide. Interviews were conducted as part of a project to develop a data collection system and referral pathway for Indigenous youth suicide and suicide attempts. Twenty-two in-depth interviews were conducted with a range of practitioners who have front-line contact in suicide related issues (such as police, primary health, community support, youth services). The interview schedule reflected the project aims, but the transcripts revealed a much broader consideration of the issue. This paper reports on a secondary analysis of the data. The two major themes of salient contributing factors and service prevention strategies provide insights into these workers' attempts to understand and respond to this issue. There is a need to ensure workers develop and maintain strong networks, are well informed about local socio-cultural factors and skilled to work with local elders, traditional healers and community members, and are well supported in their roles to ensure longevity and relationships. The results contribute to the Aboriginal and Torres Strait Islander suicide prevention sector with particular relevance for remote Australia.*

Key words: *Aboriginal, youth, suicide, remote, Australia, indigenous*

INTRODUCTION

Suicide is a significant contributor to Indigenous¹ premature mortality in Australia (Australian Government Department of Health and Ageing, 2007; Commonwealth of Australia, 2010; Elliott-Farrelly, 2004). The high and increasing rate of suicide and suicide attempts among young Indigenous peoples (Legislative Assembly of the Northern Territory, 2012; Robinson, Silburn, & Leckning, 2011) is particularly concerning. In the Northern Territory (NT), suicides have occurred in younger age groups among Aboriginal peoples compared to non-Aboriginal peoples (Legislative Assembly of the Northern Territory, 2012), with the rate of suicides for Aboriginal children under the age of 15 years (in 2001-2006) five times the overall Australian rate (Pridmore & Fujiyama, 2009). The Northern Territory of Australia is large but sparsely populated, with Aboriginal people comprising more than 30% of the population, and approximately 80% of these living in remote and very remote regions. There are over 600 Aboriginal communities in the Northern Territory (NT) with populations less than 1,000 people. The literature highlights that the Central Australian region is further characterized by considerable levels of poverty, poor infrastructure, low levels of educational attainment, and high levels disadvantage faced by Indigenous young people (Lopes, Flouris, & Lindeman, 2013). Factors such as a high workforce turnover, geographic and professional isolation, cross-cultural and language issues all contribute to the contextual features of the region as well as the personally challenging nature of cross-cultural work (Muecke, Lenthall, & Lindeman, 2011). Clearly

such demographics, geography and socio-economic features have considerable implications for service delivery across health, welfare and justice sectors.

As suicides and other suicidal behaviour among Aboriginal peoples are often the outcome of complex and multilayered factors (Kuipers, Appleton, & Pridmore, 2012; Tatz, 2005), various and combined methods of intervention are required. A considerable proportion of deaths by suicide are associated with previous suicide attempts or self-harming behaviour (Measey, Li, Parker, & Wang, 2006; Parker, 2010; Parker & Ben-Tovim, 2002) and exposure to violence and suicidal behaviour (Robinson et al., 2011). While interventions have generally focused on crisis response or postvention activities (Hunter & Milroy, 2006), there has been a steady shift to prevention and early intervention in recent years with a greater emphasis on the importance of holistic models and the social determinants of health (including environmental, socio-cultural, historical and economic factors) (Australian Government Department of Health and Ageing, 2013; Haswell, Bignault, Fitzpatrick, & Jackson Pulver, 2013; People Culture Environment, 2014) and community-based responses (People Culture Environment, 2014). The literature highlights the need to plan and coordinate prevention activities on a local/regional basis and that effective coordination and integration of community service responses and capacity building requires the development of explicit strategies (Menzies School of Health Research, 2012).

A project commenced in 2012 in Central Australia which aimed to develop a systematic data collection system for Indigenous youth suicide and suicide attempts. The project also sought to propose appropriate referral pathways between agencies in Central Australia when a young person is assessed as at risk of suicide. This project was initiated in response to findings of a 2011 Parliamentary inquiry into youth suicides in the NT, which identified the absence of any

¹Use of the term 'Indigenous' or 'Aboriginal' can reflect regional and personal preferences. We have chosen to use the terms interchangeably.

*Correspondence regarding this article should be directed to: Melissa.Lindeman@flinders.edu.au

standard framework to collect information on suicide attempts or inform coordination between agencies (Legislative Assembly of the Northern Territory, 2012). A final report (Taylor, Dingwall, Lopes et al., 2013) and published paper (Lindeman et al., 2013) presented the outcomes of this stage of the project. Workers were interviewed to gain an understanding of data collection and the current system of support and referral for Aboriginal youth in Central Australia. However, the subsequent analysis of the data reveals much broader insights and querying of the nature of this work and this issue.

The current paper thus explores key themes that emerged from the experiences and thoughts of frontline workers in Central Australia relevant to Aboriginal youth suicide. To date much suicide research has been based on statistical data (Pridmore & Fujiyama, 2009), coroner's reports (MacKian, 2003), interviews with significant others (Cavanagh, Carson, Sharpe, & Lawrie, 2003) and interviews with people with suicidal ideation or who have attempted suicide (Miranda et al., 2008). It has rarely explored the perspectives and understanding of these (many non-medical) workers. As others have noted, little guidance is available to help practitioners constructively respond to individuals who may occupy a different social location or cultural background from their own (Wexler, White, & Trainor, 2014). Our aim in the secondary analysis was to give voice to front-line workers who deal with Aboriginal young people in a variety of settings with a view to contributing to developments of more effective ways of responding to this behaviour. We specifically sought to explore (a) the contributing factors that they highlighted and (b) the preventive strategies they emphasised. Their observations and recommendations for formal services will form the basis for a subsequent publication.

METHOD

This was a qualitative study involving in-depth interviews with 22 practitioners in Central Australia, conducted in two stages: 1) primary data collection and analysis undertaken in 2012-2013; and 2) a secondary analysis of the data undertaken in 2013-2014.

Ethical Clearance

The project was undertaken with the support of the Alice Springs suicide prevention network – the Life Promotion Network - and the Suicide Story Aboriginal Advisory Group, both facilitated by the Mental Health Association of Central Australia. Ethics approval was obtained from both the Central Australian Human Research Ethics Committee, and the Flinders University Social and Behavioural Research Ethics Committee. An Aboriginal researcher was available for cultural consultation and advice throughout the initial project.

Participants

Interview participants were purposively selected and had various roles in Central Australia, both clinical and non-clinical, and were drawn from areas such as primary health, community support, research, education, police and youth services. They were representative of Government, non-government and Aboriginal-controlled organisations. Both Aboriginal and non-Aboriginal participants were interviewed, and varied in relation to age, gender, education, qualifications, and duration of time spent in Central Australia. Individuals also had very different experience and knowledge about suicide in their personal and/or professional exposure. Participants were interviewed as individuals and not as representatives of their employer. Participation was confirmed on receipt of a signed consent form.

Data Collection

Interviews were conducted at the time and place of participants' choosing, and in most cases were audio-taped and transcribed verbatim. A small number were hand-scribed according to the preference of the participant. Interviews lasted between 20 minutes

to almost two hours, with the average being around an hour. The semi-structured interview schedule reflected the main aims of the original project - Indigenous youth suicide/suicide attempts and referral procedures (including current and preferred systems, definitions, barriers and challenges, and appropriate responses). However, the data revealed much broader consideration of the issue by participants.

Data Analysis

Transcripts were initially analysed using cross-case and thematic methods involving the same four researchers who were involved in data collection. For the secondary analysis - the subject of the current paper - all transcripts were initially de-identified (by ML) which included removal of organisation names or other possible identifying information. The secondary thematic analysis was undertaken by researchers who had not been primarily involved in data collection or analysis in the first stage (PK and LG). The secondary analysis was focussed on exploring deeper insights that front-line workers provided. Themes and representative quotes were then validated and cross-checked by all authors.

FINDINGS

We report two important themes that emerged from the secondary analysis labelled as 'contributing factors' and 'prevention strategies', with sub-themes within each (Table 1). A code is used in the results to represent individual participant quotes.

Contributing Factors

Participants in this project noted, from their perspective, factors that contribute to youth suicide in Indigenous communities. Acknowledging that they were not asked for an exhaustive list, to quantify causal issues or to rank factors, the emphasis they noted provides an overview of issues which are most salient to them from their observations. They described a complex array of contributing factors in the lives of young people. For example:

"There's... ongoing and unresolved grief, substance misuse... chronic physical health problems... child deprivation or neglect, or attachment difficulties, probably some have coexisting mental illnesses, or substance abuse disorders." (P2)

However they specifically highlighted deep-seated cultural issues, family and community context issues, as well as more immediate individual factors.

Contextual Issues

Fundamentally, the issues of loss and despair were seen by these front-line workers as key to understanding youth suicide in Central Australian Aboriginal communities. As one participant said:

"Once all the reasons for your cultural system has collapsed, you've got nothing left, you cannot help but be in existential despair, and suicide, either through alcohol intoxication, violence or whatever becomes inevitable. So existential despair in the cultural sense is clearly an issue here... people slip away into death, because the cultural system has already gone." (P16)

Participants recognised that generational cultural trauma plays a part:

"There are intergenerational effects, traumatic effects by virtue of being an Indigenous person growing up in communities

Table 1.
Themes and Sub-Themes

Contributing factors	Prevention through connection
<ul style="list-style-type: none"> Contextual issues Individual consequences 	<ul style="list-style-type: none"> Promoting understanding and discussion Building relationships Formal services

where your parents and your grandparents' generation have felt disenfranchised, disempowered." (P9)

They also noted more contemporary expressions of loss of culture.

"... when I first arrived... everyone was sitting around campfires telling stories, there wasn't a television in the community, ... and you go there now you'd be lucky to see two or three fires, and everyone's sitting inside watching television." (P17)

Beyond these larger cultural issues, some specific circumstances in the home life of some Aboriginal youth were considered as contributors to suicide risk.

"There's one young girl has made a lot of threats of self-harm... she's... 12, 13... gets upset because of... her domestic situation. You know, just the constant... noise, traffic through her home. Fractious relationships with parents, siblings, etcetera." (P18)

Similarly, interviewees said that the proximity of suicidal behaviour in the family, such as "a family history of suicide, witnessed suicide..." was an important factor in their experience (P2).

Individual Consequences

A number of individual dimensions of these contextual issues were also identified. First, alcohol was seen as a key factor by these workers. Concerns about suicide risk among intoxicated Aboriginal youth were mentioned numerous times in the interviews. Beyond what has been reported in the literature, these frontline workers noted the connection between alcohol and the loss of positive cultural mores. They observed that when intoxicated, these young people were less behaviourally or culturally constrained.

"[T]hey're talking about it and they're going out there even with rope in their hand... usually when they're drunk, and for us, we believe that when they're drunk, it... opens them to speak up, speak their mind. Without alcohol they... don't speak their mind, but alcohol helps them to open up." (P6)

From the perspective of these participants, impulsivity was also seen as a common causal factor, and one which was often linked with alcohol. One interviewee characterised these impulsive acts as unplanned "highly charged and emotional" (P16), but in other cases, they bordered on the flippant:

"He says, 'Well you make me my cup of tea'... and she says... 'Why don't you do it yourself?' And he says, 'Well I'm going to kill myself, you don't love me... so I'm going to kill myself.'" (P16)

These front line workers observed that impulsive behaviour may also be an expression of a desire to die:

"Plenty of guys that survive car accidents later admitted that they, kind of, just let go of the wheel, or they drove off the road or whatever and had had enough." (P21)

Interviewees highlighted the possibility that some young Aboriginal people die by accident due to impulsive behaviour, and may not understand the lethality of their actions.

"Is their intention to die? Or was it accidental? I think there are lots of cases where an argument's happened and a person's ended up in a rage, grabbed a rope and put it around their neck... They don't realise. This is going to kill you!" (P13)

PREVENTION STRATEGIES

Promoting Understanding and Discussion

A key distinctive of the interviews with frontline workers was the recognition that it is important to foster honest and healthy communication within local communities as a fundamental basis for preventing Indigenous youth suicide. They emphasised the need

to put youth suicide on the agenda in Aboriginal communities, to encourage discussion and openness on the topic. To this end, they emphasised finding appropriate ways of engaging with extended families. For example, a few participants described working with communities to develop a common language and understanding of mental health terms. One described an innovative approach involving "developing a vocabulary specifically for Indigenous youth, (focused on issues of) shame, jealousy, context" (P1). Such initiatives are "aimed at creating a shared understanding of commonly used mental health terms and concepts, and also a compendium of words and phrases Anangu² use to describe feelings and emotions." (P10)

Participants indicated that the expectation of such initiatives is to increase mental health literacy, encourage effective referral processes and promote appropriate and safe conversations about suicide among Aboriginal families and those who work with Aboriginal people. They saw this as a possible means of increasing help-seeking and improving outcomes. Interviewees also recognised that such approaches have been met with some caution and concern, especially when working with young people. There are fears open discussion about suicide can contribute to suicide.

"... we are doing stuff in schools here, [but elsewhere] they are not even allowed to mention the word 'suicide' in schools... we do have the highest rate of suicide in Australia, and maybe that's prompting us to have a look at what we can do... [challenge] some of the dogmas... we're probably ahead of other States, but I think it's because of necessity." (P19)

Some participants noted that communication training such as 'Applied Suicide Intervention Skills Training' (ASIST) and the locally developed resource 'Suicide Story' (Lopes, Lindeman, Taylor, & Grant, 2012) had increased the infrastructure, supports and skills of workers and should be more widely advocated.

We have to be sure that at least people have done ASIST, the Suicide Story, Mental Health First Aid at the very least, and that those organisations have within their infrastructure and architecture, supervision weekly or fortnightly tele/video conference, or whatever it is, and they know who to contact if there's an issue... (P2)

Building Trust and Relationships

Many of the interviewed front-line workers highlighted that the impact of their work in identifying suicide risk and preventing suicide was attributable to their strong and trusted relationships with Aboriginal people in addition to their skills and knowledge in mental health and suicide prevention. They emphasised length of service in remote communities as key to effective support and prevention.

"By being there for a longer period of time it made it easier for me to see behaviour... I could just read their behaviour better, and they probably knew me well enough to know that maybe I wasn't a threat or if they felt that way then they would let me know... It made it much easier because I guess that's the same for anyone, the longer you're there the more you can see the signs that something's brewing and something's not right." (P14)

In the current workforce context, this cohort of interviewees and the nature of their relationships with Aboriginal people fit within the context of Central Australia and enable them to engage meaningfully. The ability to speak local languages was seen as a particularly valuable skill:

"I speak most of the languages, and I'm able to communicate quite well... I've got pretty good relationships, so, you know, I might get bailed up at a camp or at a house: 'Go and have a yarn here.' You know, and they'll give me a, a rundown." (P18)

The consequence of such relationships was the development of

²Aboriginal people from a particular region of Central Australia

trust that led to families being more likely to share information about suicide risk and workers being more attuned to noticing suicide risk. *“Somebody in the young person’s family rings up and tells us that they’re talking about suicide, or... have become withdrawn, and they’re worried.”* (P8). They emphasised that such long term relationships promote trust and respect.

“I’m working with... adults who... I met when they were in primary school... that really makes a difference... that corporate knowledge if you want to call it, just makes such a big difference in trust and respect and the sense that oh you’re just not another white fellow that’s going to fly up, fly like the wind, and come and go...” (P17)

Interestingly for these interviewees in Central Australia, relationship-oriented prevention was also described as extending to relationships between service providers. Participants saw it as critical to establish good working relationships with colleagues and other relevant service providers including the,

“primary mental health services, General Practice Network and the RFDS [Royal Flying Doctor Service]... that relationship works partly because we work at it, and we meet regularly, and it’s also because virtually all those workers have at one point worked [with us].” (P2)

Such relationships were typically tested by the high turnover of staff in this region. Participants described how considerable energy and time is required to assist new staff in negotiating the complexity of remote work and to share knowledge about family relationships and cultural meanings.

“I think the high staff turnover in those kinds of agencies... is a bit of a problem. You can have a really great relationship with a particular police officer, a particular clinic nurse and then yeah, and then it sort of doesn’t get passed on, normally you have to start from scratch with somebody new.” (P8)

Formal Services

When participants did express the need for formal services, it was not necessarily for initiatives specific to suicidal behaviour or even to mental health. They took a very broad approach, emphasising the importance of *“strengthening people’s resilience, [unfortunately] there doesn’t seem to be much energy channeled into that area in terms of, on a Government level, in terms of building peoples’ capacity.”* (P7) Interviewees showed a surprising inclusiveness to the issue of service structures for suicide prevention. They stressed that many and varied workers, agencies, cultural advisors and those with a lived experience, have important roles to play in suicide prevention. They observed that given the many factors that impact on how a young Aboriginal person might find themselves at risk of ending their life, it is vital to have a range of strategies. They noted that often organisations which are not traditionally involved in suicide prevention,

“are in a better position to try to decode some of this... because at least there’s a body of (broader) experience... Where as if it’s done from the point of view of policy and custodial anxiety, you can’t get to this detail so much. So ... it needs to be done both ways... take that story, you take that story, you take that story. And you say how we interpret this risk?” (P16)

Interviewees recognised that in many cases, relationship-based prevention had to be very practical to meaningfully address the needs of the person at risk of suicide and their family. They noted that services should

“provide the support the person and their family needs. Practical support – such as food, transport, blankets etc - is a highly valued by Anangu in times of crisis, and this sort of support is reported by members as a way of keeping people strong and available to offer the emotional support to vulnerable family members.” (P10)

Participants understood the reality of occasional visits from specialist professionals in Central Australia: *“we had psychiatrist for adults that visited at least twice, maybe three times a year and we also had a Child and Adolescent Mental Health Team come out maybe twice a year.”* (P14) As a result, the strength of the network context for these services to connect with was seen as vital. Workers in remote communities have to adjust to the lack of access to specialists and utilise the expertise that exists ‘on the ground’, drawing from the experience of family members, Aboriginal health workers, traditional healers, youth workers and others.

Likewise, they emphasised that relationship-based prevention was not necessarily associated with formal roles (such as police officer or clinic nurse), and that those in a position to build less formal relationships such as youth workers are key within this network – connecting with young people at risk. They emphasised that youth workers in particular can have a strategic preventive role; assisting in identifying strengths and building a sense of belonging and worth in a life in a remote community.

“... going out in the country, taking people hunting, sitting round a campfire, engaging with the kids, doing music, art, multimedia, getting to record stories, doing all that sort of stuff that really does make an impact when it comes to suicide prevention... I think that the youth programs particularly... have a real impact.” (P17)

However, they also noted that the co-opting of such less formally recognised workers to contribute to preventing suicide also requires effective collaboration with more formal supports, deliberate attempts to link them with resources, and also a willingness to share information across systems.

“...there needs to be greater knowledge dissemination... whether they be working in the office, whether they be working in the aged care, the women’s centre, the childcare, the youth service, the clinic... and they need to have a transparency, and they need to have an observance of a pathway established. So that when that youth worker finds out about that kid... tried to kill himself yesterday. He needs to then be able to go maybe to the school, talk with their principal about that kid, and then they go from there to the clinic. There needs to be a clear pathway.” (P17)

Interviewees also noted that real or perceived legal risks to professionals in cases of suicide could lead to heightened anxiety and inappropriate custodial care. In contrast, they emphasised a more relational approach, which still required the support and backing of more formal systems. For example:

...the Warlpiri Youth Development people... they’re able to say, this young man has threatened to kill himself, he’s not particularly intoxicated at this moment or he is, depends on the circumstances, it’s not essential to go and get the Police... So what will I do is, I will now go to see his two brothers-in-law ... and will get into the car and we’ll drive around town for an hour... and so forth... So it’s what I would call a therapeutic response, not a custodial response, bearing in mind safety ... You can only make a therapeutic response if you know you’ve got a system that will allow you to... If you haven’t, you have to do a custodial response... I would say a culturally safe response requires both. (P16)

Finally, the extent of trust these front line workers described, was also reflected in a level of trust in supporting a well-connected community to address this issue in their own way:

“... this young fella was very suicidal... they organised themselves to keep an eye on him for that two weeks, got him to do other things with someone else for the next couple of days. I was watching, and not interfering, they told me to ‘Sit down and we’ll let you know when we really need you’ and this was in town. But maybe they were a bit embarrassed about talking about it to the white people... I don’t know. But they wanted to keep him strong in their own way.”

And they have been successful and that young fella now is out on a community, he's working there, he's got a job ... Family members can play a big role ...” (P6)

Clearly a key tenet of a more diverse and informal response is not easy:

“You can have a problem sometimes with lots of people diagnosing a kid and no-one's really kind of treating them or working with them. There is a need for workers to be flexible about their roles in order to be effective in the context of remote Australia and in the context of suicide risk where the responsibility requires collaboration.” (P8).

It requires substantial coordination, clarity and willingness to cooperate. As one participant stated:

“Responsibility must be clearly defined, there is no time for arguing over service boundaries or who is available at the time.” (P10)

DISCUSSION

Although they were not specifically invited to do so in the interviews, participants clearly were engaged in consideration of contributing factors as well as prevention strategies in relation to Aboriginal youth suicidal behaviour. Based on their experiences of dealing with the issue, workers noted contributing factors to include a culture of loss and despair, negative family and community experiences, alcohol, and impulsivity. Their considerations indicated an awareness of the potential impact of ‘normalised dysfunction’ that can be a significant contributor to such behaviours. Others have highlighted the challenges confronting workers in these contexts in “working with a spectrum of issues faced by an individual, family and community” which are deeply rooted in “a socio-historical context of intergenerational grief and loss” (Tighe, McKay, & Maple, 2013) (p.9). There is thus a crucial need for workers to understand the continuing impacts of colonisation and inter-generational trauma as a means of understanding young people’s suicidal threats and suicidal behaviours (Tighe et al., 2013).

Community elders see a strong connection between a loss of cultural connection and the vulnerability of young people to self-harm (People Culture Environment, 2014) and this was also noted by participants. Initiatives to strengthen both workers’ knowledge of cultural issues, and their skills in involving elders in their work, are thus strongly implicated. The value of workers’ engagement in ‘collaborative meaning-making and joint knowledge construction’ (such as with elders and community members) discussed in overseas contexts (White, 2007) points to areas that could be addressed through professional development and support programs for front-line workers.

Understanding the importance of cultural context and place allows for a more dynamic and beneficial therapeutic relationship to be formed (Tighe et al., 2013), although this need not be limited to those formally employed in mental-health services. Prevention strategies such as promoting understanding and discussion, building relationships, and importantly, *having a broad regard and inclusivity in relation to formal service provision* could be gleaned from front-line worker perspective.

These findings suggest that prevention strategies could emphasise supporting and supervising staff to encourage longer terms of employment as well as equipping them to build trusting relationships within communities. This includes recognising the important role to be played by workers such as youth workers, and the effort required in professional preparation and on-going support (Lindeman & Flouris, 2013). A serious commitment to building a strong and enduring network (which includes a broad range of workers) is also implicated as the potential context for fly-in fly-out models of specialist service provision (Wakeman, Curry, & McEldowney, 2012).

Front-line workers saw the need to encourage dialogue – fostering honest and healthy communication – within communities. Although media campaigns are a common response to the issue of suicide prevention for mainstream populations, there was no mention of the value of such strategies for this population group. Where relevant recent public campaigns have included the broad dissemination of documents reporting the views of particular groups such as elders (People Culture Environment, 2014), these also strongly emphasise the importance of local and community-based approaches, suggesting the need to re-orientate many existing Aboriginal youth suicide prevention (and related) programs. Calls for such approaches echo those elsewhere that recommended an emphasis on the “role that stories and communities play in providing stability, hope, cultural connectedness, and a sense of belonging for young people” (Wexler et al., 2014) (p.9), and less emphasis on more established prevention strategies such as gatekeeper training and traditional medical models of intervention. The implication is for a greater need to negotiate a collaborative therapeutic arrangement that fits within the context of this region and the circumstances of the young person at risk and their family.

CONCLUSION

Previous consultations and policy documents have emphasised the multiplicity of casual factors and the need for a broad range of prevention strategies at a variety of levels (Australian Government Department of Health and Ageing, 2013; Menzies School of Health Research, 2012). These findings add to such resources by explicitly highlighting the concerns of frontline workers which have particular relevance for remote Australia. These workers highlighted the importance of strengthening networks with an emphasis on relationships within local Indigenous communities; the development of practical, community based approaches; and for responses to be highly contextualised, and emphasising the importance of those not formally trained in this work. Education and support programs for front-line workers - broadly defined - also need to be developed in local contexts and involve local elders and community members. Findings confirm the importance of developing collaborative, locally based solutions that place families and communities first. Given the unique focus of this study, from the perspective of frontline workers, many of whom were working cross-culturally, it is anticipated that the findings may have relevance to Indigenous youth suicide and cross-cultural settings elsewhere.

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