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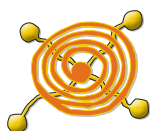
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Aboriginal Youth Suicide in Central Australia: Developing a consistent data system & referral pathway

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2013





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ACRONYMS

ABS	Australian Bureau of Statistics
AHW	Aboriginal Health Worker
AIMHI	Aboriginal and Islander Mental Health Initiative
AOD	Alcohol and Other Drugs
ASIST	Applied Suicide Intervention Skills Training
ASYASS	Alice Springs Youth Accommodation Support Services
CAAC	Central Australia Aboriginal Congress
CAHREC	Central Australian Human Research Committee
CAMHS	Central Australian Mental Health Service
CARPA	Central Australian Rural Practitioners Association
CARHS	Central Australian Remote Health Services
CAYLUS	Central Australian Youth Link Up Service
CCIS	Community Care Information System
CRH	Centre for Remote Health
DCF	Department of Children and Families
DoH	Department of Health (formerly Department of Health and Community Services)
GPNNT	General Practice Network Northern Territory (now called Medicare Locals)
FAHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
LPP	Life Promotion Program
MHACA	Mental Health Association of Central Australia
NCIS	National Coroner's Information System
NPYWC	Ngaanyatjarra, Pitjantjatjara, Yankunytjatjara Women's Council
PCIS	Primary Care Information System
PCIH	Poche Centre for Indigenous Health
RAN	Remote Area Nurse
RFDS	Royal Flying Doctor Service
ROSE	Register of Suicide Events
WYDAC	Warlpiri Youth Development Aboriginal Corporation

OPERATIONAL DEFINITIONS

Aboriginal: In this report the term “Aboriginal” is used in acknowledgement of the diversity of Aboriginal peoples in Australia and in recognition that this terminology is not universally accepted. The term Aboriginal is used in this discussion to refer to Aboriginal people in Central Australia, since this is the term most commonly used and accepted in this region. Please see “Indigenous” for the definition and distinction between terminologies.

Attempted suicide: Is an act of self-inflicted harm where the intention was for a fatal outcome but death did not occur. It is often difficult to determine whether death was an intended outcome of an act of self-injury intended death. Intentional self-harm is a phrase often used in association with suicide. Despite the differences, people who self-injure are more likely to feel suicidal and more likely to attempt suicide than people who don't self-injure. Self-harming behaviour is therefore a serious risk factor for suicide (Legislative Assembly of the Northern Territory, 2012).

CARPA Standard Treatment Manual: A standardised clinical protocol manual for use in Central Australian Primary Health Care Services.

Child: The ABS use the term ‘child’ to refer to a person in the earlier stages of life, specifically between the age of 0-14 years. This suggested age category will be used for the purpose of this report.

Copy Cat Suicide, echo suicide, suicide “contagion” or suicide clusters: It has been proposed that one suicide can influence another person to engage in suicidal behaviour especially if the second person is particularly vulnerable. Settings that are at higher risk of a suicide cluster include schools, prisons, mental health facilities and Indigenous communities. This phenomenon is also associated with the term copy-cat or one suicide leading to another suicide (Centre for Health Policy Programs and Economics, 2012).

Cultural safety: A philosophical framework for service provision that requires practitioners to examine their own cultures and the potential impact on others. It asks practitioners to examine

issues of power, racism, and discrimination.

Cultural Cutting: Cultural Cutting in this context is used to describe the traditional self-harming behaviour typically involving the cutting of the arms, chest, and abdomen as part of cultural protocols. Ashes and earth are then placed in the wound to prevent infection and promote a raised scar (Elliott-Farrelly & Francis, 2009).

Cutting: Self-inflicted cutting that is not related to cultural cutting.

Indigenous: The term “Indigenous” is used in this report to refer to a person who is of Aboriginal or Torres Strait Islander descent; and identifies as an Aboriginal or Torres Strait Islander; and is accepted as such by the community in which s/he lives or has lived. Indigenous is used in reference to broader national populations of Aboriginal and Torres Strait Islander Peoples. Aboriginal is used in the context of this research to imply the diverse linguistic and cultural groups that comprise the Aboriginal nations of Australia.

Life Promotion Program Steering Committee: LPP seeks input from government and non-government organisations via representation on its steering committee. Membership of the steering group is based on the relevant connection of representing agencies and Government departments to the issue of suicide, in recognition of the shared responsibility for dealing with suicide in the community. Life Promotion is responsible for membership and managing the interagency response to suicide among members in the Central Australian region. Steering Committee meetings are held four times a year in Alice Springs.

Payback: An Aboriginal English term for traditional punishment or retribution for a wrong-doing or matter for which someone has been blamed.

Postvention: Refers to care, interventions and other support services for individuals, families and communities after a suicide to limit the distress and future negative outcomes that can result from a death by suicide and to prevent copycat suicides.

Sorry Business: Aboriginal English term for mourning rituals

Suicide: Is the intentional taking of one's own life. To be classified as a suicide, a death must be recognised as being due to other than natural causes. It must also be established by coronial inquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life (Legislative Assembly of the Northern Territory, 2012).

Suicide behaviour: Includes suicidal thinking (ideation), threats, planning, attempts and completed suicides.

Suicide protective factors: Protective factors reduce the likelihood of suicidal behaviour by improving a person's ability to cope with difficulties and choose positive options instead of suicide (Legislative Assembly of the Northern Territory, 2012).

Suicide risk factors: Risk factors are the factors that influence the likelihood of an individual becoming suicidal. Risk factors can also be referred to as vulnerability factors (Legislative Assembly of the Northern Territory, 2012).

Suicide threat: A threat to end one's life. This can be manipulative behaviour and it can be difficult to know if there is genuine suicide risk. Threats of suicide can be a sign of underlying problems and are not only concerning in regard to the person making the threats, but can be very stressful for the person on the receiving end of these threats (Life Promotion Program, 2009b)

Youth: The ABS define 'youth' as the transitional phase between childhood and adulthood, typically someone between the age of 15-24 years.

RELEVANT ORGANISATIONS

Government Services

Department of Health (DoH) has recently undergone structural change during the period of this research. Some organisational names cited by participants in the research may have changed, along with reporting lines. References to roles and relationships between departments and other organisations may also have changed since this research was conducted.

Emergency Department, Alice Springs Hospital: Tertiary service providing emergency care.

Social Work Department, Alice Springs Hospital: General social work provided to all hospital wards.

Central Australian Remote Mental Health Services (CAMHS): Clinical service based in Alice Springs. Includes psychiatrists, psychologists and mental health nurses distributed between different teams focusing upon either care of clients during part of their lifespan, i.e. child and youth, perinatal, or care of client based on their geographical location i.e. Alice Springs community, forensic or remote setting.

Mark Sheldon Remote Mental Health Team: Team within CAMHS providing clinical mental health support for remote communities. Offers remote clinics a visiting consultation and liaison service provided by Mental Health Nurses, Aboriginal Mental Health Workers and Psychiatrists.

Central Australian Remote Health Services (CARHS): Primary Health Care Services staffed by Aboriginal Health Workers (AHWs), Remote Area Nurses (RANs), and Doctors (who may be based in the community or visit on a 'fly in fly out' basis). RANs and AHWs working in these clinics are required to follow the standard treatment protocols (CARPA) in the first instance for the care they provide to patients.

Northern Territory Police: Community policing service. In response to those at risk of suicide, police may be required to take individuals into custodial care and transport to medical services.

Department of Education and Children's Services: provide educational and training options from the early years to adulthood.

RELEVANT ORGANISATIONS

Non-Government services

Aboriginal Community Controlled Health Services

Non-government, Aboriginal Primary Health Care services located in remote communities

Central Australian Aboriginal Congress (CAAC): Aboriginal Controlled Primary Health Care service, based in Alice Springs. In Central Australia, focus is on suicide prevention and awareness, and intervention training. A previous role in the provision of telephone counselling was withdrawn due to the difficulties of training and retaining staff. No current role in working with individuals at risk of suicide or in a referral pathway for individuals.

Life Line Central Australia: primary focus is on community education and training, particularly in the area of suicide awareness and prevention.

Mental Health Association of Central Australia (MHACA): Community based support for individuals and groups with dealing with mental health issues. Their role also includes mental health promotion, advocacy and suicide prevention.

Life Promotion Program (LPP): A program operating under the auspices of MHACA, receiving targeted suicide prevention funding from both NT and Commonwealth governments. Role includes suicide prevention training and coordinating postvention responses. No role with individuals at risk of suicide at present.

Tangentyere Council: Tangentyere Council is the major service delivery agency for the 18 Housing Associations known as 'town camps' in Alice Springs. In addition to housing and related services, Tangentyere Council runs a range of family and youth services, a night patrol, day patrol and youth patrol, and also provides some services to remote area communities such as inhalant substance and youth initiatives, and the Return to Country program (Tangentyere Council, 2012)

Central Australian Youth Link Up Service (CAYLUS): A service of Tangentyere Council that supports community initiatives to improve quality of life and address substance misuse affecting young people.

Mt Theo program: run by the Warlpiri Youth Development Aboriginal Corporation (WYDAC), is a community-based suicide prevention program that was initially developed to address petrol sniffing among Yuendumu community members...but has since broadened its scope to become a comprehensive development and rehabilitation program for youths residing in the Warlpiri region (Warlpiri Youth Development Aboriginal Coporation, 2008).

Night Patrol: The core functions of Night Patrol are to provide basic services such as safe transportation, diversion from contact with the criminal justice system, and intervention to prevent disorder in communities (Central Desert Shire, 2012).

Waltja Reconnect Program: Youth program supporting homeless or at-risk young people 12-18 yrs and their families to engage with education, training, employment, community and other support services.

NPY Women's Council: Youth Program works across the organisation's tri-state region; -services comprise diversionary activities, school holiday programs, individual case management and substance abuse and mental health awareness programs.

BushMob: BushMob run a 5 bed residential treatment facility as well as programs such as The Bush Adventure Therapy Outreach Team. The BushMob Media Family Support Program and activities with remote communities like the BushMob/Santa Teresa Community Horse Culture Program.

Alice Springs Youth Accommodation Support Service (ASYASS): seeks to ensure that young people have equal opportunity and are supported to obtain safe, secure, affordable and accessible housing.

Headspace: Alice Springs based mental health support and early intervention service for all young people. Referral not required.

Yirara College: Yirara College of the Finke River Mission is a boarding school for Aboriginal students 12 years and older from remote communities. Yirara operates under the auspices of Finke River Mission which is the mission arm of the Lutheran Church in Central Australia.

Royal Flying Doctor Service (RFDS): Aeromedical organisation involved extensive primary health care and 24-hour emergency service for remote populations.

EXECUTIVE SUMMARY

Aboriginal youth suicide and attempted suicide are issues of significant and increasing concern in Central Australia. However, at present no systematic database exists to capture and collate information on suicides and suicide attempts and no coordinated referral pathways are available for agencies in the region. This qualitative project is grounded in key stakeholder perspectives and relevant literature. The study involved twenty two interviews with various stakeholders to inform the development of a standardised suicide data collection system and recommend appropriate referral pathways for relevant agencies in Central Australia.

Both Aboriginal and non-Aboriginal participants were interviewed. Participants' profiles varied in relation to age, gender, education, qualifications, roles (clinical and non-clinical), location of usual residency and duration of time in Central Australia. Individuals also had very different experience and knowledge about suicide, ranging from personal and/or professional exposure. The research was undertaken in partnership with the Life Promotion Program (LPP) of the Mental Health Association of Central Australia (MHACA). An Aboriginal advisory group was consulted during key stages of the study and an Aboriginal researcher was available for advice throughout the conduct of the research. It was found that systemic issues added to the challenge of effectively dealing with Aboriginal youth suicide attempts leading to a lack of coordination, duplication and potential for miscommunication between services. The principles of cultural safety formed the conceptual framework for this project.

The study resulted in the development of a suicide risk form and a referral pathway model for trial use among various stakeholders in Central Australia. The piloting of these resources is to form part of a second stage of research that will use action research methodologies for further development and implementation. A list of recommendations has been provided to inform piloting, implementation, dissemination and management of the resources. Findings also highlight other relevant issues, such as the factors influencing the accurate collection of suicide and suicide attempt data, cultural considerations that influence suicide assessment and notification processes as well as the need for professional development and community training programs in the area of suicide prevention. Appropriate and timely implementation of this study's recommendations will improve understanding of the issues affecting data collection and referral and lead to a more accurate picture of suicide in the region. Research will also offer outcomes that are practical, culturally and importantly locally relevant and useful to reduce the impact and incidence of Aboriginal youth suicide and suicide attempts.

Summary recommendations

Trial of referral pathway and data collection form to be undertaken in Central Australia as part of a second phase action research project that will involve implementing the following:

- A central coordination service as a first point of contact for assessment and referral to appropriate services or support must be identified and agreed to by stakeholders.
- Identification by stakeholders of an agreed agency/agencies to collect and collate suicide and suicide attempt data (possibly MHACA or a research institute).
- Coordination and data collection roles to be adequately resourced with identified designated positions attached.
- Increase positions for Aboriginal workers across services, including the employment of cross cultural consultants
- Cultural consultants (including family members where appropriate) should be engaged by non-Aboriginal people when making an assessment of an Aboriginal person at risk of suicide.
- Suicide definitions should incorporate cultural understandings of suicidal or self-harm behaviours and development of shared vocabulary for community members and service providers.
- Increase community advertising of available resources, training and support services through local media and community organisations.
- A comprehensive suite of education/training (orientation packages, training programs etc.) be developed and/or identified and rolled out across Central Australia to complement existing suicide response programs.
- All workers with a role engaging with Aboriginal youth, who have not received Suicide Awareness training, should receive such as a requirement of working in the region.
- Review of CARPA manual protocol and reference document on "Suicide Risk" to align with referral pathway and data collection form if endorsed.
- Implementation strategy to be developed for the roll out of the Referral Pathway and Data Collection Form.
- Investigate data systems that will communicate within and between services.
- Develop agreed criteria for information sharing between service providers.
- Establish a feedback mechanism to ensure follow up and communication between services and individuals at risk or supporting those at risk.

INTRODUCTION

Over the last decade suicide has become a significant contributor towards Aboriginal premature mortality in Australia (Commonwealth of Australia, 2010; Department of Health and Ageing, 2007; Elliott-Farrelly, 2004), despite being virtually unheard of prior to the 1960's (Elliott-Farrelly, 2004; Hunter & Milroy, 2006). It was estimated that between the years 2005-2009 the suicide death rate for Indigenous peoples was 2.5 times the rate of non-Aboriginal peoples (Australian Bureau of Statistics, unpublished, as cited in Steering Committee for the Review of Government Service Provision, 2011). Additionally, the rate of standardised non-fatal hospitalisations for intentional self-harm in 2008-2009 was higher for Aboriginal peoples than non-Aboriginal (3.5 per 1000 and 1.4 per 1000, respectively) and more prevalent in remote areas (4.1 per 1000) than in major cities (3.5 per 1000). Of recent concern has been the high and increasing rates of suicide and suicide attempts among young Aboriginal peoples (Australian Government Department of Health and Ageing, 2010; Krysinska, Martin, & Sheehan, 2009).

In the Northern Territory (NT) suicide is occurring at an earlier age among Aboriginal peoples compared to non-Aboriginal peoples (Pridmore & Fujiyama, 2009). The rate of suicides in 2001-2006 for Aboriginal children under the age of 15 years in the NT was 5 times the overall Australian rate. There have also been an increasing number of anecdotal reports of child and youth suicides and suicide attempts across the Central Australian region as well as a recent spark of media coverage on the issue (Australian Broadcasting Commission, 2010; Henderson, 2011; Kerin, 2011; The Australian, 2011). Consequently, a Senate "Inquiry into Youth Suicides in the Northern Territory" was convened in November 2011.

The inquiry report "Gone Too Soon" (Legislative Assembly of the Northern Territory, 2012) outlined that there is successful work being undertaken in the area of suicide prevention, however, generally Aboriginal suicide and suicide attempts among young people remains under or un-reported and poorly understood. Specifically, it was outlined that no standardised framework currently exists in Central Australia to collect information on suicide attempts or to inform appropriate coordination mechanisms between agencies.

Aim

The aim of this project was to develop a systematic data collection system for suicide and suicide attempts and suggest appropriate referral pathways between agencies in Central Australia.

Objectives

- Gain multiple perspectives from relevant stakeholders about suicide and attempted suicide data collection processes and referral processes in Central Australia.
- Develop an appropriate data collection system to be implemented by agencies in Central Australia (this will include incidence of suicides and suicide attempts).
- Recommend appropriate service coordination pathways and mechanisms between agencies in Central Australia.

Significance

Aboriginal young people are one of the most disadvantaged and vulnerable groups in Australia (Lee et al., 2008). In the southern region of Central Australia, Aboriginal youth aged 10-24 years account for 44% of all Aboriginal peoples living in Aboriginal communities (Fietz, 2006). Suicide not only impacts the individual, but also affects friends, family, communities and the broader society (Commonwealth of Australia, 2010). The economic cost of suicide is considerable and “a moral or human obligation exists to assist those at risk of suicide and those who have been bereaved by suicide” (Commonwealth of Australia, 2010, p. 13). It is therefore a priority that research and appropriate responses to address Aboriginal youth suicide are developed and implemented.

There is currently no coordinated data collection system available to collate information on suicide attempts across Central Australia. A standardised database will provide a more accurate picture of the extent and scope of the issue across the region. Additionally, it will lead to an enhanced understanding of the characteristics of suicide and attempted suicide, including: risk/resilience factors, perceived determinants and geographical incidences of Aboriginal youth suicide and suicide attempts. The data will establish where to target appropriate responses and develop a plan for what resources are required. The data could also identify the source of referral of suicide risk and highlight the efforts of non-health professionals and family in remote communities. Such evidence could promote the need for whole of community training and support. It may also provide evidence of successful programs currently operating and will contribute to their further support and distribution.

It has been identified by local stakeholders that service coordination pathways and mechanisms for agencies to respond to a suicide or suicide attempt are inadequate. Furthermore, where referral is possible, there are significant barriers to the uptake of services by individuals, families and communities. This research will provide recommendations for a systematic coordination pathway for relevant stakeholders in Central Australia to enable a more efficient and effective referral process and will provide recommendations for appropriate supports to enable effective referral. This will reduce duplication of service provision and enable improved service pathways for individuals in the system. The model may also provide a framework for others developing coordination pathways in other areas or fields. In addition, this study will explore the need for professional development, including improving the skills to identify cases and providing appropriate support and follow up for individuals.

The outcomes of this study will form the basis for future research in other aspects of Aboriginal youth suicide in Central Australia. In addition the study will contribute to research in the general area of Aboriginal suicide and will build towards collective knowledge in the community. Outcomes are intended to be practical, relevant and useful to ultimately reduce the impact and incidence of suicide in the region.

LITERATURE REVIEW

Introduction

This narrative review provides an outline of the current context of Aboriginal youth suicide in Central Australia. In particular, some suicide prevention efforts are discussed, the current data collection processes and resources are presented and the referral pathways between agencies are reviewed. The literature search involved online databases (ATSIHealth, SCOPUS, CINAHL, Wiley and Google Scholar) and the collation of grey literature from government and non-government agencies. Additional literature was accessed opportunistically through references lists. The search strategy included key terms: suicide, suicide attempt, Aboriginal, Indigenous, data collection, survey, referral pathways, and models.

Contexts of Aboriginal suicide

Aboriginal suicidal behaviour is related to various factors including history of dispossession, removal from family, social isolation, discrimination, cultural identity and racism, resilience, social capital, and socioeconomic status (Steering Committee for the Review of Government Service Provision, 2011). Alcohol and substance abuse are also commonly related to increased risk of self-harm (Measey, Li, Parker, & Wang, 2006; Swan & Raphael, 1995; Tatz, 1999; T Westerman & Vicary, 2000). With regard to Aboriginal youth, Tatz (2005) suggests that the conventional profile of determinants for youth suicide is not relevant. Instead, factors more likely to be associated with Aboriginal youth suicide include anger, hopelessness, and lack of purpose, ennui, and pessimism.

Research conducted in Queensland (Commission for Children and Young People and Child Guardian Queensland, 2009) found that Aboriginal youth suicide was most often related to arguments and relationship breakdowns (78%). Hanging appears to be the most common method of suicide among the general Aboriginal population (De Leo, Svetlicic, & Milner, 2011; Hunter, Reser, Baird, & Reser, 2001; Tatz, 1999). Suicide impulsivity is also frequently noted among Aboriginal youth compared to the wider Australian youth population (Commission for Children and Young People and Child Guardian Queensland, 2009). In addition, copycat, cluster or echo suicides occur in some Aboriginal communities, where patterns are often seen (age, gender and method) (Elliott-Farrelly, 2004; Hanssens, 2009).

There is evidence indicating the link between mental illness and suicide, particularly anxiety and depression (Hunter, 1993; Parker, 2010). Yet other researchers dispute this relationship (Elliott-Farrelly, 2004; Reser, 1991; Tatz, 1999) and studies conducted in non-western settings suggest that less than 50% of completed suicides are associated with mental disorder (Manoranjitham et al., 2012; Zhang, Xiao, & Zhou, 2010; Zhang & Zhou, 2009). It is also widely acknowledged that Aboriginal suicide is different (Elliott-Farrelly, 2004; Hunter, et al., 2001; Parker & Ben-Tovim, 2002; Tatz, 1999). There are significant differences in suicidal behaviour, epidemiology, and aetiology, not only among Aboriginal and non-Aboriginal populations, but also differences among Aboriginal communities and groups (Reser, 1991, cited in Elliott-Farrelly 2004; Tatz, 1999). As such, universal methods used to address suicide are inadequate and not necessarily effective or applicable to Aboriginal peoples. Elliott-Farrelly (2004) notes that programs that foster empowerment and are developed and implemented for the communities they are intended for also appear to have better long term success.

Aboriginal suicide prevention

Since suicide is thought to be a relatively recent phenomenon among Aboriginal Australians, activities and research in the area have only emerged since the mid 1990's (Hunter & Milroy, 2006). With the high rates of Aboriginal suicide and the concerning impact it is having on individuals and the wider community, greater effort is being made to address this public health priority (Steering Committee for the Review of Government Service Provision, 2011).

Suicide and suicidal behaviour among Aboriginal peoples is often the outcome of complex and multilayered factors (Steering Committee for the Review of Government Service Provision, 2011). As such, suicide responses in the past have generally focused on crisis response or postvention activities (Hunter & Milroy, 2006). However, various and combined methods of intervention are required to successfully address suicide. Approaches have consequently shifted from crisis response to prevention and early intervention over the past decade. There is also a greater emphasis on the importance of holistic models and the social determinants of health, including environmental, socio-cultural, historical and economic factors (Maru Marri Indigenous Health Unit, 2010; Steering Committee for the Review of Government Service Provision, 2011; Zubrick et al., 2005).

Applications for funding for suicide prevention activity targeting Aboriginal and Torres Strait Islander people and their communities, through the Department of Health and Ageing's (DoHA) Taking Action to Tackle Suicide package 2012 were assessed against the following key principles: community control and empowerment, holistic, sustainable, strength based, capacity building, involve partnerships, ensure safe cultural delivery, are innovative and evaluated, and involve community promotion and education (Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group, 31 January 2012). Suicide prevention approaches are particularly relevant given a considerable proportion of completed suicides are associated with previous suicide attempts or self-harming behaviour (Measey, et al., 2006; Parker, 2010; Parker & Ben-Tovim, 2002). Effective responses to suicide prevention require early intervention strategies and good mental health promotion. The building of resilience and resourcefulness in young people is believed to reduce the incidence and impact of problems that may arise later in life and are a vital element to an effective response to suicide prevention.

Aboriginal suicide prevention resources and activities

Numerous suicide prevention projects have been developed and implemented in Australia to address Aboriginal suicide (Anglicare NT, 2006; Auseinet, 2004; Hanssens, Bridge, & Santhanam, 2007; Kanowski, Jorm, & Hart, 2009; McKay, Kolves, Klieve, & Leo, 2009; T. Nagel, C. Thompson, N. Spencer, J. Judd, & R. Williams, 2009). Specifically, initiatives in Central Australia include the 'Suicide Story' training resource (Lopes, Lindeman, Taylor, & Grant, 2012) and the recently developed multimedia resource 'The Right Track' (MacDonnell Shire, 2012). The main aim of Suicide Story is to encourage suicide safer Aboriginal communities through strength based training that builds on the capacity within these communities to identify suicide risk and provide support. The training incorporates short films that feature the voices of Aboriginal people, animation, art work and music. It focuses on nine issues relevant to suicide, and is delivered by both Aboriginal and non-Aboriginal trainers with the support of interpreters and cultural consultants. Where training is delivered it is also expected to increase the likelihood of people seeking help, making reports and potentially improving suicide data collection (Mental Health Association of Central Australia, 2010a).

The Right Track DVD is an awareness raising resource developed within the youth programs of the MacDonnell Shire promotes a healthy connection for Aboriginal youth back to their country and traditional culture. The project has involved working with elders, clinics and schools to develop programs for young people that can then be used to encourage young people to express their feelings around suicide risk, healthy living and mental health issues. They have done this through innovative methods of multimedia including film, music, animation and art (MacDonnell Shire, 2012).

The CARPA Standard Treatment Manual as a clinical protocol manual provides one standardised assessment tool relevant for the Central Australian context, including rural and remote Aboriginal communities (CARPA 2009). There are also psychological assessment tools such as the Westerman Aboriginal Symptom Checklist (2012) and Strong Souls (Thomas, Cairney, Gunthorpe, Paradies, & Sayers, 2010) that were developed specifically for Indigenous people. The Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice resource (Purdie, Dudgeon, & Walker, 2010) provides some data and information on Indigenous suicide and the Aboriginal and Islander Mental health initiative (AIMhi) Mental Health Assessment and Stay Strong Care Plan (Nagel, Frenidin, & Bald, 2009; Nagel, G., Condon, & Trauer, 2008; Nagel, Robinson,

Condon, & Trauer, 2009; Nagel & Thompson, 2007; T. Nagel, C. Thompson, N. Spencer, J. Judd, & R. Williams, 2009) provides tools for more general mental health and risk assessments in Aboriginal contexts.

Although some of these resources have been validated as culturally relevant tools, it is still not certain that these tools are widely used or how helpful they are in every day practice. However, in general the majority of current suicide prevention approaches are adapted from existing non-Aboriginal models, which are often based on non-Aboriginal understandings of suicide, health and healthcare (Australian Government Department of Health and Ageing, 2010; Elliott-Farrelly, 2004). Challenges also exist in evaluating programs like these given the complex suicidal factors and the difficulties faced capturing and measuring the influence of specific activities.

In response to recommendations from the Senate Inquiry into suicide, *The Hidden Toll: Suicide in Australia* (2010), the Commonwealth Government commissioned the Menzies School of Health Research to develop the first National Suicide Prevention Strategy for Aboriginal and Torres Strait Islander peoples. Some of the key action areas of focus for this strategy include improving knowledge about Aboriginal suicide (Robinson, Leckning, & Silburn, 2012). In particular, some of the gaps identified include the limited evidence about the effectiveness of approaches to Aboriginal suicide prevention, lack of reliable suicide data (e.g. suicide distribution and risk factors) and the need for collaborative partnerships across various stakeholders (e.g. communities, community sectors and researchers).

Data collection on suicide and suicide attempts

The Australian Bureau of Statistics (ABS) is responsible for providing national, state and regional suicide statistics (Cantor & Neulinger, 2000). The ABS does not currently report suicide for people under 15 years of age, since cases of suicide for these age groups were extremely rare in the past (Australian Government Department of Health and Ageing, 2010). Data on attempted suicide is also no longer collected by the ABS and is instead managed by each state and territory (Cantor & Neulinger, 2000). As a result, the data collection procedures and reliability across the states and territories vary considerably.

In the Northern Territory, collection of data on completed suicides follows a standardised protocol that is part of the national system (Legislative Assembly of the Northern Territory, 2012). Coroners are required to certify deaths as suicide before data is input into the National Coroners Information System (NCIS), which is then fed to the ABS for coding, analysis and publishing (De Leo et al., 2010). The Life Promotion Program of MHACA has a formal agreement with the Southern Coronial Investigation Unit of the Northern Territory Police in Alice Springs to receive information regarding a suspected suicide in Central Australia (NT only) for the purpose of providing a coordinated and immediate follow up response for those impacted by the death, (MHACA, 2012).

There is evidence to indicate that providing postvention support (support after suicide) measurably improves the health and wellbeing of people bereaved by suicide and can help to reduce the risk of "copy-cat" suicide. There is a duty of care to ensure that those impacted by a death by suicide are provided with the option of appropriate support following this incident (Griffith University, 2011). However, no systematic protocol or database exists to collect information on attempted suicides in the region (Legislative Assembly of the Northern Territory, 2012). As a result, suicide attempt data is collected in an ad hoc manner and methods and classifications vary between organisations.

It was highlighted in the "Gone Too Soon" Report (Legislative Assembly of the Northern Territory, 2012) that the Police and Hospital records may provide two current standardised data sources on suicide attempt. There are also some local organisations that have developed their own data collection systems, predominantly with the aim of informing their own practice. Specifically Ngaanyatjarra, Pitjantjatjara, Yankunytjatjara Women's Council (NPYWC), LPP, Central Australian Remote Health Services (CARHS) and NT Police have their own suicide attempt databases (Central Australian Remote Health, 2012; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, 2011), which mostly allow for an immediate response to death by suicide. Central Australian Remote

Health Services (CARHS) also attempted to institute a register of suicide events (ROSE) in response to a number of suicides among Aboriginal youth in Central Australia, but to date no information is available on its success and level of use.

A major barrier to sharing information on suicide attempts, relates to confidentiality concerns, particularly between government and external agencies. People who are assessed as at risk of suicide have a right to privacy and the stigma associated with suicide and mental illness can inhibit disclosure of suicide risk. If their information was to be shared with other service providers for the purpose of data collection and coordinated care, they may need to be fully informed and provide consent. Some protocols for addressing suicide risk suggest absolute confidentiality is not appropriate where suicide risk is clearly present:

“If a person is suicidal there should never be absolute confidentiality. There is a duty of care to prevent a possible suicide or attempt to self-harm. It is necessary to seek permission from the client to disclose their information. However, if this is rejected you may need to breach their confidentiality to comply with duty of care”, (Queensland Government Department of Communities, 2008).

In Central Australia, the high incidence of youth suicide that was occurring in the late 1990’s led to the establishment of the Life Promotion Program (LPP) and a coordinated interagency response to completed suicide and attempted suicide. The collection of information on suicide attempts ceased as a result of concerns over breaching client confidentiality, and changes to the operations of this program, (Mental Health Association of Central Australia 2012). However, where a suicide is not completed, confidentiality concerns continue to pose a barrier to sharing information. Changing roles and expectations within and between services, has seen the previous practice of sharing information on suicide attempts with LPP ceased, leaving no central agency collating both suicide and suicide attempt data. Current efforts in the NT (Menziess School of Health and Research, 2011) and elsewhere (Western Australia Centre for Health Promotion Research, 2012 and Griffith University, 2012) are similarly exploring the feasibility of establishing suicide and suicide attempt databases.

In order to gather information on suicide risk among Aboriginal youth and to refer appropriately, there is a need for culturally appropriate referral and data collection tools. Internationally, Canada is one place that has acknowledged the need for culturally appropriate referral and data collection tools. One resource focused specifically on Aboriginal people was a protocol for early intervention that aimed to provide a culturally sensitive, suicide risk assessment (MacNeil & Guilmette, 2004) for Aboriginal youth. This tool sought to offer a comprehensive and culturally sensitive assessment that would as Tatz (1999) suggested: exclude, “racism, contempt denigration, and disempowerment [and remove the] mental disorder model” in the assessment (MacNeil & Guilmette, 2004).

Suicide data collection challenges

Aboriginal suicide rates are typically underreported, where in certain communities actual numbers of Aboriginal suicide are likely to be three or four times higher than official records (Tatz, 1999). These discrepancies are due to the various complexities involved in capturing accurate data (Harrison, Miller, Weeranmanthri, Wakerman, & Barnes, 2001). The challenge to collect information on suicide attempt and self-harm is then further compounded by the variability and complexity of individual cases.

Particular barriers to collecting information for completed suicides commonly include the misclassification of Aboriginal status on death certificates and other data systems (Elliott-Farrelly, 2004). Sometimes identifying a death by suicide can also be arduous. A death can occur from injuries that were inflicted without the intention to kill, while other acts may not result in death but may occur with an intention to end one’s life (De Leo, et al., 2011). In circumstances where suicidal intent is unclear or the autopsy report is inconclusive, the case is coded as an “undetermined” or “accidental” death. In Central Australia, deaths due to setting oneself alight while petrol sniffing, drug overdoses, falling asleep on roads or rail tracks, injury from inappropriately conducted

bereavement cuts could be suicidal in intent, but are usually categorised as accidental. Instead of these important data being hidden among ambiguous categories, Tatz (1999) suggests that Coroners be allowed a model with three options: definite suicide, probable suicide and possible suicide. Coroner's reports are also known to take a considerable amount of time to draw conclusive results meaning that it can take years for reliable figures on confirmed suicides to be available (Legislative Assembly of the Northern Territory, 2012).

Given the heterogeneous nature of Aboriginal cultures and communities there are also distinct variations in the definitions and understandings of suicide and suicidal behaviour (Elliott-Farrelly, 2007). As a result of these complexities, making an assessment can often be difficult and subjective and vary depending on a wide range of factors including those relating to the person making the assessment (their professional experience, personal experience, relationship with the person etc.). It is also vital to consider cultural variations in what may be perceived as suicidal behaviour which may be part of Aboriginal ceremony. Suicide intent is not always clear and sometimes self-harm is perceived as '...a letting of blood in order to feel the warmth and vitality of life, an affirmation that one is alive' (Tatz, 1999). A study conducted in NSW by Elliott-Farrelly & Francis (Elliott-Farrelly & Francis, 2009) also found that the definition of self-harming behaviour is influenced by a number of cultural factors specific to the communities investigated. It was illustrated that a group of Aboriginal youths engage in self-harm as a way to unite the group and as a form of initiation. Other traditional self-harming behaviour included "cutting" as a process of mourning rituals and male initiation ceremonies. There have also been reports that suicide is sometimes used as a threat, which makes it difficult when making a decision about seeking help (Life Promotion Program, 2009a; Lopes, et al., 2012).

There are also challenges with defining Aboriginal youth categories given initiation and cultural lore. Tatz (2005) argues that research needs to discard the traditional and inappropriate definition of "youth", which encompasses the 15-24 year age group. There have been a number of incidences of suicide in the NT of Aboriginal people under the age of 15 and therefore it would be useful for the purposes of accurate recordings and appropriate responses to include a younger cohort. The fear of 'cultural payback' impacts on the willingness of Aboriginal community members to intervene when a person is at risk of suicide due to the real possibility of blame and retribution (Lopes, et al., 2012). The stigma, shame and negative stereotypes associated with suicide and mental illness may inhibit people from seeking help or making a report.

Referral pathways between agencies

Referral pathways can assist in different aspects of suicide prevention. Referral pathways are an important element of health care that ensure coordinated management of individuals within, to and from health care services to the most appropriate services (Rotter et al., 2010). A referral pathway in the context of this research is a clearly articulated protocol for ensuring an individual at risk of suicide is identified, safe and put into contact with the appropriate supports, individuals and services which may be broader than clinical services. These pathways can provide support for those identified as high risk to alleviate the risk of a completed suicide by providing constant care and monitoring from the first point of contact. Referral pathways and coordination are also an important part of a successful postvention response, in order to respond to the community's reaction and to prevent suicide clusters or other associated effects.

Australia's National Suicide Prevention Strategy has six key objectives, one of which is to "take a coordinated approach to suicide prevention". This includes program and policy coordination and cooperation, regionally integrated approaches and effective linking of local services so that those at risk and those who are supporting them can easily navigate their way through the services. Nationally, in regard to suicide prevention there are efforts to improve coordination or communication on a broad scale, such as online databases with contact information of service providers for specific topics like suicide prevention.

Conclusion

Aboriginal youth suicide is a complex, multilayered and sensitive issue, which requires immediate action given the suspected high rates. There are a number of suicide prevention programs and responses across the country and at the local community level that are having positive outcomes (although few have been well evaluated). There are also many related programs that may be impacting on suicide rates (i.e. drug and alcohol initiatives, recreation programs, support through the legal system, family violence programs etc.). The importance of these programs that explore and address the broader social determinants of suicide (including environmental, socio-cultural, historical and economic factors) has been highlighted. Additionally, various approaches are required such as early intervention, crisis response and postvention, including specific responses for the communities being targeted, with culturally safe principles imbedded into practice. For all Aboriginal youth suicide prevention approaches, it is essential that they are evidence-based. The collection of data on suicide attempts among Aboriginal young people will provide evidence to support suicide prevention efforts and provide an indication of where resourcing should be targeted.

In Central Australia, there is currently no official or standardised classification or reporting system in place for suicide attempts by Aboriginal youth. As a result, suicide attempt data is collected in an ad hoc manner and methods and classifications vary between organisations. Although these data are extremely valuable and highlight the alarming rate of youth suicide in parts of Central Australia, the sustainability of this approach is limited. Given the data collection processes are also likely to vary, there are severe limitations to their comparability.

Referral pathways are not clear and are not well coordinated in the Central Australian region. They are limited by geography, by obligations to confidentiality of information, lack of knowledge about the service to refer to, a lack of trust in the support being offered, lack of appropriate response, the shame associated with suicide and the scope and diversity of suicidal incidence that occur. These factors prohibit the ability to understand the scope and severity of the problem within Aboriginal communities and hinder the development of an improved system of referral and support for young Aboriginal people at risk.

METHODS

This qualitative study involved interviewing various stakeholders to inform the development of a standardised suicide data collection system and recommendations for appropriate referral pathways for relevant agencies in Central Australia. The research was undertaken by a research team comprising staff of CRH and PCIH and Menzies in partnership with LPP of MHACA. The Life Promotion Steering Committee and the Aboriginal Advisory group (supported by MHACA) An Aboriginal advisory group was consulted during key stages of the study and an Aboriginal researcher was available for advice throughout the conduct of the research. The principles of cultural safety formed the conceptual framework for this project.

Research ethics

Ethics approval was obtained from the Central Australian Human Research Ethics Committee (CAHREC) (26/04/2012) and the Flinders University Social and Behavioural Research Ethics Committee (SBREC) (23/05/2012).

Participant Recruitment

Potential participants included individuals from relevant agencies in Central Australia that had experience or expertise in the area of Aboriginal suicide and could offer feedback about suicide data collection processes and referral pathways. The research advisory group and LPP provided advice about possible study participants and were instrumental in the recruitment process. Some participants also offered suggestions of other potential participants. Information sheets (Appendix A) and consent forms (Appendix B) were distributed to potential study participants by email or face-to-face.

Focus was given to recruiting individuals working for youth related agencies and effort was made to recruit no more than one or two representatives from each agency. The agencies/individuals were also nominated to reflect both clinical and non-clinical focused services. Equal representation from Aboriginal and non-Aboriginal participants was sought as well as equal gender balances. Since the geographic scope of the study covered Central Australia it was also important to capture the various perspectives from people working in different settings, including rural and remote contexts and clinical and non-clinical settings.

Interviews

A total of twenty two (22) individual interviews were conducted and ranged from ten minutes to more than an hour during the period May-July 2012. Upon providing consent, each participant was contacted to arrange a time and place for an interview. Semi structured interviews were guided by an Interview schedule (Appendix C). Participants were asked about their perspectives of the classification of Aboriginal youth suicide and suicide attempts and the current practice of how suicide and suicide attempt is reported, the referral pathways that are employed and any barriers that are faced. All interviews were conducted in a location of participants' choice. Three interviews were undertaken over the phone and another participant provided responses via email.

Interviews were conducted by four members of the research team (JL, KT, ML, KD); most were audio taped and transcribed, while some were hand scribed. Where necessary some transcripts were sent back to the participant to provide the opportunity for participants to review comments or add further details.

Participant Profiles

Participants were interviewed as individuals and were not required to express the views of their employing organisation, as outlined in the Information sheet (Appendix A). Despite this, many of participant responses related to their roles as employees of their respective organisation. Study findings have been carefully represented to ensure participant confidentiality is maintained. Direct quotes are referenced with a code (P1-P22) indicating Participants 1-22 and care has been taken not to provide any information that could identify individual participants.

DATA ANALYSIS

Stage One

On completion of all interviews and transcribing, the data were analysed by four research team members (KT, KD, JL, ML). An initial meeting was held to develop a plan for data analysis, to read through interview transcripts and identify and discuss broad themes from the interviews. Individual tasks were then allocated to each researcher. The key themes that were identified from the interviews were divided among the four researchers. The individual tasks involved each researcher re-analysing the data in depth and identifying quotes from the transcripts relevant to their respective theme. As a group, the team then drafted the suicide data survey based on examples from relevant literature and supported by information from participant interviews.

At the second meeting each researcher presented a summary of their findings from their individual tasks. Next, the group developed a draft of the referral pathway diagram which was underpinned by information from participant interviews. Two researchers each were then allocated to working on either the suicide data survey tool or the referral pathway diagram. Following this session researchers were required to work in their group of two to finalise drafts for the second stage of data analysis.

Stage Two

Once drafts of the suicide data survey and referral pathway diagram were completed, the team leader from LPP was invited to attend a meeting with the research team. LPP were provided with an overview of broad study findings and a detailed explanation of the survey and diagram. Feedback and advice from LPP were an important part of developing the resources given their expertise in the area and their knowledge of Central Australian agencies in suicide prevention or related areas.

The next stage of consultation was to involve presenting the survey and referral diagram to the LPP Aboriginal Advisory Group and LPP Steering Committee. However, the research team agreed that this stage was best dealt with in any subsequent projects to be completed and will require additional resources. One such project, already in train, will be conducted as a project of the Centre for Research Excellence in Rural and Remote Primary Health Care. Specifically, this will address the current report (presented as a summary and analysis of the qualitative data collected to date) and focus in greater detail on the adoption of the recommendations in the service system. Further consultation with both advisory groups will occur as a first step in the next project.

Partnerships & Advisory Groups

CRH, PCIH and Menzies conducted this project in partnership with LPP of MHACA. LPP have established relationships with various stakeholders relevant to Aboriginal youth suicide and recently formed an advisory group that was consulted, including the Suicide Story Aboriginal Advisory Group that was established to help guide and advise on the Suicide Story Training Program. This group agreed to be included in consultation on this research project at key stages of the project. Group members are from various communities in Central Australia/Northern Territory and have a range of work and personal experience in health, education, mental health and suicide prevention. Some advisory group members were also interviewed as part of the study. Specifically, the advisory group was consulted early in the project for advice about direction and data collection systems and referral, data collection and dissemination.

RESULTS

The key objectives of this research sought to gain multiple perspectives from relevant stakeholders about suicide and suicide attempt data collection and referrals processes in Central Australia and then develop an appropriate data collection system and referral pathway to be implemented by agencies in Central Australia.

Suicide Data Survey

At the time of conducting this research, Central Australian service providers had no standardized method of collecting suicide data. Data collection was found to be specific to the needs of individual organisations (P3, P10, P11, P18), sometimes duplicated and often not actioned or accessed in any useful way (P1, P4, P5, P6, P7, P20, P22). Obtaining an accurate picture of Aboriginal youth suicide and suicide attempts was not possible in this context.

Existing data collection on Aboriginal Youth Suicide is obtained and recorded in the following ways:

- Informally through the work of individuals within various organisations and/or via Aboriginal community links ie: family member informs an Aboriginal worker within the community
- In individual case notes at the discretion of staff – ie: not always required by the service
- Recorded on Primary Care Information System (PCIS) for DoH when individuals come to the attention of remote health clinics auspiced by DoH
- Recorded on Community Care Information System (CCIS) when individuals enter the mental health system, Department of Health
- Recorded on Communicare for clients of Central Australian Aboriginal Congress and remote Aboriginal Community Controlled Clinics
- Recorded on hospital databases – including medical records files when individuals come to the attention of hospital emergency departments
- Via the Coroner's process for completed suicide
- Via the Southern Coronial Investigations Unit in Alice Springs and the Life Promotion Program for completed suicide

It should be noted that many different data bases exist, even within one Department. Front line clinicians do not necessarily have access to all and maintaining access to different databases is time consuming. If not relevant for their core position P1 suggested staff were unlikely to keep updating passwords and learning about data base updates.

Where recording of data is a requirement it is broadly defined to include any reference to self-harm (P8). Services that provided some residential care had an obligation to use a specific reporting system, but it was usually de-identified data, difficult to use as a database and not formalized in the sense of data being utilised other than recording for the individual organisation (P4). Unless data collection on suicide attempts was mandated and shared between services, P4 believed that there was no accurate way of knowing the extent of the issue.

Some respondents suggested that the collection of suicide data was not a priority for their organisations (P20). The only way some organisations could collect suicide and suicide attempt data was if the individual presented through an emergency department (P20, P22). This would then be available to others within the hospital via the hospital data bases.

'...the only way we could would be through presentations at ED and it would be noted as to whether the person's making suicidal threats, suicidal ideation or has attempted that would go up at Triage and that then goes onto kind of a database to be allocated to a worker'. (P20)

Each organisation managed the collection of suicide data differently. P18's organisation has a database" ... which is attached to that person's ID, on that system. So, what will happen, that whenever that person is looked up ... in reference to anything, there will be an alert that pops up and says "On this day, this person threatened-slash attempted..." One participant stated that their organisation had a mental health nurse who collected information about suicide attempts and was able to refer to a local health centre if required (P8). P10 and P11 had data bases for Aboriginal youth suicide attempts which allowed for immediate referral to another agency. P11 cited a lack of training in suicide risk identification as a barrier to effective responses to individuals by their organisation, whilst P10 noted the need to develop mental health literacy in order to talk effectively between services and communities.

Some participants expressed frustration at the legal barriers that prevented services sharing information about clients (P4) although many agreed it would be useful to be able to share information and know which other services are involved with a particular client.

'I think we got to get out of this stigma "it's not my business" and make it your business'. (P11)

It was suggested by P11 that important information may not be followed up because it was not the core business of the agency that initially identified a person at risk. If their core function was not health service, then P11 believed people felt or may feel anxious about intervening in a situation that is perceived as the business of health professionals. Even when obliged by law to report anyone at risk under 18 years of age, it was noted that:

'DCF...have a central intake number...in Darwin and you get a telephone person or they might put you on hold. They might go press star/hash and we'll ring you back in a couple of hours later and they won't... We have to have some fairly hard evidence before we even bother because they either way take us seriously or they won't' (P4).

It was suggested that unless mandated and supported with appropriate training, many individual workers, including health professionals who are not specifically trained in mental health, are reluctant to label an event as a possible suicide attempt, especially when such documentation/reporting/labelling could not be changed within current patient information systems following further assessment:

'There is a reluctance for us to label, when really we should label until it's shown otherwise' (P3).

With such reluctance noted for clinicians, non-clinical workers such as Police, also expressed concern about the responsibility to label someone 'at risk of suicide'. The development of a Suicide Referral Report Form that could be used across services may alleviate initial responsibility from non-clinical workers and/or community members for conducting assessments. It is a report of their concern about possible suicide risk for someone they have encountered or been told about. Even though not all suicidal behaviour is associated with mental illness, there was some agreement that the subsequent formal clinical assessment of risk should be undertaken by a health professional.

Ideally this would be from a local remote health centre or town based service or in telephone consultation with the nearest centre. However, with appropriate training, such as ASIST, any individual can and should be encouraged to make an initial assessment of risk and respond appropriately. (For example, by seeking help and ensuring someone remains with the individual concerned until responsibility for care is taken by the appropriate support person(s) or service). If services in remote and town communities were advised of the need to immediately contact the local clinic or mental health service, this removed personal responsibility to make risk assessments for which workers and/or community members may not be qualified or confident (P15).

The form that follows was developed based on participants' responses to gaps they perceived in present protocols. The italicised text is by way of explanatory notes and would only appear as part of the implementation of this form if adopted. The need to have a centralised accessible

and shared database was reinforced by comments such as those made by P1 who described their organisation's current approach:

'(Data) ...gets entered on there and then disappears into a big, black hole in Darwin. It provides some capacity to collect suicide data, but is not well used' (P1).

Many participants therefore stressed the importance of being able to access and share information in order to be able to identify which other agencies were involved with a client so that they could better coordinate their services. P5 also questioned the purpose of having a data base of 'vulnerable members' if there was no clear pathway for positive intervention that included addressing some of the underlying issues, like homelessness...

'...because the possibility is that you're just stigmatising and alienating even further. Obviously if you're going to collect that data then you also have to talk to the Aboriginal family care networks. If you want better data and work with what is an existing Aboriginal leadership around suicide prevention and if you can persuade them that the data collection is important then they could have a fair bit of influence on how it is reported'.

P1 was also aware that their use of data was mostly concerned with postvention rather than prevention. In responding to the question of how confident people were about having an accurate picture of Aboriginal youth suicide and suicide attempts P5 stated:

'I think we've probably got a very incomplete picture to be honest. I think the sort of level of fragility in the community is poorly recorded and I think we live in the sort of environment that is where in the Aboriginal youth...there are real stresses on a whole lot of the care networks that are happening there makes for a lot of vulnerabilities'.

Problems with referrals

Many respondents felt that even when there was awareness of a person at risk of suicide, there were numerous problems with being able to appropriately refer to other services or supports. This was due to either a lack of clarity about how to proceed, dealing with transience of the population and incompatible data collection systems, overstretched and unresponsive services, concerns about information sharing between organisations and historical mistrust.

Participants gave examples of efforts to engage other services only to find a lack of responsiveness or significant delay in response (P4, P8). P4 advised that they have called the mental health hotline in the past but have not '...found them to be reliant' (P4). P8 gave the example of how difficult it can be to access Police out of hours: '...a lot of people are really frustrated with using the 000 number.... There can be a pretty big lapse of time between somebody saying they're going to do something dangerous and anybody being around to help...' P8 also identified the need for a central source of information, because youth move around between communities so much- especially when in distress. Such mobility calls for a shareable kind of information about why they have moved. P15 suggested that current responses needed to consider this mobility and shift focus from responding to communities where the initial concerns were raised to instead focus resources and supports on the individual wherever they locate themselves.

Remote community clinics and even the town based tertiary services were not always seen as a safe option for referral for some community members. Historical mistrust was something that had to be overcome for some families and individuals & service providers. P6 for example, emphasised that some Aboriginal youth had difficulty trusting some organisations and highlighted the importance of having Aboriginal workers assist in referring them on.

'Just handing them over, I think that's important. And just telling them: well you better go over there, because I think as soon as they walk out that door, they'll be off in another direction'.

P5 felt there is a sense that some of the services that you would normally report these things to '... being so overwhelmed and so appallingly resourced that you're reluctant to involve them for fear that it actually has negative consequences.' When asked how services in a particular part of Central Australia worked together, P6 was emphatic that this did not happen well at all because...

'...they're still struggling to understand what happened with people at risk that are thinking about suicide and how to get further support for them....we've been trying to go into every organisation, at least make contact, and lets share information...but it's very difficult...to get in contact with the Managers.'

P6 also noted a lack of clarity about what to do with information obtained from family and community members:

'If I know about something, who do I pass it on to? And what I've been doing lately is telling Mental Health, "You need to speak to so and so." I've heard from family that this person's struggling...there's no central place...we should have a central office, someone there that looks after mental health, wellbeing and networking...'

Confidentiality posed a challenge for effective referral (P6, P13), particularly when dealing with Government agencies. P6 believed that this could be overcome by clear explanations to communities of the need to collect suicide information and benefits for individuals and families.

P7 mentioned the effort it took to get hospital staff to change discharge planning practices to more appropriate and safer options for Aboriginal youth. The previous practice of discharging youth at 11pm with no family contact, support and nowhere to go was identified as unsafe.

P13 believed that due to many of the problems already identified by others, a lot of suicide attempts were not being identified, nor reported:

'We start hearing from the Police that they were clearly at risk. So something's falling down. They're not getting referred to Mental Health or the Health Clinics ...or Congress Social Emotional Wellbeing. Or ED... there all sorts of reasons why the referral system doesn't work.'

P13 identified instances where on hearing of a death by suicide, police for example, will have identified the individual as being clearly at risk as they knew of previous suicide attempts but for some reason the health services were never informed of the risk.

The potential for over-servicing of individual clients was noted, as was the call for a central coordination point and a confidential suicide reporting number:

'I always think there needs to be a designated person or body that is responsible because if we all leave it thinking someone else is going to do it it's not going to happen. So it needs to be a designated person' (P19).

'I think if you can do it for a child abuse line, I think it should also be anonymous for a suicide line. ... even a central core place because that way then they can monitor how many times you've actually had calls about that person' (P11).

There was also a strong recommendation that CAMHS be adequately resourced for potential increased responsibilities. It was also recommended that the protocol of only assessing people with 0% BAC be reviewed or explained to other services, as those at risk can choose to later mask their intent where alcohol is involved. This was perceived as an important barrier to an effective response.

Definitional issues

The difficulty of collecting information and then appropriately referring Aboriginal youth at risk of suicide was found to be compounded by a lack of clarity in defining matters of identity, age, service criteria, policies on sharing information as well as differing data collection systems and the rates of staff turnover throughout the region (P1, P4, P5, P6, P7, P10, P11, P15).

For those working in or closely with the hospital, access to hospital records usually noted the ethnicity of clients. For other service providers however, the issue of identification of who may or may not be Aboriginal and who might be considered to be 'youth' is less well defined. Most organisations were clear about defining suicide risk although it was agreed that some other behaviours may potentially mask suicide attempts (P4, P5, P15, P21). P4 defined someone at risk of suicide or suicide attempt as:

'...anybody who mentions it, even once. Even if they go "I'm going to kill myself, no, only joking". We would flag at risk.'

Most identified an increase in the use of suicidal threats by Aboriginal youth, but also agreed that even suicidal talk should be flagged as a potential suicide risk (P7, P8, P15). This was not to say that every response had to be clinical, but it was more critical to identify the right response for the individual at risk.

P13 suggested that suicide attempt is harder to define than suicide:

'We spent a long time...talking about the definition of suicide attempt...it's about the person's intention to die, or was it accidental...'

Most respondents considered intent as a key criteria, for example:

'...we regard a suicide attempt as acts of purposeful action, engaging in behaviours that have the potential to cause great harm or death to you. We don't regard someone saying they're going to kill themselves as a suicide attempt... some degree of lethality to their behaviours. Saying they want to kill themselves and jumping off a rock three feet high, that's not really a suicide attempt.'

It was also noted that not all who attempt or complete suicide have a mental illness, which highlights the need for a coordinated response that includes non-clinical services and supports:

'... the clients who are actually committing suicide are not necessarily mentally ill in the normal sense. They're not the people who... necessarily who have a diagnosed psychosis or something like that. They're people who are unwell, whose lives are in crisis, who are... you know, have multiple things going on and accumulated distress and so on, but who simply are not necessarily seeing themselves as ill, or as... you know, they're not seeing mental health treatment as any kind of support that they need'. (P21)

Defining Aboriginal youth was in itself problematic with different services using different age categories and even in some instances continuing to deal with individuals who technically were either older or younger than their own organisation's official criteria. For P6 youth was defined from age 10 to 19, acknowledging that the law can determine adult status at 18. Personally however, P6 felt that the age of 20 is a more appropriate age for adulthood. P7 was specifically funded to work with 12-18 year olds, but acknowledged that their whole of family approach meant working beyond this specific age range, including following up with individuals who had been previous clients:

'Just because someone legally becomes an adult at 18, doesn't mean that they're not going to need continued support and somewhere to go. And a lot of services do cut people off at 18...whereas other service now are thinking around extending youth to 25...so we would still keep working with someone... we would certainly flag them by the right people...'

P10 advised that definitions of Aboriginal youth were based on funding agreements that included ages 10 to 25, but acknowledged that the community members had differing definitions of youth related to cultural milestones. P20 identified the different definitions of youth in the hospital setting.

'...for Paeds, it's up to 14...obviously youth can be... up to 25, considered a minor until 18 and then considered an adult after that in the hospital setting'

P20 and P19 identified the limitation of current definitions that considered youth as aged 15 and above. P20 identified people as young as ten to thirteen who had made threats and experienced ideation. There was concern that this group may be overlooked. P19 suggested a broadening of data collection criteria was important to gain an accurate picture of the issue of suicide and suicide attempts:

'I think all suicides of young people, irrespective of whether they're six, ten, or 15, must be recorded, because otherwise it's not going to give a clear picture of what's happening, and the reality is we've got youth out there contemplating suicide for whatever reason, but unless those stats are collected people won't realise that's a problem, and if they don't realise there's a problem they might not do anything to address it'. (P19)

Whatever definitions are used, P10 proposed that:

'...referral models must enable a rapid response that provides an effective presence where it is needed. Responsibility must be clearly defined (there is no time for arguing over service boundaries or who is available at the time).'

THE SUICIDE DATA REPORT AND REFERRAL FORM

The form developed is suggested to serve two distinct purposes:

- To initiate a referral pathway for an individual at risk of suicide or suicide attempt
- To collate data on suicide/suicide attempts among Aboriginal youth

At this time, there was no consensus about who might accept the forms in the first instance or whether the same organisation needs to be involved for the two distinct purposes. MHACA was suggested as being a suitable organisation for collating data, and CAMHS for initial assessment and referral management, with human resource implications in either case. Although other organisations might equally take on the role of data collection (Headspace, CAAC, or a research institute, for example), MHACA (and LPP specifically) was identified as an appropriate organisation by a number of participants. At present, MHACA has limited authority to collect data or progress this process and this would need some consensus from the Government and other services to occur. The 'required' fields would be the minimum needed for accurate data collection, whereas the completed form would be necessary to initiate a referral pathway. This reflected the kind of information already collected by some organisations (P10). CAMHS was identified throughout the research as the most appropriate organisation to initiate clinical action in response to individuals at risk. However, in some cases their involvement may decrease depending on the individual situation and involvement of other agencies and supports. As previously stated, suicide is not always related to a mental health problem and non-clinical and other therapeutic services may be more appropriate. However, this could occur once a clinical assessment has been made.

Some were concerned at how any new documentation would be received. P4 highlighted the pressures already in existence which needs to be considered to ensure compliance with any new requirements.

'So I wonder how you would engage people in documenting that information, like what would be the incentive when people are already really stretched' (P4).

P20 suggested the inclusion of

'...a comprehensive genogram so you can see on paper where this child's place is in their family because and especially from an Indigenous point of view, that's really important to them because that's something that's been taken away a lot of the time. They can't see where their place is in that family...and in an ideal world, where they're at in terms of education, ...because that will help you work out what their level of understanding towards their behaviour is or what they're capable of in terms of understanding' (P20).

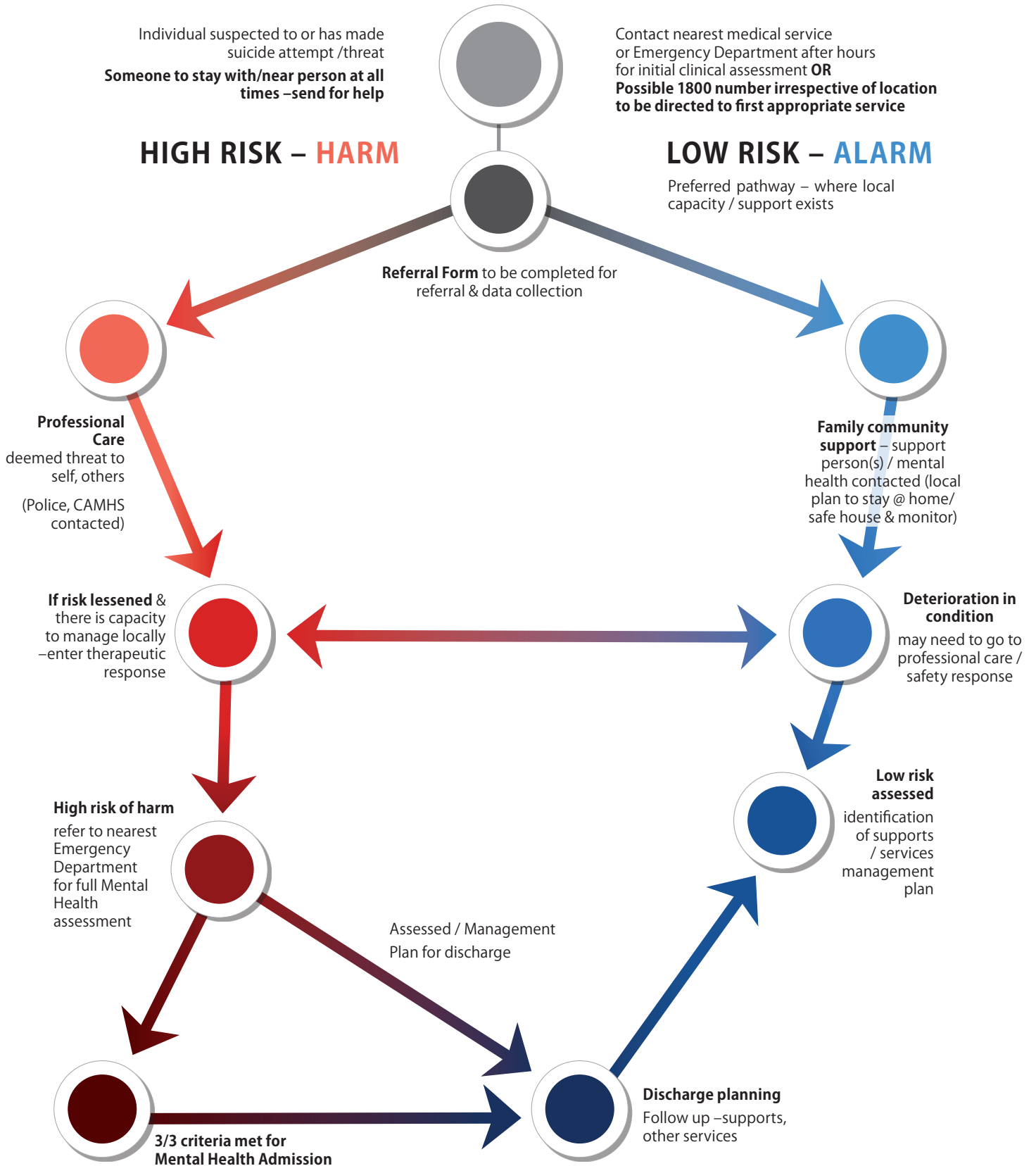
Whilst acknowledging the suggestion for inclusion of a genogram, this is best placed within client files, rather than the data collection form which serves a different purpose. Overall, respondents stressed that the data system needed to be simple and user friendly. An implementation strategy would also be required to educate communities and services about the use of the reporting form. Copies could be held at key locations in communities including police, schools, councils, women's and art centre and clinics. The required fields for data collection purposes allow for de-identified data to be collected. Completing this form could be done via access to a dedicated phone service who would then forward the information directly to the appropriate health services for action. Once the form is received, action may include an automatic email alert to the managing service (e.g. CAMHS or MHACA) that then could identify the appropriate service to lead a case coordinated response.

DATA REFERRAL FORM

NAME:	Name could be removed for sending to any agreed organisation who will only be involved in data collection, but not management of suicide risk.		
AKA:	This may help identify to different services a client that is already known to them or under the care of multiple agencies		
Age or DOB:	Gender		
Home Community:	This is needed to alert services to any possible pattern or influencing factors		
Presenting issue/incident*: This should be a brief description of the event that caused an individual to report their concerns to the clinic, eg: shopkeeper noticed someone carrying a rope....			
Date of Incident:			
Community / Place of Incident:			
Referral Action:	CAHMS ASH Health Service: _____ Other: _____ Other: _____		
Client aware of referral?:	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Flags / Risk factors:	Threat Has Plan Family History Violence Isolation Recent Bereavement	Means Previous Attempts History of Mental Illness Substance Use History of abuse /trauma Physical Health Problems	Has Means Injury Resulted Relationship Breakdown
Family support / responses:			
Involvement with other agencies:	<input type="checkbox"/> Mental health Services CAMHS <input type="checkbox"/> DCF <input type="checkbox"/> MHACA <input type="checkbox"/> A&OD Services <input type="checkbox"/> CAYLUS <input type="checkbox"/> Hospital <input type="checkbox"/> Headspace <input type="checkbox"/> Other <input type="checkbox"/> Yes Date:		
Referred by:	Name: _____ Contact details: _____ Action notification required:		

ABORIGINAL YOUTH SUICIDE REFERRAL PATHWAY

Based on results from the research study, the following suggested referral pathway is presented for feedback and revision:



ABORIGINAL YOUTH SUICIDE REFERRAL PATHWAY

The Pathway explained

The steps identified in this referral pathway arose from participants in this study along with a synthesis of international referral pathways. It should be noted that the resulting pathway although arising from individual perspectives is agency focused. Any development of the pathway should by necessity ensure a consumer and community perspective as well.

A number of scenarios were suggested to track the preferred referral pathway for Aboriginal youth who are at risk of suicide or suicide attempts. The pathway for referral can take one of two directions initially, with the preferred pathway always the "Family/ Community support". This involves using local community supports where available and appropriate (P16, P17, P18). "Professional/Custodial Care" should only be followed where safety is an immediate and ongoing concern. The following explanation relates to the "Family Community Support" Scenario.

- An Aboriginal youth expresses suicidal threats or is observed to be of concern – potentially at risk of suicide.

The first person to identify potential concern contacts health personnel immediately. It is essential that that someone remain with the individual at risk (P19, P16). This can be at a remote community, outstation or in town. A free call 1800 number could be established to be used within NT to connect with the nearest health service.

Rationale: evidence suggests that most often it is non–health professionals, youth workers, family members, or others who will first encounter or be concerned about an individual at risk of suicide. Most respondents agreed that the onus should be on trained health professionals (clinic staff and/ or mental health services) to make initial clinical assessment of risk and determine appropriate action based on all the available information (P1).
- Depending on location, Clinic or DMO to make an initial clinical assessment and contact CAMHS as required during business hours–first health personnel involved have responsibility to ensure person's safety, whether it is via the custodial care or therapeutic care pathways.

Suicide referral/data form to be completed by the health personnel as part of referral process and also sent to the agreed body for collating of data on suicide attempts. Rationale: Results indicate no current standard referral pathway or coordinated data collection process exists. There is confusion and uncertainty about where and who will take responsibility for an at-risk individual. Service providers who are not trained health professionals identified a need to place responsibility for early clinical assessment and follow up with the health services until a comprehensive assessment of need is completed (P14).
- Family/Community response - If resources are available and it is safe to manage locally, the pathway follows the family/community low risk direction. This should only occur when the relevant services and CAMHS agree for care in community with the involvement of family and/or appropriate local supports. It allows for a flexible response to incorporate local capacity and resources to care for an individual in their community.
- If the individual deteriorates or circumstances make it unsafe to remain in their community, the referral pathway may go to Professional Care or referral to other appropriate services.
- Where the individual is able to stay in their community, a management plan should be developed to include relevant services for ongoing support and follow up.

ABORIGINAL YOUTH SUICIDE REFERRAL PATHWAY

The Pathway explained

The following explanation relates to a scenario in which “Professional / Custodial Care” is required. “Professional / Custodial Care” should only be followed where safety is an immediate & ongoing concern.

- An Aboriginal youth expresses suicidal threats or is observed to be of concern – potentially at risk of suicide.

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- Professional Care. This pathway is followed only if the individual is assessed to be at risk of harm to self or others and only where other measures are unavailable or unable to guarantee safety.

- If situation improves, an individual being managed in a custodial care response may divert to the low risk Family/Community support pathway.

Rationale: Due to the nature of Aboriginal youth suicide/attempts, family and other key personnel are sometimes reluctant to identify a relative at risk and risk behaviours may be difficult to assess. Police involvement is a ‘last resort’ option to be employed if other local supports are inadequate or unavailable. Safety however is the agreed priority.

High risk of harm requires the individual to be evacuated to ASH ED with Mental Health involvement.

- Where 3/3 criteria are met, the individual still at high risk, is admitted to hospital under the Mental Health & Related Services Act.

- If safe to do so, the individual may be discharged from ED with appropriate discharge planning and follow up. Alternatively where admission is necessary, discharge from the Mental Health Unit also will entail appropriate planning and follow up of appropriate service(s).

- Rationale: CAHMS was identified by most respondents as the appropriate service to take responsibility for the management of individuals at risk. This does not mean necessarily ongoing involvement, but as the initial responding service, to refer on as required.

With resolution of the immediate crisis, and follow up supports with appropriate services in place, the individual may return to their local community for ongoing therapeutic support and follow up. The safety plan should be communicated to the initial clinical referrer and other services if the individual consents.

Rationale: Agreed goal is to ensure a safe transition from hospital to the care of other services and supports when safe to do so. Follow up needs to be clear to CAMHS and those involved. The issue of who has responsibility, at which point in the process of management and referral should be clearly established.

The need for a Referral Pathway

The need for a coordinated referral pathway for dealing with Aboriginal youth suicide attempts became apparent early in the data collection process. It was consistently confirmed that there was no current systematic approach to identifying and therefore managing Aboriginal youth at risk of suicide attempts in the Central Australian region (P1, P2, P6, P7, P15, P20, P21, P22).

When asked how data was collected across key organisations, responses revealed the problematic nature of collecting information that was not clearly integrated within a referral pathway for action. A key finding was that even if someone was identified as being at risk, there was uncertainty about which individuals and services then took carriage of coordinating an effective response. This was a key finding that participants perceived as the major problem – the lack of an agreed organisation to coordinate responses once a referral is made. P20 also identified the demarcation that is sometimes made once a client is assessed as being at risk of suicide. Such an assessment then places them in the health care system under a “mental health” category which can lead to a ‘hands off response’ from other health professionals:

‘...the distinction of making it mental health, everyone kind of seems to see it as not, well, ‘it’s nothing to do with me’ so I guess if you’re the nurse or you’re the doctor on triage, ‘oh, that’s mental health, that’s for...’, it’s not even in their scope of ‘that’s important’, it’s immediately referred to over thereI think that’s part of the challenge, everyone else gives it kind of hands off, ‘that’s for mental health’ (P20).

There can be the opinion of ‘they don’t really mean it’ or ‘they’re just saying that’ or something like that, so there’s no importance placed on what they’ve said, even though they have to go to mental health ‘cause of what they’ve said. That’s a big part of it and then you’ve got the constant rotations in of new staff from cities, from a whole realm of other jurisdictions that don’t have the contextual knowledge of what’s going on here.’(P20)

It was also suggested by P17 that any referral information needs to be easily accessible and made part of any induction for new staff:

‘...information about the pathways needs to be plastered in and kept in these places where people are always being able to reference it. And when they get inducted, when they get given the information about where they’re going, that needs to be part of the information package’.

Additional findings

Professional development

A commonly expressed concern was the lack of professional development re suicide risk assessment and appropriate response. Many participants identified this as a barrier to effective identification and referral of Aboriginal youth at risk of suicide. (P1, P4, P11, P18, P20). It was indicated that a lack of confidence in accurately assessing suicide risk, particularly from a cross cultural perspective, was implicated in the under reporting and inappropriate referral of youth at risk. P6 acknowledged that remote health clinic staff also find...

‘...it difficult to provide that support...they haven’t got the information for awareness...how to deal with these people when they come into the clinic’.

P20 believed that a strong protocol will only overcome barriers if it is highlighted as important in induction training. A greater focus on cultural training and giving staff more historical context in their professional development was needed in order to respond effectively to suicide threats. P20 also pointed out that the local staff turnover created the need to constantly define their position, educate on what is risky behaviour, and what is a risk outside the hospital setting.

P21 was concerned that GPs need to have undertaken specific training, before they can refer to a psychologist or psychiatrist but heard that the training is not being done in some places so, they're unable to refer. It was also noted that youth are not the easiest to engage when it comes to health and that practitioners and in fact most workers and families are not necessarily trained to ask the right questions to effectively determine suicide risk in a cross cultural context.

The importance of formal supervision and system support for practitioners was also identified:

'But it's so important ... to know how to assess or where to refer, or when to refer and when to be confident that the person you ... are referring to, or the system, will take it seriously. Because this is one of the issues of course. ... (O)ne can become blasé and particularly if someone's done this serially, you say 'Oh they've done it again' and become dismissive and rejecting or blasé about the assessment, and miss a crucial difference from the previous one or two times that they've behaved in that fashion. And that could be the difference between an attempt and a more tragic outcome. So the assessment process is important and you can't miss steps. But all of us are human and ... this is where the supervision support from the Tertiary Services may be, or whatever, wherever it comes, is to help people recognise their own emotional reactions to difficult situations, difficult patients ... countertransference, it can be positive' (P2).

P19 highlighted the futility of implementing a data collection system and/or referral pathways without adequate professional development:

'...you need to almost re-educate everybody who's in the ED, have some education and training about what is a suicide attempt, not just for those who are collecting the data, but for the ones who are actually on the coalface, they need to have some training around this is what we're looking at, this is what we would class as (an attempt)... because if they're not defining it correctly, then we're not going to get any of this information at all, it won't be the correct information'.

P2 reinforced the need for a well informed and up to date professional development program for staff:

'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, and that the Clinic Staff, they are very much apprised of the CARPA approach to assessment and management. And that also... to keep those skills up, you really need to be... it's like CPR, if you've done CPR 20 years ago, you might be able to, but would you be able to actually implement it...'

Any implementation of the data collection form and referral pathway protocol would therefore require professional development of those expected to use these resources. Access to the data collection and referral form could be provided on-line through whichever organisation is identified as the repository for data collection.

Community awareness and training

There was consensus across participants that greater community awareness and training were integral to any uptake or effective coordination of services to deal with Aboriginal youth suicide. As a more recent phenomenon within Aboriginal communities, one key concern was the lack of suitable language to discuss the various factors implicated in youth suicide and suicide attempts. For Aboriginal people in Central Australia, even the use of the word suicide was believed to be a 'hurtful word' (Lopes, et al, 2010).

P4 believes that there is reluctance among practitioners and community members to raise the issue of suicide.

'People don't openly talk about suicide which results in misconceptions about suicide. Eg: what's wrong with my family?'

Suicide Story training was identified as a valuable program that was much needed in communities (P4, P11, P15). P15 believed that training takes stigma away, but that training must be relevant for other organisations to enable communities and experts in mental health to work together. Whilst other training in communities was identified P21 suggested that gatekeeper training as an example, lacked a solid implementation strategy, taking

'...a bit of a scatter gun approach to getting people better equipped to understand what's happening for individuals...'

The need to educate the community about appropriate pathways and management is important to ensure families and individuals are not overburdened and missing support that is available. P1 gave examples of families attempting to manage a relative at risk without service support:

'I think we need help ... at different levels about the seriousness of suicide threats and how you can manage them. A lot of the work [LPP] does is about strengthening communities, so that they can support each other, so that's at a community level. But there'll be people that communities can't support, that happens in white society, there'll be people that will be distressed. When I worked at [community x] a family ... said, 'we've cut her down from a tree twice in 24 hours, and we can't stay awake and watch her and watch her'. She [had] to go to Alice Springs' (P1).

Cultural factors

For the Aboriginal workers participating in this study, the burden of identifying and reporting Aboriginal youth suicide and suicide attempts is profound, due to their dual responsibilities as employees and community members (P4, P6, P11). This sometimes led to Aboriginal staff withdrawing, but mostly it was recognised that having Aboriginal staff available increased the quality of information and the level of trust.

P4 explained that they...

'...just had a few too many suicides too close to home for me so I wanted to ...distance myself...'

P6 revealed:

'I hear the people, other people sharing information, plus I experience it being in the community as well, living with families and even through work...'

For non-Aboriginal workers, P5 felt there was a difficulty in distinguishing traditional cultural responses to grief and bereavement from other self-harm that may be aggravated by alcohol use. Behaviours that might otherwise be considered self-harm, such as cutting oneself, can later be identified by the individual and other family or community members as being linked to "Sorry Business" (Aboriginal English term for mourning rituals).

P6 says some people tell and others don't ...

'...because they're too scared to for other people to know their business....and want to deal with it within the family. So for 24 hours they kept watch and did things for the young fella, they took turns looking after him and yeh it was successful. ...and this young fella was very suicidal...they organised themselves to keep an eye on him for two weeks.'

Whilst these examples were evidence of a resilience and capacity within some families and communities, it was also suggested that concerns about stigma, mistrust and even a lack of awareness of available supports meant that families were often coping alone and the real extent of suicide attempts may be underestimated. This example, suggested that other options, appropriately resourced and supported, can offer viable alternatives to hospitalization, which is highly stigmatising.

There is a need for greater understanding of suicide and suicidal behaviours in a cross cultural context. Participants identified emerging behaviours that may be overlooked or underestimated in their significance by those who don't have the experience or insight into what may be happening for individuals and communities. P12 identified suicide threats, for example, as an increasing pattern of behaviour in community:

'...young people threatening (suicide) it to get attention and self-harm ... comes in waves. ...(Y)ou'll actually see it ... as a wave go through schools' (P12).

P22 saw a need for the development of locally appropriate as well as culturally appropriate assessment tools and training in cross cultural assessment for staff, in recognition of the diversity of Aboriginal cultures. P22 identified some issues that should be considered when examining the issue of youth suicide among Aboriginal populations:

'Well, Tracey Westerman has a specific indigenous tool of assessment. ... the issues you have to take into consideration when you are speaking with Indigenous people is certainly language, you get the nuances and gender proper... I couldn't talk to a young girl or that sort of thing, you'd have to get a female and usually an Aboriginal female to speak with that girl and family members... Also just what the level of cultural engagement is in regard to the child's view and whether any of the issues in regard, the motivating factors of suicide, were influenced or informed by cultural beliefs'. (P22)

Challenges to service delivery

The participants in this study identified multiple barriers to dealing with Aboriginal youth suicide and suicide attempts. These were evident at the level of individuals, communities as well as in service structures, policies and protocols. Whilst remote regions are often characterised as resource poor, there is a situation in which multiple agencies may deal with an individual Aboriginal youth, but have little or no capacity or motivation to collaborate in the care of that individual.

P4 was concerned that without appropriate information sharing, there was the risk of duplication.

'Most people are so multi agencied...if we had a standard system we could go...there's already five people working with them, do we really need to take them on...'

The potential for over-servicing of individual clients was identified and the need for a formal service coordination approach was noted, as was the call for establishing a central coordination point:

'I think if you can do it for a child abuse line, I think it should also be anonymous for a suicide line. ... even a central core place because that way then they can monitor how many times you've actually had calls about that person' (P11).

'I always think there needs to be a designated person or body that is responsible because if we all leave it thinking someone else is going to do it it's not going to happen. So it needs to be a designated person' (P19).

Relationships with and between communities and service providers was a perceived barrier, with examples of historical mistrust preventing the uptake of services in some instances:

'...the history...of relationships with Police and other sort of professionals, what are seen as White services. This sort of fear around the consequences of reporting...means that often Aboriginal witnesses are reluctant to provide enough background information that you can make those sorts of assessments.' (P5)

P7 noted that among Aboriginal youth there were

'...really high levels of impulsivity with young people, so there are young people that have not displayed any self-harming or at risk behaviours...a situation can escalate and ...there's been no prior indication that that person was at risk of suicide.'

Whilst the perception that no prior indication may be evident, it should be acknowledged that numerous risk factors exist in regard to Aboriginal youth generally and the complete social and emotional context should be examined for flags to even seemingly impulsive behaviours (P22).

On a system level, P7 also cited...

'...a lack of preventative focus and that in terms of strengthening someone's resilience...we've noticed the opposite, we think actually the systems in place now are much more punitive...and as a result people do take more desperate measures...'(P 7)

Confidentiality concerns and a lack of information sharing between organisations were notable barriers to effective service delivery (P1, P2, P3, P5, P7, P 15, P21). P15 identified rigid boundaries for work as being problematic in remote settings where collaboration is not only desirable, it is necessary. School counsellors and youth workers are also challenged by notions of client confidentiality as key workers with access to Aboriginal youth:

'...young youth workers just need to realise that that sort of confidentiality when it comes to such a critical issue around sort of potential or attempted suicide or even thinking about it, it's something that they need to break the silence' (P17).

'You need to know the names of who's involved with this young person and you need it not to be a jigsaw puzzle where one organisation knows something but that's confidential, another organisation knows something but that's confidential, ...doesn't help that young person at the end of the day...I think that's the minimum of what you need to know to keep them safe... I think you've got to be able to get past the confidentiality issue because you're balancing against someone's future and a youth suicide perspective, if that act follows through, then they've lost 30 or 40 years' (P20)

However, not all respondents agreed that handing over information was necessary or appropriate and that it may in fact lead to a breakdown of confidence in service providers:

'I would be concerned that if we had to hand over data on children who walked into our Emergency Departments, for example, and told us that they wanted to kill themselves that we would then go and give that to somebody else...one thing that would happen is they would stop coming into Emergency Departments. They tell you things in confidence...you have a legal obligation to not disclose. Ultimately people have the right to seek medical treatment and advice in public hospitals and not have that information disclosed to anybody...If my son tried to kill himself and went to an Emergency Department I would be pretty upset if somebody from some NGO or some other organisation came knocking on our door, wondering how everything was going. I would actually be outraged but that's me and that hasn't happened to me. It is an area fraught with... and what is a suicide attempt and so on. It is difficult...'(P22)

P10 and P11 saw inconsistency in responses from referral agencies as a problem with a lack of suitably skilled personnel to respond appropriately for acute intervention, diagnosis and management. Clinical practice is also hampered by different world views and a lack of appropriate conceptual frameworks:

'There is no terminology to talk about children and trauma, not clearly anyway ...we don't have the vocabulary to talk about Mental Health in adults, so how is it done with children?' (P1)

A number of respondents mentioned the policy of CAMHS only reviewing clients with a zero Blood Alcohol Content (BAC) (P1, P3, P6, P18). There was a perception that this policy may be a barrier to accurately identifying Aboriginal youth at risk, as they could later deny their attempt as suicidal in intent. Alcohol was identified as a trigger or risk factor for Aboriginal suicide and suicide attempts including incidents with youth. For one respondent, it was important not to miss an opportunity to talk to anyone...

'...even when they're drunk or sober...for us, we believe that when they're drunk, it gives them their...it just opens them to speak up, speak their mind. Without alcohol they don't, we don't feel that, strongly feel that they don't speak their mind, but alcohol helps them to open up...'

While there was considerable good will at the service delivery level, systemic, resource, historical and political challenges were perceived as hampering effective responses to Aboriginal youth suicide and suicide attempts.

DISCUSSION

Definitions and protocols

As identified in the results, each organisation generally has different guidelines and definitions of “youth” and “suicide attempt”. There appears to be a case by case approach that requires some local knowledge and experience, which makes it challenging for new staff. The fact that even defining youth and suicide attempts lack consistency across the region is something that makes standardisation challenging.

In seeking to coordinate the collection of suicide attempt data, there needs to be agreement as to which organisation will act as the central repository and how any data collected will be accessed and used by contributing organisations. As data collected by some agencies is predominately used to inform their own practice, the flexibility to continue collecting relevant data should remain, with agreement as to what constitutes core or common data. A problem with both data collection and referral was also noted by participants who felt that there was no shared vocabulary with which to discuss suicide issues in an intercultural context.

There have been successful attempts to develop similar systems or risk management, data collection and referral overseas (MacNeil & Guilmette, 2004; Oregon Department of Human Services - Public Health Division, 2008; World Health Organization, 2002). While it is not possible to simply duplicate these models from elsewhere the processes of their development provide important lessons. The extensive processes of consultation, partnership development and trust-building that underpinned the development of these models are fundamental requirement for any initiative. What emerged from this study was the recommendation that any form or data collection process needed to be user-friendly to account for a range of potential users and still allow for localisation as required.

Recommendations

- A central coordination service (e.g. CAMHS) be identified as a first point of contact for clinical assessment of suicide risk and referral to appropriate services or support.
- An agreed agency/agencies be identified to collect and collate suicide and suicide attempt data (possibly MHACA or a research institute).
- Coordination and data collection roles to be adequately resourced with identified designated positions attached.

Cultural considerations

The literature review highlighted the view that suicide is a relatively new phenomenon for Aboriginal communities. Cultural beliefs, values, attitudes and understandings influence the way suicide and suicide attempts are responded to within Aboriginal families and communities. Concerns that any involvement by Aboriginal individuals may lead to threats and/or payback can result in a fear of reporting. Family obligations also make it difficult for certain family members to be involved in reporting. However it is essential that families find a way to circumvent such barriers. The important thing with regard to youth suicide attempt is that someone outside of the family be notified of any concerns irrespective of potential shame and stigma. Consequently, there is a need to establish effective systems of support that will encourage referral and rebuild trust in some services that may currently be limited. The safety of those at risk is paramount.

The other challenge for health professionals in the region is the difficulty of making assessments that are cross-cultural in nature. Evidence suggests that Aboriginal suicide is different and non-Aboriginal health professionals may not be familiar with many of the culturally important cues when assessing. Westerman (2010) advocated the use of cultural consultants in assessing the mental health of Aboriginal clients in order to manage these issues.

As mentioned previously, cultural definitions of youth and adult can present uncertainty for service providers, not only due to funding criteria or bureaucratic concerns, but because culturally adulthood is determined by factors other than age.

Recommendations

- Increase positions for Aboriginal workers across services, including the employment of cross cultural consultants
- Cultural consultants (including family members where appropriate) should be engaged by non-Aboriginal people when making an assessment of an Aboriginal person at risk of suicide.
- Suicide definitions should incorporate cultural understandings of suicidal or self-harm behaviours and development of shared vocabulary for community members and service providers.
- Increase community advertising of available resources, training and support services through local media and community organisations.
- A single lead agency should be identified for coordinating responses to Indigenous youth suicide and suicide attempts.
- Develop and promote the use of visual resources (pictures, paintings etc.) to assist in the assessment of suicide risk and the understanding of the risk factors for suicide.

The role of education and training

The results of this study were unequivocal in highlighting major gaps in the training and education of those potentially involved in responding to Aboriginal youth suicide attempts. Greater cross-cultural education for staff is essential given that many are attempting to make informed decisions on behaviours that may be less perceptible between those of differing cultural backgrounds.

Education and training is required to improve accurate data collection processes as it was apparent that many workers were reluctant or unable to confidently identify suicide risk and attempts and were using diverse criteria for defining youth, Aboriginality and suicide attempt.

Recommendations

- A comprehensive suite of education/training (orientation packages, training programs etc.) be developed and/or identified and rolled out across Central Australia to complement existing suicide response programs.
- All workers with a role in engaging with managing Aboriginal youth, who have not received Suicide Awareness training, should receive such as a requirement of working in the region.
- Review of CARPA manual protocol and reference document on "Suicide Risk" to align with referral pathway and data collection form if endorsed.
- Implementation strategy to be developed for the roll out of the Referral Pathway and Data Collection Form.

Challenges for a coordinated approach to suicide prevention

There are certain barriers that impact on the effectiveness of a coordinated approach and referral pathway for suicide prevention. This could be related to a person's first point of contact (e.g. prior to contact with a service provider) or subsequent pathways through the system (e.g. referrals from first contact organisation or follow up). The person at risk of suicide may also choose not to consult a health service and may instead turn to a friend, family member, youth worker, or other service provider. As a result, not all attempted suicide or at risk individuals will be reported or followed up. This highlights the importance of programs such as ASIST and Suicide Story Training. However, there are often concerns with confidentiality and privacy, particularly when living in small communities. Various service providers and other community members may face the dilemma of making a report and facing the risk of breaking trust with the individual. However in considering these issues it was identified that the safety of the individual at risk was paramount.

In Canada in 2004, what was believed to be the first suicide risk management tool specific to Aboriginal cultures was developed (MacNeil & Guilmette, 2004). This was achieved through partnerships between Aboriginal and non-Aboriginal health care professionals and was developed in order to develop appropriate strategies for addressing the problem of suicide in First Nations adolescent populations. The tool that was proposed was removed from the 'mental disorder model' and focused on a complete system of care that required services to be well linked so as to provide "an opportunity for early intervention by supplying culturally-based support from members within their own community" (MacNeil & Guilmette, 2004, p.347). The 'traditional network model' proposed in the Canadian system may also be suitable for Central Australian communities, however much more extensive consultation and capacity building in relation to suicide prevention would be required. The Canadian tool was extremely detailed and more complicated than the kind of tool that was required and recommended to be used by multiple agencies and individuals in Central Australia.

Regionally, there is some effort to improve coordination and networks. The Commonwealth Government, in an attempt to improve coordination of suicide prevention activities is funding Wesley Mission for example, to assist regional towns to establish suicide prevention networks across Australia. They currently support three suicide prevention networks in the Top End of the NT. Another effort is from General Practice Network Northern Territory (GPNNT), now called Medicare Locals, who provide support to general practitioners and primary health carers including mental health services. In Central Australia, MHACA, provides a forum for sharing local and national suicide prevention information via the Life Promotion steering committee. These are voluntary meetings made up of a local Government and NGO representatives and vary in participation and attendance, located in Alice Springs. LPP also produce, share and distribute relevant resources among these members. Additionally, they offer training such as ASIST, Mental Health First Aid Training and their locally developed Aboriginal specific training program "Suicide Story". Lifeline Central Australia coordinates suicide prevention training activities and is the key agency for the delivery of ASIST and Safe Talk training. They also support the schools network to ensure that all teachers and senior students receive training. The NT Government Department of Health currently has a funded suicide prevention coordination position, although the Gone Too Soon Report acknowledged the need for additional positions to coordinate prevention responses across the NT. There are also specific resources available, such as contact number sheets distributed by the Lifeline and MHACA, NPY Women's Council has a resource for the cross border communities to access services in mental health and drug and alcohol support. The CARPA manual provides an overview of agencies particularly relevant to the Central Australian context (including rural and remote communities). Although there is anecdotal evidence of the benefit of these resources they are not endorsed systematically across the region, they can quickly become out of date and are not used within all agencies that come across suicidal behaviour.

For some agencies there are certain referral pathway protocols in place. For Central Australian Remote Health Services (CARHS) the current practice is that when a young person attempts suicide in a remote community they are assessed using the CARPA manual protocol and offered referral to the Central Australian Mental Health Services (CAMHS) team for assessment and further support. At the Alice Springs Hospital, anyone with an index of suspicion for suicide attempt is referred to the CAMHS. There are then those services such as night patrol and youth workers where suicide prevention is not the core business, but may be one part of their various roles. In remote communities, the Mark Sheldon Remote Mental health Service (part of CAMHS) is a visiting service and the option to bring the young person to town for admittance to the hospital may not be the most appropriate option. Other services such as Headspace are “walk in service” and do not require young people to be referred. However they can be referred to the CAMHS if there is concern about suicide risk. The Mt Theo Program in Yuendumu provides a coordination role in supporting young people at risk of suicide and support after suicide. They do this with the support of young people who are trained as mentors and leaders and in collaboration with mental health service providers from Alice Springs. There are many other service providers who are not health professionals who come into contact with suicide risk among young people in Central Australia. These workers need training and support to know how to appropriately respond to suicide risk, who to refer to and how they can be kept informed of the outcome.

As previously outlined, an increasing body of work is being undertaken in the area of Aboriginal suicide prevention across the nation, including within Central Australia. These programs and activities are being delivered by various government and non-government agencies and offer differing suicide prevention responses. Despite the importance of diverse suicide prevention approaches, it has become difficult to gain a clear understanding of what services are operating in certain areas, what service provision parameters they have and what role each play in suicide prevention. Those with longevity in the region may have a better understanding than others, however, staff turnover, changing roles and responsibilities and a lack of community awareness may mean services are not effectively accessed at times. This has resulted in duplication of service, lack of sustainable effort and burn out, and young people falling through the gaps. Since suicide is an outcome of complex determinants it is clear that a combined and collective approach is required. However, as stated in the recent senate inquiry, service responses to suicide in the NT generally lack coordination and collaboration.

More generally, Suicide Prevention Australia (SPA) has noted that on a national scale since suicide statistics are dependent on a complex process of capturing, distributing and processing information which involve various individuals and organisations can be challenging. Further, no one body or portfolio is responsible for producing mortality data. Multiple parties collect data for different, sometimes disparate, purposes (e.g. legal, statistical, or research-oriented) with different standards of proof and reporting timelines. In relation to suicide attempt, there is no system in place to collect this information nor is there an obligation. There are also issues around responsibility and who will manage the data. It relies on dedicated organisations or often an individual employee to initiate or follow up the data collection and reporting process. The setting up of a register of suicide events (ROSE) by Central Australian Remote Health Services (CARHS) was triggered by concerns from remote health clinics; however it raised issues about adequate resourcing, not only to collect data but also to respond appropriately to suicide risk.

The reality within many remote Central Australian communities is that there is a scarcity of service providers in some instances or an ineffective uptake of existing services to adequately address and support the complexities of Aboriginal suicide (Lopes, et al 2012). For example, visits from psychologists vary in time and from community to community. It is well recognised that there is no equitable access and availability of service provision across the region. There are also concerns around availability and accessibility of services, not only referring to the provision of services in area of need but whether they are appropriate and utilised by Aboriginal peoples.

Programs are also run by different agencies, government or non-government with their own agendas their own indicators to reach etc., which are not aligned with each other. Services are often restricted to specific roles (alcohol, youth) and may not see suicide prevention as their core business or area of expertise. Since the incidence of suicide is relatively low in comparison to many other issues facing Aboriginal youth, it is often seen as a low priority. Different agencies therefore have differing perceptions of suicide as a priority. No single service addresses suicide as the factors related to this issue can be addressed indirectly through various services. This may be implicated in why some agencies do not prioritise suicide as they deal with certain aspects and perceive other factors to be the responsibility of other services. It is recognised that in the approach to service delivery and referral pathways, 'top down' approaches are not effective and these pathways need to acknowledge local preferred ways of operating. There is a need to utilise the resources, programs and activities that exist currently in the region.

Recommendations

- Investigate data systems that will communicate within and between services.
- Develop agreed criteria for information sharing between service providers.
- Establish a feedback mechanism to ensure follow up and communication between services and individuals at risk or supporting those at risk.

Limitations

This research was conducted in a specific geographic region, namely Central Australia and as such results and recommendations relate only to this region. This was also a first stage of a proposed multi-tiered research project and findings were reflective of this. The development of a data collection and referral form, along with the referral pathways could only be taken to a draft stage, as questions arising from the research need to be clarified before any resources can be implemented. For example, an agreement needs to be reached between the key stakeholders as to which service or organisation will take responsibility for data collection. Agreement needs to be reached on matters of confidentiality and information sharing. This research has been limited to the agreed aims of developing a data collection system and referral pathway informed by multiple stakeholder perspectives. Further research is now required in Stage Two to progress development of the resources arising from this study.

SUMMARY RECOMMENDATIONS

- Based on the results of this research, the following recommendations are made:
- A central coordination service (ideally CAMHS) be identified as a first point of contact for assessment and referral to appropriate services or support.
- An agreed agency/agencies be identified to collect and collate suicide and suicide attempt data (possibly MHACA or a research institute).
- Coordination and data collection roles to be adequately resourced with identified designated positions attached.
- Increase positions for Aboriginal workers across services, including the employment of cross cultural consultants
- Cultural consultants (including family members where appropriate) should be engaged by non-Aboriginal people when making an assessment of an Aboriginal person at risk of suicide.
- Suicide definitions should incorporate cultural understandings of suicidal or self-harm behaviours and development of shared vocabulary for community members and service providers.
- Increase community advertising of available resources, training and support services through local media and community organisations.
- A comprehensive suite of education/training (orientation packages, training programs etc.) be developed and/or identified and rolled out across Central Australia to complement existing suicide response programs.
- All workers with a role in managing Aboriginal youth, who have not received Suicide Awareness training, should receive such as a requirement of working in the region.
- Review of CARPA manual protocol and reference document on "Suicide Risk" to align with referral pathway and data collection form if endorsed.
- Implementation strategy to be developed for the roll out of the Referral Pathway and Data Collection Form.
- Investigate data systems that will communicate within and between services.
- Develop agreed criteria for information sharing between service providers.
- Establish a feedback mechanism to ensure follow up and communication between services and individuals at risk or supporting those at risk.

Future Research

It is intended that this study will be part of a multi stage project and subsequent research should include:

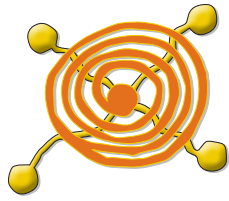
- A trial of the database among a defined group of health centres or relevant agencies across the Central Australian region (for which will seek separate CAHREC approval). This will involve an evaluation of effectiveness and benefit of the database and referral system and recommend appropriate revisions. Also, guidelines may be recommended for the analysis of data collected through the developed system.
- Exploration of issues of confidentiality, establishing a centralised call centre, and the development of unique patient IDs.
- Exploration and identification of the social determinants of Aboriginal youth suicide in Central Australia.
- Informing the development and delivery of appropriate interventions and resources for Aboriginal youth suicide and suicide attempt in Central Australia.

Conclusion

This study has developed a standardised suicide data collection & referral form and suggested appropriate referral pathways for agencies in the Central Australian region. As a first step, it is essential that evidence-based approaches to Aboriginal youth suicide are developed. By capturing accurate data on suicide and suicide attempts, greater understanding of the issue will emerge. This will ensure that resources and funding can be targeted and strategically put in place to ultimately reduce the incidence and impact of Aboriginal youth suicide in Central Australia.

The refinement, implementation and adoption of these resources will be a matter for the key stakeholders that play a role in responding to Aboriginal youth suicide and suicide attempts. This research provides an evidence based platform for progressing the goal of standardised and effective responses to Aboriginal youth suicide and suicide attempts in Central Australia.

APPENDIX A: INFORMATION SHEET



Centre for Remote Health

A joint centre of Flinders University and Charles Darwin University

This information will be interpreted verbally in relevant language if required

This is for you to keep

Information sheet

Aboriginal youth suicide in Central Australia

The Centre for Remote Health in Alice Springs is conducting a study about how data is collected on Aboriginal youth suicide in Central Australia. The rate of Aboriginal youth suicide and suicide attempt in Central Australia is seemingly increasing at alarming rates. However, at present, there is no systematic or coordinated database to collect this information. This project will therefore lead to the development of an effective suicide classification and data collection system for implementation by relevant Central Australia agencies.

To inform the development of this database, we would like to ask you some questions about your experience and thoughts during an interview. We are particularly interested in your comments about your current practice of how suicide is reported, any barriers you face or any concerns you have about the collecting this data.

It is expected that interviews will last approximately 30 minutes and if you agree, we will use a voice recorder. We are interested in your personal views and not the views of your employing organisation or agency. As such as are making this request to you as an individual.

If you agree to participate, please sign the attached consent form and return it in the reply paid envelope. **You are free to say “no”, or to change your mind at any time. Saying “no” is OK and will not have any impact on you.** If you agree to participate, a researcher will contact you to make a time for an interview in a location of your choice once we receive your signed consent form (attached). Please be assured that your confidentiality will be maintained – your name, and any other information that may identify you, will not be used in this study.

If you have a concern or complaint about this evaluation, please contact the Ethics Administrator, NT Department of Health and Families and Menzies School of Health Research, Phone 89227922 or ethics@menzies.edu.au.

If you experience any concerns during any stage of your involvement in this study please contact CRANA Plus Confidential 24 hour Support Line on 1800 805 391.

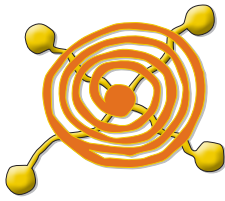
If you would like to make any amendments to your interview transcript, they will be made available during a second interview. If you have any questions at all about this project, please contact me on 89 514 700.

Thank you for your time in considering this request to be part of this study exploring Aboriginal youth suicide.

Melissa Lindeman
Centre for Remote Health
a joint Centre of Flinders University & Charles Darwin University

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APPENDIX B: CONSENT FORM



Centre for Remote Health

A joint centre of Flinders University and Charles Darwin University

This information will be interpreted verbally in relevant language if required

Consent for interview

PROJECT TITLE: Aboriginal youth suicide in Central Australia

Name of participant: _____

Name of investigators: Melissa Lindeman, Kerry Taylor, Jess Lopes. _____

1. I being over the age of 18 years hereby consent to participate in the project named above, the particulars of which - including details of the interview - have been explained to me. A written copy of the information has been given to me to keep.
2. I authorise the researchers to use the interview data referred to under (1) above.
3. I acknowledge that:
 - (a) The potential risks and benefits of the interview have been explained to me to my satisfaction;
 - (b) I have been informed that I am free to withdraw my consent at any time. **This means I can say 'no'**;
 - (c) The project is for the purpose of research;
 - (d) As the sample size is small, and my privacy is important, all data will be de-identified in any publication arising from the study;
 - (e) Confidentiality of the information I provide will be safeguarded subject to any legal requirements.
 - (f) I can request an interpreter if necessary.
4. I agree for my voice to be recorded (please tick) Yes No

Signature

Date

(Participant)

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APPENDIX C: INTERVIEW SCHEDULE

Interview Schedule

How does your organization collect data on Indigenous youth suicide/suicide attempts?

How does your organization define a suicide/suicide attempt?

What criteria do you use to define Indigenous youth?

What barriers or challenges do you experience in collecting data on and/or appropriately referring Indigenous youth who may be at risk of attempting suicide?

What response would you/your organization take to a reported Indigenous youth suicide attempt?

How would you describe the relationship between your organization and other organizations and people involved in responding to and/or preventing Indigenous Youth Suicide and suicide attempts.

Who do you believe should be involved in investigating and following up on a reported Indigenous youth suicide attempt?

What about incidents which may be considered a suicide attempt that are not reported?

How confident are you that you have an accurate picture (of the incidence/prevalence) of Indigenous Youth Suicide and suicide attempts in Central Australia? Why or why not?

Any other comments to make about the classification of and collection of data related to Indigenous Youth Suicide and suicide attempts?

Do you know of any good examples of databases and referral algorithms/models in relation to youth suicide and suicide attempt?

Do you have any other comments?

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