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Whole of community suicide prevention forums for Aboriginal Australians

Tracy Westerman[1,2] | **Lorraine Sheridan**[1]

[1]Indigenous Psychological Services, Perth, Western Australia, Australia

[2]School of Psychology, Curtin University, Perth, Western Australia, Australia

Correspondence
Lorraine Sheridan, Curtin University, School of Psychology, PO Box U1987, Bentley, WA 6845, Australia.
Email: lorraine.sheridan@curtin.edu.au

Abstract

It is well known that Aboriginal Australians are at increased risk of suicide. Contributors to suicide differ for Indigenous and non-Indigenous populations (Westerman, 2003; 2019). This study evaluated whole of community suicide prevention forums conducted across six locations. Attendees were youth ($N = 136$), service providers ($N = 225$), and community members ($N = 158$). The content of the forums was empirically based and, for service providers and community members, covered knowledge of suicide, and depression specific to Aboriginal people, skills relating to working with depressed and suicidal Aboriginal people, and intentions to help an Aboriginal person who is suicidal. Content for youth attendees focused on knowledge of suicide and depression, coping skills, intentions to help a friend, and beliefs about suicide. While the results demonstrated significant gains across most domains, there was a potentiating effect with some skills increases becoming more significant over each phase. This demonstrates that a whole of community approach to Indigenous suicide prevention is required, and that clinical and cultural skills require a longer-term approach for impact and sustainability.

KEYWORDS

community, evaluation, indigenous, suicide, suicide prevention

1 | INTRODUCTION

Suicide has contributed significantly to premature mortality in Australian Aboriginal communities with youth being most at risk (Australian Institute of Health and Welfare, 2016). In 2017, suicide was the leading cause of death from external causes in Indigenous males from New South Wales, Queensland, South Australia, Western Australia, and the Northern Territory (ABS, 2017). Early data suggested a suicide rate of around three per 100,000 from 1950 to 1964 (Moodie, 1973). In contrast, more recent data indicate rates of Aboriginal suicide deaths of approximately 39.6 per 100,000 among males and 11.9 per 100,000 among females during 2017 nationwide (ABS, 2017). National data from the Australian Bureau of Statistics estimates the proportion of total deaths to intentional self-harm as 5.5% for Indigenous and 2% for non-Indigenous populations (ABS, 2017). Intentional self-harm ranked as the fifth leading cause of death for Indigenous populations and 13th for non-Indigenous populations.

These ABS rates were standardised for age and are conservative when compared to those calculated by Tatz (1999). Tatz estimated the Indigenous New South Wales suicide rate over a 30-month period between 1996 and 1998 to be 40 suicides per 100,000. He also estimated that the state's male youth cohort (ages 15–24) suicide rate was 127.8 per 100,000. This disparity is due in large part to under-identification of Indigenous status at the time of death. Tatz estimated the child rate

(ages two to 14) to be 15.6 per 100,000. Using data from the Queensland Suicide Register, Soole, Kõlves, and De Leo (2014) examined the suicide rate among children aged 10–14, finding it to be 12.63 times higher for Indigenous children than for non-Indigenous Australian children.

As a country facing this growing tragedy, we still have no nationally accepted evidence-based programmes across the spectrum of early intervention and prevention activities. In the face of all this distress, communities, and families are often left to respond to these critical events in the absence of adequate support both in terms of culturally and clinically impactful counselling and therapy as well as intervention programmes that are able to successfully target at-risk individuals. A qualitative study was undertaken by Nasir et al. (2017) who consulted both Indigenous and non-Indigenous community members and organisations in Queensland on their perceptions of existing suicide prevention training programmes. The results highlighted a lack of Indigenous-appropriate training programmes, echoing the findings of a review of the international literature that this research team had conducted earlier (Nasir et al., 2016). Nasir et al.'s (2016) work also pointed to a need for culturally appropriate suicide prevention programme, as well as evaluations of both the cultural appropriateness and effectiveness of any programme. Similarly, Shahtahmasebi (2014) argues that it is not sufficient to train Indigenous persons to deliver a dominant culture's suicide prevention strategy. Shahtahmasebi instead advocates for a grassroots approach that compliments the target culture (Shahtahmasebi, 2013). Ridani et al.'s (2015) review of 72 Indigenous Australian prevention programmes revealed that outcome evaluations were uncommon. The review nevertheless indicated the whole of community investment and involvement is fundamental to success. Furthermore, Ridani et al. suggest that a focus on belongingness, connectedness, and cultural heritage may yield benefits.

Sveticic, Milner, and De Leo (2012) analysed all suicides in Queensland between 1994 and 2007, finding the non-Indigenous cases were almost twice as likely to have ever sought help for mental health problems than the Indigenous cases. This likely reflects a lack of cultural appropriateness of mainstream mental health services. Historically, research in this area has not focused upon determining whether there is a different set of risk factors for suicidal behaviours that can be established at a population level. This has meant that existing intervention or prevention programmes that have established themselves within a mainstream context often struggle to translate into effective community-based strategies for at-risk Aboriginal people. This article seeks to fill a gap in the Indigenous suicide prevention field and offers opportunities to address generational suicide risk that tends to cluster around remote locations where service access is limited.

What is already known about this topic

1. Aboriginal Australians are at increased risk of suicide.
2. The causal pathways to Indigenous and non-Indigenous suicide differ.
3. Suicide prevention programmes need to be culturally appropriate.

What this paper adds

1. A whole of community approach to Indigenous suicide prevention is required
2. The application of clinical and cultural skills requires a longer-term approach for impact and sustainability.

2 | THE NATURE OF ABORIGINAL SUICIDE

It is widely accepted that the causal pathways to Indigenous and non-Indigenous suicide differ, although the precise nature of the differences is so far unclear (see, for example, Ridani et al., 2015). Westerman (2003) in her Doctor of Philosophy (PhD) research explored this issue via the development of a unique screening tool, the Westerman Aboriginal Symptom Checklist (WASC-Y: Westerman, 2003, Westerman, 2007, in preparation), to identify Aboriginal youth at risk of suicide, depression, alcohol, and drug use, impulsivity, and anxiety. This enabled the exploration of whether there were factors unique to Aboriginal youth (aged 13–17) that could account for suicide risk. The WASC-Y also importantly includes a subscale that determines cultural resilience, an important focus in this field given that prevention often requires the ability to not only target known risk factors for suicidal behaviours but to also develop protective factors within individuals as a more effective long-term strategy of managing risk. Cultural resilience encompasses the holding of common beliefs and values, with core elements including 'language, conventions, socialization, social institutions, enhancing survival, comfort, and psychological needs for meaning and significance.' (Spence, Wells, Graham, & George, 2016, p. 300). Cultural resilience is generally regarded as

being associated with positive social and psychological outcomes. In addition, Westerman (2012, in preparation) finalised the Westerman Aboriginal Symptom Checklist—Adults, further contributing to understanding the specific nature of Aboriginal suicide. The exploration of a different aetiology for Indigenous suicide and a unique set of protective factors (as cultural resilience) has failed to occur at a population level based upon unique, culturally validated psychometric tests. WASC-A and WASC-Y provide this opportunity. They also provide significant opportunity to inform the focus (content) of Indigenous-specific intervention programmes and importantly, provide a unique opportunity to measure programme and clinical impacts of treatment.

Further discussion and analysis of the key findings from this research is beyond the scope of this current paper, and so will only be explored for the purpose of providing a basis for the programme that is the focus of the present work. Findings indicated that 42% of youth ($N = 323$) acknowledged frequent thoughts of suicide, with 23% of the overall sample considered to be at clear risk for suicide. Of these, approximately 20% had made a previous attempt on their life. In addition to this, while depression was linked with ideation, impulsivity provided the strongest relationship with suicide risk with a correlation of 0.80 as opposed to only 0.20 between depression and suicide risk.

In the adult sample, there was a similarly strong correlation (0.63) between impulsivity and suicide risk. This relationship increased for participants from increasingly urbanised environments. Impulsivity was also associated with a lack of appropriate coping mechanisms, and this was quite specific to a proximal trigger (predominantly relationship breakdowns), the absence of effective coping skills and the use of alcohol and drugs as an enabler to suicidal behaviours. This is important when considering that in non-Aboriginal populations, suicide risk is best explained by the presence of depression. As with the youth sample, while depression was an important contributing factor, the relationship between suicide risk and impulsivity was significantly stronger. Other key risk indicators included the impact of contagion, which has already been determined as a high-risk event by other research (e.g., Hanssens, 2016; Hillman, Silburn, Zubrick, & Nguyen, 2000). A high percentage of the sample that was considered at risk for suicidal behaviours had knowledge of someone who had died by suicide (29.3% of the youth sample and 48.1% of the adult sample). There was a moderate correlation (.45) between those individuals who had previously attempted suicide and knowledge of someone who died by suicide. In addition, those who reported knowing someone who had ended their lives had higher mean scores on the suicide subscale than those who did not. This relationship was further explored via the adult scale, with findings indicating that there needed to be established impairment as a result of knowing someone who ended their lives which meant that there was a direct relationship between the exposure and the person's own suicide risk. Exposure alone was not enough to increase suicide risk. This is an important distinction to make, given the high percentage of adults and youth who knew someone who ended their lives. The most relevant correlation (0.78) related to 'knowing someone who ended their life and made me think about suicide' (impairment).

It is important to note that the virtual absence of intervention to those exposed to suicide risk is a strong contributor to overall 'clusters' of suicide risk. The need for practitioners to be able to assess the impact of suicide exposure and respond accordingly is possible using WASC-Y and WASC-A. Just as trauma frequently becomes a central organising principle in the psychological structure of the individual, trauma has become a central organising principle in the psychological structure of whole communities. This is known as 'repetition compulsion', meaning that those individuals who have had a previous traumatic event are at increased risk for future trauma experiences. Suicide 'clusters' are an obvious and common consequence of trauma repetition compulsion.

Both studies also demonstrated that the cultural resilience subscale had a negative relationship with risk thus demonstrating a link between cultural resilience as a moderator of suicide risk for the first time. While, unfortunately, levels of cultural resilience, or protective factors, were characteristically low with only 16.9% of the youth sample having high to very high levels, this provides a crucial opportunity for suicide prevention. Consistent with this, the adult data showed that high levels of cultural resilience were reported in only 16.7% of the sample. However, a sole focus on risk factors alone offers limited opportunity for prevention. The WASC-Y and WASC-A in operationalising cultural resilience as protective of suicide risk enable treatment to be focused upon those factors that ultimately provide a better opportunity for the prevention of Indigenous suicides.

3 | OVERVIEW OF THE FORUMS

The present paper focuses on results from training forums that were delivered in six Aboriginal communities in Western Australia and the Northern Territory up

to 2009. The forums described are unique in at least four ways. First, they emphasise a whole-of-community approach to intervention. The forums are delivered to three separate groups identified by the research outlined above as being pivotal to the provision of 'first line' intervention to suicidal individuals within Indigenous communities (Westerman, 2003). This includes service providers, community members (parents, elders) and most importantly, Aboriginal youth (aged 15–25 years). This represents both indicated and selected intervention components to the programme representing the multilayered nature of suicide and the need to have different suicide prevention strategies capable of addressing different needs. Furthermore, training content had to be delivered in a manner that tapped into Indigenous learning preferences—given that the programmes were delivered across different language groups, capacities (including language and skills-based training) as well as environmental and cultural contexts.

Delivery of suicide prevention training to youth does not occur in standard suicide intervention packages. This is largely due to concerns regarding the capacity of youth to relate to the complexity of suicidality in a manner that can be readily applied within day to day contexts. However, Westerman (2003) noted that the extent of exposure to suicidal behaviours among Aboriginal youth was significant and warranted selected and targeted intervention to ensure that potential risk exposure did not manifest into actual suicidal behaviours. This is effectively what different suicide intervention strategies should be aiming to do. Identify potential at-risk groups; measure actual impact of risk exposure; provide programmes capable of risk reduction and then measure risk reduction attributable to programmes delivered. Importantly, tools such as the WASC-Y and WASC-A enable practitioners to directly assess what impact suicide exposure has had in terms of contributing to individual risk. This is crucial for prevention and is currently not occurring in high-risk Aboriginal communities (Westerman, 2019a, 2019b).

Second, the training packages are based upon empirically and culturally validated risk and protective factors (cultural resilience) specific to suicidal Aboriginal people (see Westerman, 2003, 2010). While an Indigenous-specific aetiology has long been argued within existing research, Westerman (2003) determined this for the first time at a population level.

A third aspect of the uniqueness of the forums is the longitudinal approach to the forum design. Forums were delivered over three phases including an Introductory phase, a follow-up phase (approximately 6 months later), and a Skills Consolidation phase (approximately 12 months after the initial introductory phase). The rationale for a longitudinal approach is to ensure that remote areas can receive assistance to build on the foundation of skills and knowledge gained over time. An important aspect of the whole-of-community approach involves consultation with community members during the planning and implementation stages to ensure it is 'community led'. It also ensures the training content is able to be adjusted to specific community contributors to Indigenous suicide (e.g., gambling, alcohol usage, trauma).

Finally, all training outcomes have been evaluated utilising a protocol developed specifically to monitor the effectiveness of the forums. Including outcome evaluations have helped guide and refine the implementation of the forums and it has also contributed to the evidence-base supporting this approach to prevention.

4 | METHODOLOGY

4.1 | Participants and training objectives

At each of the three phases identified above, workshops were delivered for service providers, community, and youth. *Service providers* are those who work in the areas of health, education and mental health, and who are in the 'front line' of support to Aboriginal people. The service provider forums focus on the latest research and best-practice models of culturally appropriate service provision for Aboriginal clients, with predominately unique content developed by Westerman (2003). In these workshops, there is a focus on the signs and symptoms of Indigenous depression and suicidal behaviour, as well as the key risk indicators. Basic counselling skills and engagement strategies are also covered with an emphasis on adapting these techniques to ensure they are culturally appropriate. *Community members* include parents and elders within the local community. This workshop focuses on developing skills based on the 'natural gatekeeper' model of prevention. The term natural gatekeeper refers to the important support role played by those who are often the first port-of-call for people at risk—that is, the community themselves. The community member forums follow a psycho-educative approach, with the content addressing conflict management, anger reduction, and identifying suicide and depression. The workshop forums involve active participation, with attendees practising strategies through guided role plays. *Aboriginal youth* (aged 15–25 years) workshops also take a psycho-educational approach offering information on the nature of depression and suicide (and the relationship between the two) as well as life coping skills (with particular emphasis on managing difficult emotions) that have a demonstrated association with increased suicide risk. There is also a focus on engendering peer support

networks that encourage youth to develop concrete suicide prevention crisis management strategies.

Demographic information on participants is not provided here due to confidentiality risks. All communities where the forums were delivered were classed as remote and at high risk for suicide, and a significant proportion of participants had English as a second language. All data were deidentified and participants gave their informed consent.

4.2 | Evaluation protocols

Two structured questionnaires were utilised in these forums at pre- and post-training levels. These evaluation questionnaires have been utilised for over 17 years with more than 1000 participants across three different states and territories of Australia. The questionnaire for service providers and community members was based on a similar approach to that undertaken by Capp, Deane, and Lambert (2001) and grounded upon unique characteristics of Indigenous suicide (Westerman, 2003; Westerman, 2010). Participants were assessed for shifts at pre- and post-training levels across the areas of (a) overall knowledge and skills in the area of depression and suicidal behaviours specific to Aboriginal people; (b) skills relating to working with depressed and suicidal Aboriginal people; and (c) intentions to help an Aboriginal person who is suicidal, including beliefs about whether suicide is preventable.

The youth questionnaire was developed based on a version of the Westerman Aboriginal Symptom Checklist—Youth (WASC-Y, 2003) that specifically addresses (a) factual knowledge of suicide and depression; (b) internal coping skills relative to risk for depression and suicidal behaviours; (c) external coping skills, (d) intentions to help a friend who may be unhappy; and (e) beliefs that suicide is preventable.

5 | RESULTS

The same self-assessment evaluation questionnaire was completed at three points: (a) immediately before the forums took place, (b) immediately after the introductory phase (phase one), and (c) immediately after the skills consolidation phase (phase three). Specific areas of skills and knowledge assessed are detailed in Tables 1 to 3. Results are provided separately for youth, community, and service providers. Only questionnaires with no missing data were analysed. Analyses were not conducted in relation to phase two of the training as too many cells had an n count of <5.

5.1 | Youth

Pre- and post-forum questionnaires were completed by young people who had attended the forums. One hundred and thirty-six young people completed evaluation questionnaires. These forums took place in four locations within Western Australia and the Northern Territory. Across the four locations, 80.1% of youth stated their ethnic origin as Aboriginal. Just 3.7% were non-Aboriginal and the remainder declined to answer this question. Table 1 provides responses to pre- and post-forum questionnaires.

Following phase one, there were no significant differences in pre- and post-forum scores in relation to myths about suicide. However, the examination of the data revealed ceiling effects, with pre-scores showing that the majority of the youth did not agree with statements indicative of holding beliefs regarding suicide myths.

Table 1 indicates that the forums resulted in significant shifts in young peoples' attitudes regarding willingness to help, and beliefs that they can help a suicidal Aboriginal person. The youth participants also recorded considerable shifts in knowledge about how to identify someone who is feeling depressed and suicidal. In combination, this effectively means that youth are more capable of understanding risk in themselves and others and importantly have increased capacity and knowledge concerning what resources are available to them to assist.

Following completion of all three workshop phases, the largest gains were seen in terms of reductions in endorsement of myths around suicide (which were already low at baseline levels) and personal levels of comfort in terms of approaching local specialist services for personal help. Gains were not seen in for the items relating to coping with difficult emotions such as sadness and anger.

5.2 | Service providers

As with youth attendees, identical pre- and post-forum questionnaires were completed at three-time points by 225 service provider attendees. The forums took across six locations in Western Australia and the Northern Territory. Across the five locations, 60% of service providers stated their ethnic origin as Aboriginal. A third (31.9%) were non-Aboriginal and the remainder declined to answer this question. Table 2 provides responses to pre- and post-forum questionnaires.

The results demonstrate that service providers had low baseline levels of endorsement of myths around suicide, and these remained stable over time. Large scale

TABLE 1 Youth pre- and post-forum scores following (a) introductory and (b) skills consolidation phases

Questionnaire item	Pre- and post-test scores following phase one X^2(df), *p*, Cramer's *V*	Comparisons of scores post-phase one and post-phase three X^2(df), *p*, Cramer's *V*
Levels of comfort with approaching services for support		
Comfort level in seeking support from local services for family/ friends if having problems	16.92(5), $p < .04$, .36*	11.41(5), $p = .18$, .29
Comfort level in approaching a local service if feeling unhappy	21.91(5), $p < .02$, .40*	18.64(5), $p < .05$, .37*
Skills and knowledge and intentions to help		
I understand how to tell when someone is depressed	17.07(5), $p < .02$, .36*	1.74(5), $p = .97$, .12
I understand what makes someone suicidal	22.79(5), $p < .01$, .42*	5.16(5), $p = .88$, .20
I understand how to tell the difference between someone who is really suicidal and one who is not serious	16.56(5), $p < .04$, .36*	7.32(5), $p = .49$, .24
I do not reckon you can stop someone from wanting to suicide	17.90(5), $p < .03$, .37*	13.56(5), $p = .14$, .32
If someone I know told me they were suicidal I would try to help	19.33(5), $p < .04$, 39*	13.54(5), $p = .18$, .29
If I knew that someone was suicidal I would not have a clue what to do to help	28.33(5), $p < .003$, .47*	13.02(5), $p = .22$, .32
Managing difficult emotions		
When I feel unhappy, I can usually do something to make myself feel better	13.56(5), $p < .09$, .23	9.12(5), $p = .33$, .26
I know what to do when I am feeling stressed	7.16(5), $p = .62$, .32	10.18(5), $p = .34$, .28
I know how to control my anger when someone annoys me	7.76(5), $p = .56$, .24	13.96(5), $p = .22$, .33
Knowledge about suicide/sadness		
If someone is suicidal then they always will be	1.45(1), $p = .16$, .13	12.96(1), $p < .001$, .39*
If someone tried to kill themselves once, there is a greater chance that they will try again	.01(1), $p = 58$, .02	0.07(1), $p = .48$, −.02
Talking about suicide might give someone the idea that they should kill themselves	2.51(1), $p = 07$, .17	10.30(1), $p < .001$, .34*
If a depressed or suicidal person feels better, it usually means that the problem has passed	.06(1), $p = 56$, −.08	24.67(1), $p < .001$, .53*
Young Aboriginal men are at highest risk of killing themselves	.26(1), $p = 39$, .06	.43(1), $p < .35$, −.07
People who talk about killing themselves will never do it	.28(1), $p = 88$, .06	3.95(1), $p < .04$, .21*

Note: $N = 136$.
*Significant at <.05.

TABLE 2 Service providers pre- and post-forum scores following (a) introductory and (b) skills consolidation phases

Questionnaire item	Pre- and post-test scores following phase one X^2(df), p, Cramer's *V*	Comparisons of scores post phase one and post phase three X^2(df), p, Cramer's *V*
Knowledge about suicide/sadness		
If someone is suicidal then they always will be	0.90(1), $p = .64$, .08	2.78(1), $p = .59$, .14
If someone tried to kill themselves once, there is a greater chance that they will try again	2.45(1), $p = .29$, .14	2.33(1), $p = .68$, .13
Suicidal people want to die	1.88(1), $p = .39$, .12	5.74(1), $p = .22$, .21
Talking about suicide might give someone the idea that they should kill themselves	5.11(1), $p = .08$, .20	7.22(1), $p = .12$, .23
If a depressed or suicidal person feels better, it usually means that the problem has passed	0.92(1), $p = .61$, .07	3.81(1), $p = .42$, .17
Young Aboriginal men are at highest risk of killing themselves	5.14 (1), $p = .16$, .20	3.65(1), $p = .72$, .17
People who talk about killing themselves will never do it	1.18 (1), $p = .40$, .12	3.63(1), $p = .46$, .16
Skills and knowledge and willingness to help		
The signs and symptoms of depression for Aboriginal people	1.18 (1), $p = .40$, .12	68.68 (4), $p < .001$, .72*
The link between suicide and depression for Aboriginal people	29.36 (4), $p < 001$, .47*	91.48 (4), $p < .001$, .83*
How to conduct a risk assessment with Aboriginal people	33.69 (4), $p < 001$, .50*	74.28 (4), $p < .001$, .75*
Culturally related suicidal behaviours	40.23 (4), $p < 001$, .55*	67.99 (4), $p < .001$, .72*
How to raise the 'question' in a culturally appropriate way with Aboriginal people	29.05 (4), $p < 001$, .47*	54.93 (4), $p < .001$, .64*
What is involved in conducting a debriefing in an Aboriginal community after a suicide has occurred	25.39 (4), $p < 008$, .44*	71.83 (4), $p < .001$, .74*
Acting as an advocate for your Aboriginal person	21.19 (4), $p < 003$, .40*	60.53 (4), $p < .001$, .67*
Applying culturally appropriate counselling skills when working with suicidal or depressed Aboriginal person	33.70 (4), $p < 001$, 50*	57.01 (4), $p < .001$, .65*
Working with an Aboriginal community to provide debriefing after a suicide has occurred	20.03 (4), $p < 05$, .39*	49.58 (4), $p < .001$, .60*
Conducting a risk assessment interview with an Aboriginal client	40.55 (4), $p < 001$, .54*	55.97 (4), $p < .001$, .64*
Understanding why an Aboriginal person may self-harm	29.31 (4), $p < 001$, .47*	54.21 (4), $p < .001$, .64*
Intentions to help an Aboriginal person who is suicidal		

(Continues)

TABLE 2 (Continued)

Questionnaire item	Pre- and post-test scores following phase one X^2(df), p, Cramer's *V*	Comparisons of scores post phase one and post phase three X^2(df), p, Cramer's *V*
If someone has made up their mind to kill themselves, there is nothing I can do to stop them	20.58 (1), $p < .05$, 38*	6.20 (1), $p = .58$, 11
There is no point trying to seek help for someone who wants to suicide, as they will do it anyway	13.21 (1), $p = .28$, 33	9.46 (1), $p = .41$, 08
If someone was suicidal, I would try to do something to help	7.40 (1), $p = 69$, 24	5.61 (1), $p = .77$, 14
If I know that someone as suicidal, I would find it too hard to do something to help	8.75 (1), $p = 56$, 26	7.83 (1), $p = .70$, 11

Note: $N = 225$.
*Significant at <.05.

increases in culturally relevant skills and knowledge concerning suicide in Aboriginal populations were observed. These increases were more substantial, as indicated by Cramer's *V* values, after attendees had completed phase three, the skills consolidation phase.

5.3 | Community

One hundred and fifty-eight community members who attended three forums on Aboriginal suicide prevention completed the same questionnaire at three points in time. The forums were held across six locations in Western Australia and the Northern Territory. Across the six locations, 65.3% of the community members stated their ethnic origin as Aboriginal. A third (34.7%) were non-Aboriginal and the remainder declined to answer this question. All participants were parents or guardians of Aboriginal children. Table 3 provides details of the responses to pre- and post-forum questionnaires.

Table 3 reveals that gains were seen across all three domains. The largest gains covered the domains of skills and knowledge concerning identifying, talking with, advocating for, and supporting a depressed or suicidal person, and approaching local support services.

6 | DISCUSSION

In sum, the results demonstrate the value of a whole of the community, Indigenous-specific suicide intervention approach as a mechanism of increasing individual and community capacity to respond to suicidal behaviours. Despite the programme being developed prior to the recommendations made by Nasir et al. (2016, 2017), Ridani et al. (2015) and Shahtahmasebi (2013, 2014), programme content was consistent with these proposals in that it was culturally appropriate, it was evaluated, it was based on a whole of community approach, and focussed on belongingness, connectedness, and culture.

It is crucial that evidence-based, risk factor reduction approaches to this issue become the standard approach to the escalating suicides in our communities. Quantitative analysis derived from pre- and post-outcome evaluations has demonstrated significant gains in participants' self-reported skill- and knowledge-levels across all forums. Furthermore, some of these gains increased further following skills consolidation forums, held approximately 12 months after the introductory forums. The forum outcomes clearly reinforce the fact that significant gains can be made via increasing participant understanding of the complexity of suicidal behaviours when training is provided in different phases. It is also further indicative of the complexity of suicide generally and that skills development requires a longer-term approach. The nature of suicide risk is that it changes. Being able to predict and monitor suicide risk takes years and years of clinical and cultural expertise and well-honed clinical insight and judgement. Throw culture into the mix and this becomes a rare set of skills held by few in this country.

The results from the youth scores are particularly encouraging, as they indicate an important shift among a target population who have been reported as being at higher risk for suicide. Gains were observed in relation to the willingness of youth to approach local specialist services to obtain help for themselves and their peers. This is extremely encouraging and important, as Indigenous

TABLE 3 Community pre- and post-forum scores following (a) introductory and (b) skills consolidation phases

Questionnaire item	Pre- and post-test scores following phase one X^2(df), p, Cramer's *V*	Comparisons of scores post phase one and post phase three X^2(df), p, Cramer's *V*
Levels of comfort with approaching services for support		
If a friend, or someone you know really well told you that they were feeling not so good about themselves, and you were worried about them would take them to a local service for help?	35.53(4), $p < .001$, .53*	3.18(4), $p = 53$, .32
If you did take a friend to a service how comfortable would you feel talking up for them if you had to?	20.88(4), $p < .02$, .41*	6.12(4), $p = 18$, .45
How comfortable would you feel going to a local service if you were feeling very unhappy?	28.58(4), $p < .001$, .55*	1.03(4), $p = 91$, .53
Would you know what local services to go to that could help young people?	34.42(4), $p < .001$, .52*	2.56(4), $p = 17$, .28
Skills and knowledge		
How to tell if someone is depressed	26.13(4), $p < .002$, .52*	12.21(4), $p < .02$, .63*
How to tell whether someone is actually at risk of suicide	28.79(4), $p < .001$, .55*	12.68(4), $p < .02$, .64*
How to ask someone if they feel like killing themselves	26.41(4), $p < .002$, .54*	9.77(4), $p < .05$, 56*
What is involved in giving support to people in my community after a suicide has occurred	29.67(4), $p < .001$, .49*	11.68(4), $p < .04$, 60*
Speaking up for a suicidal Aboriginal person who needs help	25.66(4), $p < .004$, .45*	14.55(4), $p < .04$, 48
Using skills that make sure that Aboriginal people will talk about their suicidal feelings and thoughts	29.56(4), $p < .001$, .48*	19.70(4), $p < .04$, 43*
Intentions to help an Aboriginal person who is suicidal		
If someone has made up their mind to kill themselves, There is nothing I can do to stop them	26.55(4), $p < .003$, .46*	7.67(4), $p < .03$*
There is no point trying to seek help for someone who Wants to suicide, as they will do it anyway	12.88(4), $p = .23$, .33	8.19(4), $p = .08$, .51
If someone was suicidal, I would try to do something to help	6.38(4), $p = .78$, .23	15.33 (4), $p < .005$, .70*
If I know that someone as suicidal, I would find it too hard to do something to help	12.39(4), $p = .26$, .32	11.54 (4), $p < .02$, .62*
Knowledge about suicide/sadness		
I believe that once someone is suicidal, he or she will be suicidal forever	5.55(1), $p < .06$, .21	7.02(1), $p < .05$, .32*

(Continues)

TABLE 3 (Continued)

Questionnaire item	Pre- and post-test scores following phase one X^2(df), p, Cramer's *V*	Comparisons of scores post phase one and post phase three X^2(df), p, Cramer's *V*
If someone tried to kill themselves once, there is a much smaller chance that they will try to die	3.30(1), $p < .05$, .16*	5.78(1), $p < .06$, .21
Suicidal people clearly want to die	4.27(1), $p < .04$, .19*	5.55(1), $p = .74$, .18
Talking about suicide might give someone the idea that they should kill themselves	2.71(1), $p < .08$, .14	18.12(1), $p < .01$, 44*
If a depressed or suicidal person feels better, it usually means that the problem has passed	0.77(1), $p = .26$, .08	22.97(1), $p < .01$, .47*
Young Aboriginal men are at higher risk of killing themselves	6.91(1), $p < .008$, .23*	3.28 (1), $p = .50$, .26
People who talk about killing themselves will never do it	4.60(1), $p < .03$, .20*	2.52(1), $p = .64$, .21

Note: $N = 158$.
*Significant at <.05.

youth have been identified as being half as likely as non-Indigenous youth to approach specialist services for support (Sveticic et al., 2012). This is also consistent with the collectivist and collaborative (rather than individualistic) nature of Aboriginal communities in which kinship ties and responsibilities are central to a sense of belonging. These programmes, in being delivered to cohorts and within small communities, provide skills in a manner that capitalises on a collectivist culture by developing 'group' or 'collective' skills to reinforce and aid long-term individual wellbeing.

The results indicate that the forums are appropriately pitched in that participants were able to absorb and retain the content, in both the short- and long term. This is a critical issue when working with a range of attendees from disparate educational, cultural, and language backgrounds and again, defines these programmes. Appropriateness is a major issue, and it now accepted that suicide prevention initiatives must be specific to Aboriginal populations as Aboriginal suicide is both quantitatively and qualitatively different. Furthermore, for programmes to work, it is essential that skilled clinicians are capable of addressing community need. This is a primary aspect of these programmes—the content has been driven by responsiveness to a community context. It is essential that more culturally skilled clinicians capable of these types of interventions are mobilised into our highest risk remote areas.

The realities are that Aboriginal people are at most risk in our most isolated and remote communities. It is essential therefore that approaches speak to this and ensure that communities have the capacity to respond during high-risk times and when services are not always available to respond to crises. Built into this is training in culturally competent treatment and intervention with service providers to ensure that there is a greater level of confidence going forward. The forum results indicate across the board increases in confidence from youth and community in referring themselves or others at risk into local or other services. This outcome provides significant validation of the 'community gatekeeper' approach and offers direct opportunities in reducing barriers to care.

Less positively, gains were not observed for youth attendees within the domain of managing difficult emotions, namely anger, and sadness and stress. This is reflective of the complex and entrenched nature of maladaptive coping styles and indicates the need for a greater emphasis on these skills in a whole of family context rather than with youth alone. When suicide becomes entrenched, approaches need to be long term and sustainable. This finding could also reflect the assessment protocols used in the present work. A simple self-report of confidence questionnaire was employed, as opposed to a symptom-based checklist. Future work should seek to take a more sophisticated approach to determine reduction in mental health and suicide risk factors following targeted intervention programmes.

Future work should also seek to unpack the reasons why some of the largest gains were seen following the skills consolidations forums. Were the gains due to a simple refreshing of content, or because attendees had had the opportunity to put into practice

the skills and knowledge that they had obtained from earlier forums? Either way, it may be stated that participants are at the very least retaining the information delivered within the forums. Comments provided by attendees would seem to suggest that they are putting into practice the skills and knowledge imparted by the forums. For example, 'I believe your workshops should be mandatory for all people working with Aboriginal communities', 'our youngins' (sic) and their families will certainly benefit from all you taught us', Other responses talked about how attendees employed skills and knowledge from the forums to directly intervene with a suicidal young person which is a significant impact—'because of these workshops I am significantly more confident in working with suicidal young Aboriginal people'.

The effects of the forums were positive and enduring. What is not yet known is whether the forums impacted directly on reductions in suicide or in suicidal ideation. This is difficult to measure without direct access to data at the granular level, and without a multi-faceted longitudinal study of the impact of input from youth, community members and service providers. Although such investigations are complex, they are necessary to examine both causal pathways to suicide in Australian Aboriginal populations and to identify what works in relation to suicide reduction. It is imperative that suicide prevention programmes are properly evaluated, and their content and results are transparent. The building blocks for any programme must be culturally appropriate and be able to reach a broad range of attendees. It is not appropriate for one specialist group of professionals to provide an intervention. What is known about the nature of Aboriginal suicide indicates that a whole of community approach is required. The present small-scale evaluation of such an approach is promising, and future work will seek to replicate the findings in more socially and geographically diverse locations and track local outcomes that include official suicide and parasuicide data.

ORCID

Tracy Westerman https://orcid.org/0000-0001-6715-5785
Lorraine Sheridan https://orcid.org/0000-0002-8705-0531

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