Pathways to prevention: closing the gap in Indigenous suicide intervention pathways

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Note: We respectfully identify Aboriginal and Torres Strait Islander people as Indigenous Australians within this manuscript.

Abstract

Background: It is unclear how effective existing suicide intervention pathways are in providing Indigenous appropriate management of suicide risk. The aim of this study was to identify gaps in the management of Indigenous people at risk of suicide and explore alternate ways that could improve intervention outcomes.

Methods: Semi-structured, face-to-face, community consultations with 63 individuals from 34 service providers or community organisations, were conducted across five rural and regional towns of Queensland. The consultation sessions discussed many concepts surrounding suicide prevention. Thematic analysis was performed to identify and analyse patterns and consistent themes.

Results: Community consultations indicated that current pathways were not effective or culturally appropriate for Indigenous people at risk of suicide. Methods of intervention were not sustainable for rural and remote Indigenous communities. Suggestions focused on implementing social, emotional, cultural, and spiritual underpinnings of community wellbeing.

Conclusions: Evaluations of current pathways indicate that an Indigenous community-led approach to suicide prevention is essential to encourage connectedness. Providing culturally appropriate training is essential for to providing effective solutions for Indigenous communities.

Background

Suicide remains the leading cause of death among young Australians between 15 and 34, with males accounting for approximately 3 in 4 suicide deaths[1]. In 2015, the standardised death rate for suicide of 12.6 deaths per 100,000 persons was the highest recorded in the past ten years[2] in Australia. Young Aboriginal and Torres Strait islander men and women between 15 and 19 years die by suicide at 4.4 and 5.9 times the rates of other young Australians respectively[1]. Suicide rates also increase with remoteness of area, with Indigenous populations in very remote areas having twice the suicide rate as those in major cities[3].

A higher risk of social determinants, coupled with a history of colonisation, racism, and removal from families leads to increased life stressors, and psychological distress within the Australian Indigenous population[4]. These factors all contribute to an increase occurrence of suicidal ideation, attempts and occurrence for this population.

Renewed national approaches to suicide prevention, especially for Indigenous Australians[5,6], emphasise the need for community-led, holistic and integrated approaches to suicide prevention that focus on social and emotional wellbeing to improve individual resilience. However, despite the continuing high rates of suicide in Australia[7], it is still unclear how effective existing suicide prevention pathways are in providing Indigenous appropriate management of suicide risk. Exploring gaps in current management practices of persons at risk of suicide, may identify elements that affect positive outcomes.

Preventing the occurrence of suicide is a complex interplay of skills and services and involves the collaboration of a whole community. Intervention or prevention of suicidal behaviours such as suicidal ideation, suicide attempts and completion require a multi-faceted response. Effective management of persons at-risk requires caregivers to have a high level of skill in assessment and treatment of suicide ideation.

Intervention and postvention care is currently dispersed across several health care service providers. However, often those who attempt suicide have not attended any mental health service or seen a professional before their attempt[8]. A beneficial suicide prevention approach therefore also relies on many other agencies and organisations (e.g. homeless shelters, schools and colleges, workplaces, sports groups) who are more likely to come into contact with suicidal individuals[9]. Ultimately, informed, educated and supported caregivers across all levels, from government services to grass-root community members, is critical for suicide safer communities.

The Indigenous Network Suicide Intervention Skills Training project

The Indigenous Network Suicide Intervention Skills Training (INSIST) project, funded by the Australian National Health and Medical Research Council (NHMRC), aims to design, implement and evaluate a new multi-faceted, culturally-tailored gatekeeper training program for preventing suicide among Indigenous people, especially Indigenous youth. Evidence highlights the importance of a culturally-tailored gatekeeper training intervention program in preventing suicide among Indigenous peoples[10].

The first phase of the project involved extensive community based participatory research across various regional and rural areas of Southern Queensland. This paper reports the findings from consultations held with community members and key stakeholders for the purpose of identifying gaps in the current pathways for a person who has attempted, or may be at-risk of suicide.

Methods

Research approach

Community based participatory research (CBPR), a valuable research method especially for Indigenous communities[11,12] was conducted over a period of 18 months. Involvement of Indigenous researchers, and participation of Indigenous community members and organisations was critical to the study. The design and implementation of the research was conducted with strong community engagement and involvement at every step of the research process. Indigenous as well as non-Indigenous community members, stake-holders and service providers all played a key role in the community-engaged consultations. Consultations involved both one-on-one interviews as well as focus groups with larger groups of people. The research was carried out using informed guidelines[13] and further reported using standard methods[14]. Detailed participant demographics were not recorded to maintain confidentiality, however consultations were carried out with both non-Indigenous and Indigenous people, and people representative from all demographic backgrounds of the consultation

settings. The usual method of data collection by recording was not conducted due to the nature of the consultation topic, as well as keeping in mind the sensitivity and cultural appropriateness for the participants. Community concerns were prioritised and cultural sensitivity and relevance was maintained during the collaboration process due to the nature of the sensitive topic of discussion. The resulting outcomes of each consultation were interpreted and discussed with participants to ensure the validity of the generated outcomes.

Study sample

The research consultations were carried out across South-West, South-East, and Central Queensland towns and cities, covering Toowoomba, St George, Cunnamulla, Charleville, Warwick, Rockhampton, among others. Communities where Indigenous suicide prevalence was reportedly high, were visited by the research team and time was spent building rapport and getting to know the local community. Consultations were then arranged with interested participants. Frontline service providers were the first point of contact for consultation. Other consultations included those with local community members, health care service providers, volunteer workers, and key stakeholders. A total of 39 consultations with individuals and larger groups were conducted that ranged in duration from ten minutes to three hours. Consultations were both with individuals, and also with larger groups of people. Consultation outcomes were grouped into major themes and ranged across a broad spectrum of ideas and subject areas.

Data analysis

Questions explored the current pathway of someone who has attempted suicide, or may be at-risk. Examples included: “Can you please identify the way a person at risk is currently looked after, after he or she has attempted suicide?”, “Do you think that the current intervention methods used by caregivers is suitable for Indigenous people of your community?”, “Can you comment on the cultural appropriateness of current intervention methods or pathways?”, “What would be a better way to intervene or look after someone who has attempted suicide?”, “Can you identify some key items that should be incorporated into a suitable intervention pathway for your community?.”

On completion of each consultation session, interviewees and investigators identified significant ideas and observations fundamental to the consultation process. The consulted community members played a key role in checking the validity and relevance of the documented resulting outcomes and consultation themes. Indigenous communities and organisations were provided the opportunity to verify the data collected and ‘voice’ their concerns. Systematic, thematic analysis was then performed with the information gained. Quality analysis assessment[13,14] was conducted by the investigators to enhance and substantiate the analysis outcomes. The University of Queensland Human Research Ethics Committee approved the study (Approval #: 2015000662).

Results

Identifying the gaps

Participants identified that problems occur in the current suicide prevention pathway due to “service providers not knowing which interventions should be prioritised”. It was reported that the current system is “fragmented, with gaps in services in some areas, or individual programs working in parallel”. This causes people “to fall through the ‘gaps’ between services and in some cases restricts access to appropriate services”. Participants noted that “sometimes it’s just a person having a bad day and the services need to know how to tell what kind of help the person needs.” Participants also reported how service providers don’t have culturally appropriate training in dealing with someone at-risk or who may have attempted suicide.

In rural Queensland, the current pathway relies on the police force to intervene when someone attempts or is at-risk of suicide; the individual is then transferred to the closest hospital Emergency Department, sometimes up to 700km away, often handcuffed and escorted in the back of a Police van. It was suggested that "this extreme intervention often deters families and friends from contacting the Police if subsequent suicide attempts occur." Participants indicated that "sometimes the person just needs someone understanding and supportive to talk to" and the current stigma of suicide within communities deters people seeking appropriate help. One comment made was that "there's nobody to turn to and nobody is taking responsibility to make it happen (prevention)" [sic].

A lack of time and resources for front-line service providers that provide services related to suicide prevention services was also identified in the majority of consultations. Due to this issue, participant indicated that current front-line, and other service providers are not trained properly to "deal with the situation like community needs [sic]."

Access to care

A major theme that emerged from all consultations was that of access to appropriate care for suicidal ideation, intervention, and post-attempt. Participants identified that often the people that require care and support don't seek help for suicide related concerns. Participants recorded a variety of reasons for their reluctance to engage with existing services, including current misconceptions about service providers ("authorities"), "fear of being charged or incarcerated", lack of trust in services, and being judged "as soon as they walk in the door" [sic]. There was also a lack of education and knowledge in regional communities of the types of resources and services available for them, despite the resources and services being minimal. This was identified as resulting from a lack of integration and collaboration between and within services.

Participants elaborated that due to factions within both communities and services, sometimes a "person does not get the care or help they need in time". The consultations also recognised that general practitioners and front-line service providers often lack the training and experience needed to identify and treat acute mental health conditions and identify those at risk of suicide. Getting treatment in a timely fashion and availability of these services also results in failure to identify at-risk individuals; "where do we go if it's the middle of the night or on a weekend to get good help?" [sic]. Community members indicated that there is a dire need for these services to be trained in "Indigenous culture and healing to help the people who are thinking of suicide".

Lack of information flow

Another important theme that emerged from the consultations was the lack of current accurate reliable information about suicide attempts or completions. Communities often reported suicide rates that were not indicative of nationally reported rates. A lack of information flow between services was identified. The idea that the suicide prevention pathway is not systematic, or elaborate enough was discussed. Participants acknowledged that due to a lack of communication between services, the current pathway faces many challenges, including individuals "falling through the cracks". Service providers in these regions acknowledged a more connected, step-wise pathway approach would be more beneficial where "they let each other know what's happening about a person and the person is taken care of wherever they go".

Communication and information sharing between Indigenous and non-Indigenous community members was also identified as an area of concern when it comes to preventing suicide. Community members recommended that involving Indigenous community members at each step of the prevention pathway would be beneficial. Using language and communication styles that are more appropriate,

e.g. “not being well” or “not looking too good” instead of ‘having a mental illnesses”, would also be constructive. Providing community ownership of local prevention activities and initiatives, instead of “telling them what to do” could also be advantageous within local suicide prevention programs. Consultations identified that when an individual has suicide ideation or is at-risk of self-harm, involving family, considering the location, being aware of cultural and gender differences is of utmost importance in order to provide appropriate and effective interventions.

Post suicide-attempt care

Communities from all consultations, both rural and regional, ascertained that there is a lack of support, especially for Indigenous youth, after a suicide attempt. Participants acknowledged that after a suicide attempt, the individual at-risk comes back to the same environment in which a suicide attempt was made, and this causes the same issues leading to ideation to take place again. Community members highlighted that there needs to be more support and activities specifically tailored for those who have survived a suicide attempt. Service providers highlighted that a change of environment, a change in routine, or “something else to look forward to” is essential to diminish subsequent suicide ideation. There was a general consensus that even though jobs and opportunities for youth were scarce in rural regions, “just having sports to play or going on a trip”, or “learning something new” would help individuals who have attempted suicide. Participants indicated that the families and friends “need to take care of the person and keep them busy and think of other things [sic]” after a suicide attempt.

Discussion

The occurrence of a suicide in a community is difficult to predict. From our consultations we have been able to identify possible strategies that may lead to its effective prevention. Firstly, communities largely indicated that despite the gaps, until the communities themselves start to take action and play a role in prevention, desirable outcomes will be hard to achieve. Changing the norm, and eradicating the stigma surrounding suicide is imperative. A need for improved education and knowledge of services, and training programs, not just within their own communities, but also across other communities, has been substantiated. Communities who collaboratively become involved in suicide prevention activities and make efforts to initiate, support and run programs can ultimately benefit in reduced suicide rates[15]. Intervention strategies with high levels of local Indigenous community involvement are the most effective[16] but also require communities to become self-sufficient and able to both recognise risk factors and implement early intervention. Providing culturally appropriate suicide intervention training to those who are in frequent contact with youth and people at-risk, e.g. front-line responders, health-care workers, local youth groups and clubs, homeless shelters, and to teachers and school leaders, also emerged as a more effective method to identify and assess those at risk.

There is also a current gap in communication between services and access to information. Identifying services that are helping individuals cannot be achieved unless systems are routinely linked to patient care history with suicide ideation, attempt or fatality outcomes. Synchronised involvement from all levels of the healthcare system is required[17]. Despite this gap, communities indicated that the first point of call for someone at-risk is usually close family or friends. Providing suicide prevention training to Indigenous families, local Elders, and key community leaders, will be beneficial in identifying individuals with ideation or those at-risk. These community members can also play a role in providing appropriate care and support after a suicide attempt by connecting with service providers. Studies

have shown how local community teams can assist in providing appropriate support and follow-up to assist in the suicide prevention pathway[18].

Lastly, participants identified that it was crucial to provide appropriate follow-up care after a suicide attempt, in order to prevent further suicide ideation or risk. It was acknowledged that small, rural communities cannot bring about change in the current environment where suicide ideation is often higher, unless improved engagement with high-risk populations (e.g. schools, sports groups, treatment centres) is instigated. Postvention strategies can include the development of community response plans and support networks[19], increased awareness and skills training[20], counselling, screening high-risk individuals, promotion of healthy lifestyles, and responsible media reporting[21].

Doing more to promote what works for Indigenous communities, and encouraging conversation to remove the stigma of suicide is essential in order to reduce suicide rates. With innovation through technology, improved coordination and collaboration of services, and increased awareness within local communities, the wellbeing of whole communities can be achieved.

Conclusion

Years of suicide prevention research and program implementations have not yet led to a complete, highly effective, evidence-based approach to suicide prevention[22]. Evaluations of current pathways indicate that an Indigenous community-led approach is essential to encourage connectedness and prevent suicide. Years of suicide prevention research and Western-based, isolated program implementations have not yet led to a holistic, effective, evidence-based approach to suicide prevention. To overcome existing barriers and close gaps in current prevention pathways, evidence suggests an Indigenous community-led approach is essential to the development of an effective suicide prevention training program. Future research should focus on providing culturally appropriate, sustainable and collaborative skills training to Indigenous communities which is more likely to reduce the occurrence of suicide.

Competing interests

The authors declare that they have no competing interests.

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Presenter

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