Suicide prevention in Aboriginal communities: application of community gatekeeper training

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Abstract

Objective: Concern over the high rate of suicide among Aboriginal people on the south coast of NSW led to the development of a project aimed at preventing youth suicide in the Aboriginal communities of the Shoalhaven. This paper describes the development, implementation and evaluation of the project.

Method: Following extensive consultation with the Aboriginal community, a range of culturally appropriate interventions were developed. The main focus was a series of community gatekeeper training workshops, which aimed to increase the potential of members of the Aboriginal community to identify and support people at risk of suicide and to facilitate their access to helping services.

Results: Evaluation of the workshops demonstrated an increase in participants' knowledge about suicide, greater confidence in identification of people who are suicidal, and high levels of intentions to provide help. Attitudes, subjective norms and barriers predicted intentions to help.

Conclusions: The project indicated community members could be successfully trained in the recognition of individuals at risk of suicidal behaviour. Gatekeepers' attitudes and perceived barriers to helping predicted intentions to help those in need. There is a need for longer-term follow-up to assess the extent to which new knowledge and skills are used in practice.

Implications: Suicide awareness and skills training have been demonstrated to be an effective early intervention strategy. Gatekeeper training empowers Aboriginal communities and is generally accepted. There is demand for such programs outside the Shoalhaven. The project has a methodological framework that can be easily adapted by other communities.

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The Shoalhaven region has the seventh-highest population of Aboriginal and Torres Strait Islanders in New South Wales, representing 3.3% (2,491) of all Shoalhaven residents.[1] During the period from 1989 to 1996, the hospitalisation rate in the Shoalhaven for attempted suicide among Aboriginal people was 9% (61).[2] The crude average annual hospitalisation rate for attempted suicide among Aboriginal people (502 per 100,000) is more than four times higher than in the non-Aboriginal population (119 per 100,000) in the Shoalhaven area. One of the most significant positive predictors of a further suicide attempt after an initial presentation is being of Aboriginal or Torres Strait Islander background. In the Shoalhaven the suicide rate for Aboriginal people was approximately 22 per 100,000 population per annum, significantly higher than the non-Aboriginal population (13 per 100,000 per year) for the same period of time.[2]

It is self evident that the suicide rates are disproportionably high. Suicide is associated with depression and high levels of psychological distress. However, few people seek help when psychologically distressed. A recent Australian national survey of more than 10,600 persons found that, while more than one in five adults meet the criteria for a mental health disorder, 62% do not seek any professional help.[3] Evidence[4] suggests the process leading to suicide is not an impulsive act but the end point in a pathological regression, "a continuum beginning with ideation, continuing to attempted suicide, and ending with completed suicide".[5] Consequently, people displaying suicidal symptoms who do not seek and receive appropriate treatment or advice are at high risk for suicide completion.[6] In contrast, people who receive appropriate help and advice when suicidal are likely to reduce their level of risk and distress.[7] In the Shoalhaven the most significant negative predictor of a further suicide attempt for Aboriginal people aged 15-29 years attending an emergency department for first attempt presentation was having a referral for follow-up and the patient being seen by the mental health team.[2] Help seeking and facilitating appropriate help seeking has been shown to be an effective preventative strategy.

In order to address these problems, an early intervention program was undertaken in collaboration with the Shoalhaven Mental Health Service, University of Wollongong and the Shoalhaven Aboriginal community. In the initial stages, community consultation was conducted through a series of discussion groups[8] to identify factors associated with suicide in the local area, barriers to help-seeking, and how information on suicide prevention could be disseminated within the Aboriginal community. Feedback from the discussion groups was used to inform the design of a series of community gatekeeper training workshops. Of particular concern were attitudes and beliefs suggesting it was not anyone else's business if someone wanted to kill themselves. Community gatekeeper training focuses on identifying key people in the community who have contact with youth and training them to recognise a person at risk of suicide, and to facilitate an appropriate referral to professional helping resources.[9-11]

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The Institute of Medicine (IOM)[12] model identifies different levels of suicide prevention according to the level of disorder/distress in various populations targeted.[13] It incorporates universal interventions that target whole populations at average risk, selected interventions that target groups at increased risk, and indicated interventions that target individuals at highest risk. Community gatekeeper training has been classified according to the IOM as "indicated/early intervention".[13]

Although gatekeepers and gatekeeper training has been utilised for the past 20 years as a strategy for identification and early intervention in the prevention of suicide, a review of gatekeeper programs in Australia found few were evaluated and those that were usually focused on participant satisfaction surveys.[9] Furthermore, it appears that very few, if any, gatekeeper programs have been implemented in Aboriginal communities.

The evaluation of the gatekeeper training in the present project was an integral part of program planning and incorporated both qualitative and quantitative measures to evaluate process and outcome. The evaluation examines community attitudes towards suicide and comparisons are made between Aboriginal participants and non-Aboriginal groups from other studies. Participants were also asked to rate a range of potential barriers to seeking or supporting professional help seeking for those in need. Changes in participants' knowledge about suicide, confidence in identifying people who are suicidal, intentions to seek help, and intentions to refer those in need of help to the mental health service were assessed. The evaluation also provides a preliminary test of the utility of the Theory of Planned Behaviour[14] to explain and predict intentions to help.

Method

Gatekeeper training program

The first stage of the project involved extensive consultation with young Aboriginal people and local community groups. The purpose was to obtain advice and information on appropriate suicide prevention strategies for their community. Eleven discussion groups were attended by 110 participants, of which 97 were from the local Aboriginal community. To ensure information was obtained from a broad cross-section of geographical, age and community representation, the following groups participated: Jerringa Aboriginal Community; Nowra Department of Community Services; Nowra Police; Nowra Aboriginal Youth Touch Footie Team; Aboriginal Education Assistants; Wreck Bay Aboriginal Community; Women's Support Group; Oolong House (residential alcohol and drug treatment centre); Dharawal Aboriginal Community; Elders Group; and Gerringong Aboriginal Touch Footie Team. The information obtained from the discussion groups provided the basis upon which the project team developed the interventions and resources.[8]

These discussion groups were also crucial from a evaluation perspective as they provided informal feedback on the knowledge level about suicide in the community, attitudes towards suicide, and the barriers that prevented people from seeking or offering help.

The second stage of the project, which is the focus of this paper, involved the development and implementation of community gatekeeper training. Eight free one-day workshops were held in Nowra and the small, isolated Aboriginal communities of Wreck Bay and Jerringa. Although other activities were carried out, this was the main focus of the project evaluation.

The aim of the workshops was to increase the ability of the local community to identify individuals at risk of suicide, mobilise local informal helping networks and, where necessary, facilitate help-seeking behaviour. It became evident following consultation with the community that in some cases the informal community support networks were not well formulated or clearly identifiable. The workshops endeavoured to provide clarification of these resources and to also identify key individuals in the community who are willing to be a point of contact for people at risk for suicide.

By increasing knowledge about suicide, increasing early identification of suicidal behaviours, establishing ways to help when someone is suicidal, increasing individual confidence and willingness to help when someone is identified as suicidal, clarifying sources of help and how to successfully gain access to them (e.g. overcoming potential barriers to help seeking, etc), it was felt that the community would be better prepared and capable of helping youth at risk of suicide.

The structure as well as the content of the workshop and the resource manual[15] were designed to include information identified by the discussion groups. This included local statistics, risk factors for Aboriginal people and stressors within the Aboriginal community associated with suicide. The components emphasised at each workshop were determined by the specific need of the group. For example, workshops targeting health workers included information on legal issues such as duty of care, confidentiality and assessment skills, whereas the general community required training on awareness of suicide including warning signs, communication and listening skills, how to respond to someone at risk, and how to make an appropriate referral. Because the number of participants was usually fewer than 10, this allowed for a variety of teaching methods including role-play and small group work. An important component of the workshops was to have the coordinator of the Shoalhaven Mental Health Service discuss the service, address questions, and explain the role of the mental health team and its place in suicide prevention and intervention. The content of the workshops and the resource manual utilised both recent published resources and information from the local discussion groups.

The content covered in the workshops was delivered flexibly, dependent on participants' level of experience and knowledge. The following information usually included: myths and facts; attitudes and beliefs; statistics (local and national); stressors (including local perspective); risk assessment (including local perspective); warning signs; communication skills; how to help (including helping hand cards, and local contact numbers); personal and community support networks; referral strategies and information; confidentiality; and duty of care.

The workshops also introduced participants to the use of individualised 'survival maps' that identified personal resources and support networks of each participant.[8]

Participants

Participants targeted were members of the Shoalhaven Aboriginal communities and workers from the Shoalhaven Aboriginal Interagency Network (ie. Aboriginal health workers, youth workers, Aboriginal education assistants). Community members and workers were recruited by personal invitation, word of mouth, hand-delivered fliers, and posters promoting the workshops at community centres. The personal invitation was extended by the Shoalhaven Aboriginal suicide prevention/education officer at the Aboriginal Interagency monthly meeting.

Participation was entirely voluntary. Those who attended the workshops were invited to take part in the evaluation. Fifty-seven people attended the workshops and fifty-three (93%) agreed to participate in the evaluation. Although the workshops targeted Aboriginal people, nine (16%) non-Aboriginal people attended the workshops. Of the 48 Aboriginal people who attended, 44 (92%) consented to participate in the evaluation. For the purpose of this evaluation, only the Aboriginal participants are included in the analysis. The mean age of participants was 36 (SD=11 years) and the range was 19 to 55 years. Ninety-one per cent (40) were female and nine per cent (four) male.

Of the participants, 18 (41%) were members of the general community, 20 (46%) were professionals including Aboriginal education assistants, drug and alcohol workers, youth and health workers, and six (13%) were TAFE students.

Measures

Suicide Opinion Questionnaire

Items from the Suicide Opinion Questionnaire[15] were used to measure aspects of attitudes towards suicide based on key issues raised in the discussion groups. The SOQ has been used both in Australia and internationally to examine attitudes within and between different groups and cultures.[16-21] The SOQ consists of 100 items that cover a wide range of attitudes towards suicide.

For the purpose of this evaluation, only eight items were selected from the standard 100 items. Community reluctance to answer long questionnaires necessitated reducing the standard measure. Six items were selected relating to the notion that suicide is both "acceptable and normal", and two questions on 'lethality', which assessed the attitude that suicide goes beyond a mere 'cry for help'. Items from this measure were included because of concern from the discussion groups that some members may have viewed suicide as an acceptable means of resolving problems. Others had expressed reluctance to help someone who was suicidal because "it's none of my business" or the belief that "there was nothing you could do to help". Each item was rated on a five-point Likert scale from t 'strongly agree' to 1 'strongly disagree'. The 'acceptability and normality' subscale is the most factorially robust in the SOQ.[22] Of the original 16 items from this subscale, six were selected based on either high eigen values (>0.7), or being identified during discussion groups as strongly help beliefs or attitudes (e.g. suicide is an acceptable means to end incurable illness). Items from the SOQ were also selected because this permitted the results to be compared with previously collected Australian university student norms.[17]

Knowledge

Knowledge about suicide was measured by 10 items based on common misconceptions and facts about suicide. Eight of the items were adapted from Kirk, Health Department of Western Australia, and New South Wales Department of Health.[23-25] Due to concerns about the reading difficulty, minor modifications were made to the questions to simplify the language (e.g. replacing "Talking openly with individuals about suicide will increase the risk of suicide" with "Talking about suicide will make people want to do it"). The remaining two items consisted of misconceptions that were repeated frequently by community members attending the discussion groups (e.g. beliefs that mental health workers were not trained in suicide prevention). All items had 'true', 'false' or 'don't know' response options.

Constructs pertaining to the Theory of Planned Behaviour

In the Theory of Planned Behaviour,[14] intentions are predicted by attitudes, subjective norms and perceived behavioural control. In turn, intentions are theorised to be the immediate precursor to actual behaviour. Items for each of the measures were constructed following procedures recommended by Ajzen and Fishbein.[26]

The need to limit the number of items resulted in assessment of general components of attitude and subjective norms, but more specific components of perceived behavioural control (PBC). Perceived behavioural control incorporates barriers to behaviour as part of its definition. For the purpose of the present project, barriers were used to capture aspects of PBC. Barriers received additional attention because of evaluative data obtained from the discussion groups where concerns about a range of barriers were identified by participants.

Attitudes to help seeking were measured using four evaluative semantic differential items with seven points between the anchors. These were rated in response to the prompt, "For me to seek help for someone else who is suicidal is:" (e.g. harmful to beneficial). Scores on the four items were summed to provide a total attitude score.[26]

Subjective norms were assessed using two items rated on seven-point Likert scales. The first question, "Most people who are important to me would think I should seek help for someone who is suicidal", was rated from 1 'strongly disagree' to 7 'strongly agree'. The response to the second question, "Generally, I want to do what most people who are important to me think I should do", was rated from 1 'not at all' to 7 'very much'. Responses to both questions were multiplied to form the score for subjective norms.[26]

Barriers (PBC) were measured by six questions relating to a

Table 1: Comparison of Shoalhaven Aboriginal community sample and Australian university student sample on 'acceptability and normality' items from the Suicide Opinion Questionnaire (SOQ).

	Shoalhaven Aboriginal community			Australian university students (Domino, Niles & Raj, 1993)		
Factor	Mean	SD	n	Mean	SD	n
Acceptability and normality (six items)	2.31	0.74	44	2.96	0.64	82

Notes:
The response scale assigns 5 'strongly agree' to 1 'strongly disagree'. The lower the mean score the less acceptance of suicide.

variety of internal and external control factors. Four items were developed from the discussion groups that assessed the possible problems or obstacles that prevented participants from seeking or offering help for someone who was suicidal. They related to issues of confidentiality, trust and privacy (e.g. "Kooris keep things to themselves rather than talking about it."). A further two non-specific barrier items were included (e.g. "There is nothing to stop me from obtaining help for someone who is suicidal"). All items were rated on a Likert scale from 1 'strongly disagree' to 7 'strongly agree'. Items were summed to form a total barrier score.

Intentions were measured by two questions. The first was a broad measure of 'intentions to help' and the second measured 'intentions to refer to the mental health service'. The score from the former question provided a general measure of help seeking intentions for testing the Theory of Planned Behaviour constructs. The questions were measured on a Likert scale with participants rating their responses from 1 'extremely unlikely' to 7 'extremely likely'. These items followed the same structure as those used in previous research assessing help seeking intentions.[27-29]

Confidence to identify a person at-risk for suicide was measured by one item and scored on a Likert scale from 1 'not at all confident' to 7 'very confident'.

Procedure

Development of questionnaires

The content of the questionnaires were reviewed and developed in consultation with the Aboriginal suicide education/prevention officer and the Shoalhaven Aboriginal Advisory Group. In planning the evaluation, it was necessary to incorporate feedback indicating that Aboriginal communities were "sick of doing long questionnaires". There were reports of a number of examples where researchers had simply handed out questionnaires that were subsequently not completed. Thus, a very conservative approach was taken in order to minimise demand on participants. In any single administration block the number of items was restricted to 10 or less. Some components were assessed once (SOQ, TPB variables) and others were repeated (knowledge, intentions and confidence) to evaluate change. To ensure a seamless evaluation, the items were integrated into the goals of the workshop and administered in a sequential manner. Used in this way, the questions stimulated group discussion and were seen as relevant to the participants. The questionnaires were administered by a member of community who was trained and funded by the project. To allow for any problems with literacy, the questionnaires were put on overhead transparencies and read out to participants. The language and cultural appropriateness was assessed by the Aboriginal members of the project team, followed by the Shoalhaven Aboriginal Mental Health Advisory Group.

The research received ethical review and approval from the Wollongong University Human Ethics Committee.

Results

Sample sizes vary for some analyses due to small amounts of missing data on some variables.

Suicide Opinion Questionnaire

Table 1 shows the means and standard deviations for comparison between Aboriginal and university student samples. The results indicate there is very little difference between groups and both generally view suicide as *not* acceptable or normal behaviour.

Repeat measures of knowledge, intentions and confidence

Paired sample t-tests were performed to assess whether change occurred in areas of knowledge, intentions to help, intentions to refer to the mental health service, and confidence in identifying a suicidal person. Table 2 presents the results.

The results on knowledge show a significant increase in the number of true/false items answered in the keyed direction from Time 1 to Time 2 (i.e. over the course of the workshop), $t(40)=-7.05$, $p<0.001$ (two-tailed, $n=41$). For confidence, there was a significant increase over time, $t(39)=-1.77$, $p<0.05$ (two-tailed, n=39). There was no significant change in intentions to help from Time 1 to Time 2. In contrast, the likelihood ratings of "intentions to refer to the mental health service" decreased significantly from Time 1 to Time 2, $t(39)=2.11$, $p<0.05$ (two-tailed, n=40). A reduction in intentions to refer to the mental health centre was an unexpected finding, therefore an attempt was made to explore what may have contributed to this finding by conducting *post hoc* analyses.

Self-determination has been a strong political agenda for many Aboriginal communities.[30,31] We speculated that as the confidence of members of the Aboriginal community increased, so too did their beliefs that they may be more able to help people who were suicidal within their own community networks. Thus, they may be less likely to refer to the mental health centre because they are more confident of managing those individuals themselves. Support for this hypothesis would be present if changes in confi-

Table 2: Means and standard deviations for comparisons between repeat measures.

		Time 1		Time 2	
Measures	**N**	**M**	**SD**	**M**	**SD**
Knowledge	41	5.59	1.84	7.59	1.79[b]
Intentions to help	40	6.58	0.78	6.50	0.85
Intentions to refer to MHS	40	6.50	0.91	6.13	1.24[a]
Confidence to ID suicide risk	39	4.87	1.88	5.44	1.57[a]

Notes:
(a) p<0.05
(b) p<0.001
Knowledge scale maximum score = 10; Intentions scales ranged from 1 'Extremely unlikely' to 7 'Extremely likely'; Confidence scale ranged from 1 'Not at all confident' to 7 'Very confident'.

dence, specifically an increase in confidence represented by the difference between Time 1 and Time 2, were negatively correlated with changes in intentions to refer to the mental health centre. Similarly, there should be a positive correlation between increased confidence and intentions to help.

To explore the relationship between intentions and confidence, Pearsons correlation coefficients were calculated using the mean difference score (Time 1 to Time 2) for the confidence and intention measures. The results show a negative but non-significant correlation (r=-0.21) between changes in confidence and intentions to refer to the mental health service. In contrast, there was a positive correlation (r=0.13) between increased confidence and increased intentions to help (also not significant).

Predicting intentions

To determine the predictors of help seeking intentions, standard multiple regression analyses was completed. Table 3 provides the correlation matrix and regression coefficients for predicting intentions to help someone who is suicidal. The likelihood of seeking help for somebody who was suicidal was the dependent variable, with attitudes, subjective norms, and barriers as the independent variables. These variables produced a significant regression coefficient and together accounted for 37% of the variance in intentions ratings, $F(3,38)=7.29$, $p=0.001$. Both attitudes (standardised Beta=0.43, t=3.01, p=0.005) and barriers (standardised Beta=-0.28, t= -2.05, p<0.05) were unique significant predictors of help seeking intentions. Positive attitudes to seeking help were associated with higher help seeking intentions. Barriers were negatively related to intentions. As perceived barriers increased, intentions to help decreased.

Barriers generated from the discussion groups concerning issues of trust, privacy and confidentiality were perceived as being major obstacles preventing people from seeking or offering help. A detailed description of the barriers is provided in the report to the NSW Centre for Mental Health.[32]

Discussion

The results from the SOQ suggested that in the Aboriginal sample, suicide was not considered normal or acceptable behaviour. This is not surprising, as the people who attended the workshop were self-selected and highly motivated to prevent suicide in their community. At a descriptive level, the acceptability of suicide does not appear any greater in this Aboriginal sample when compared with an Australian university sample.[18] However, considerable caution is needed before attempting to generalise these findings to the wider Shoalhaven Aboriginal community. An examination of the discussion group transcripts painted a very different picture of attitudes. The following comments came from discussions with young Aboriginal men: "You know that's their business. If you want to die that is their business, it is their life", "... he just hung there. I just sat there right through it".

It is reasonable to say that there is a diverse range of attitudes related to suicide among members of the Aboriginal community. There is a need for a more detailed and comprehensive examination of a broad cross-section of the Aboriginal community to obtain a more complete assessment of attitudes. There is also a lack of data on differing cultural constructions and understandings of suicide and future research should more comprehensively address these.[33]

There was a significant increase in knowledge over the course

Table 3: Standard multiple regression of predictor variables on intentions to help.

Variables	**2**	**3**	**4**	**M**	**SD**	**Beta**
1. Intentions to help	0.54[b]	0.22	-0.36[b]	6.55	0.80	
2. Attitudes		0.29[a]	-0.25	6.33	1.13	0.43[b]
3. Subjective norms			0.18	32.88	15.73	0.15
4. Barriers/PBC				3.47	1.10	-0.28[a]

Notes:
(a) p<0.05.
(b) p<0.01.
r^2=0.37, adjusted r^2=0.32, r=0.60, n=42
Listwise deletion was used resulting in some missing data for this analysis.

of the workshops. The finding that knowledge increased was similar to the outcomes from other gatekeeper training programs.[34-36] However, the increase in knowledge may only be short term and long-term follow-up would be necessary to examine whether this information is retained.

It is also relevant to comment on two statements where the correctness of the keyed response could be questioned. For example, the item, "Mental health workers are trained in helping people who are suicidal" (keyed, "true") is arguable. Bognar and Harmatz[37] reviewed the clinical psychology programs in the United States and found only 40% offered formal training in the study of suicide. It was evident from the discussion groups that people did not think mental health workers were trained in suicide prevention. It is important that the community is made aware of the various roles of mental health workers as this is often the only crisis service available. The second statement concerns the debate over whether suicide is a mental health issue or not. This issue had been raised during the discussion groups. For example, one participant made the following comment, "Well, you're not always mental if you try to suicide are you?" Once again this is debated in the literature with some suicide prevention programs deliberately de-emphasising the link between mental illness and suicide. Garland and Zigler[38] suggested that attempting to destigmatise suicide can result in "normalising the behaviour and reducing potentially protective taboos" (p. 174). Other groups argue suicide is a reflection of social issues.

Both these statements generated helpful discussion in the workshops, but it was important to clearly identify local mental health services as appropriate sources of help for suicidal individuals.

There was also a significant increase in confidence in identifying individuals who were suicidal. Increases in knowledge and confidence do not guarantee improved skills. Future research should begin assessing skill acquisition. One possible measure in the future would be Neimeyer and MacInnes[39] 25-item Suicide Intervention Response Inventory. This would better show whether skills training is effective when dealing sensitively with suicidal persons.

There was no increase in intentions to help someone displaying suicidal behaviour, but these intentions remained extremely high both at Time 1 (M=6.58, out of a maximum 7) and at Time 2 (M=6.50). Such high baseline levels of helping intentions were most likely a function of a highly motivated sample. This finding is consistent with other gatekeeper programs, which did not show expected gains in knowledge, and this was attributed to participants' high levels of pre-existing knowledge.[40]

The likelihood rating of "intentions to refer to the mental health service" decreased significantly from Time 1 to Time 2. This was an unexpected finding but may also be attributed to very high levels of baseline intentions and possibly regression to the mean.

However, to further explore this finding the relationship between changes in intentions ("intentions to help", and "intentions to refer to MHS") and confidence was examined. The results showed a positive relationship (r=0.13) between changes in confidence and intentions to help. In contrast, there was a negative correlation (r=-0.21) between changes in confidence and intentions to refer to the mental health centre. As confidence increased, intentions to refer to the mental health centre decreased. These findings are highly speculative because the correlation coefficients were not significant. However, they are intuitively consistent and are presented as a cautionary consideration for those using such training in the future.

A further explanation for these findings requires an understanding of the history and relationship between the Aboriginal community and mental health services. From the discussion groups, it was evident people had a reluctance to use the mental health service. There was a perception that non-Aboriginal mental health workers would not understand the experiences of an Aboriginal person. Furthermore, the community was suspicious of mental health services. Combined with a strong political agenda of self-determination it is possible that training may empower Aboriginal people to use their own available helping resources, rather than calling for outside help.

The Theory of Planned Behaviour[14] was used to help determine the factors most important in the prediction of people's willingness to help. Attitudes, subjective norms and barriers explained 37% of the variability in intentions. This finding is similar to prior studies examining help seeking intentions.[27,28] Both attitudes and barriers were unique predictors of intentions.

The discussion groups and workshops provided an ideal opportunity to obtain qualitative data regarding attitudes and barriers. Barriers concerning privacy, confidentiality and trust were described as major obstacles preventing people from help seeking. Privacy issues concerned a blurring of professional and personal roles associated with small communities. It was not clear whether there is a general reluctance to discuss personal problems within the community or whether it was specific to suicide. It was reported that some Shoalhaven Aboriginal families have experienced suicide of more than one family member and have refused help from outside agencies. The workshops aimed to assist in breaking this cycle of avoidance and to facilitate help seeking. One participant said, "If you can influence one person in the family they can open the door [to help]".

On the other hand, it may be that they do not have the traditional source of help wisdom, or structure previously provided by elders. For example, one participant made the following comment, "Previously, elders were there to go to, [people] took notice of them, [it] still does take place, but not enough". One of the participants has been referred to as an "elder" but she was reluctant to accept this role, because she felt "too young". Another important consideration is that Aboriginal people are not getting "old". High death rates in younger and middle Aboriginal adult life, with a life span some 20 years shorter compared with non-Aboriginal Australians,[41] has resulted in fewer elders.

It may be that further research is needed to help identify which specific attitudes and barriers have the strongest influence on preventing people from seeking help for someone who is suicidal. The Theory of Planned Behaviour provides a promising start to this process and an additional step will be to examine the extent

to which intentions predict actual helping behaviours.

Furthermore, there is a need to evaluate the long-term effectiveness of sustained community gatekeeper training in Aboriginal communities. For example, the evaluation process should assess how many participants identified and tried to facilitate help seeking for someone who was at risk of suicide. Ideally, such evaluation should include whether there are increases in referral rates and engagement with mental health services or other helping resources (e.g. elders, community members, Aboriginal Medical Services).

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