

A Feasibility Study on Implementation of the Peer-Gatekeeper Program in Western Australian Secondary Schools

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Declaration

I declare that this Master of Arts in Community Development dissertation is my own work and has not been submitted in any form for another degree or diploma at any university or other institute of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references is given.

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Firstly, I would like to thank my family, Kenmei Shimanuki, Setsuko Shimanuki, Kentaro Shimanuki, and Kensuke Shimanuki, for their continuous support. Their support was essential for me to pursue my dreams, overcome difficult times, and reach this far.

A huge thank you to my partner, Brad Evans, for being there for the whole duration of time I was working on this thesis. You have always been the first person with whom I share laughs, fun, achievements and happiness, and also the first person from whom I seek support when things were difficult. Thank you for always being supportive and believing in me.

Thank you very much, Dr. Jeremy Northcote, for your supervision. Your advice, support, and wisdom were essential to complete this thesis. Thank you very much for helping me get through this journey.

For the 19-year-old boy who passed away on 31st October 2000.

Abstract

The present study examines the possibility of implementing a peer-gatekeeper program in Western Australian secondary schools by focusing on barriers for the process of implementation and effectiveness of those programs. The present research focuses on rural/remote areas of Western Australia, Indigenous communities, culturally and linguistically diverse (CALD) communities, school settings, issues around youth involvement, and limitations of gatekeeper programs to identify possible barriers. The study then identifies some strategies to remove those barriers. Suicide prevention strategies and those efforts in Western Australia require a human ecological approach which focuses on a variety of systems existing in complex society. As such, a peer-gatekeeper program should be considered as a part of multi-layered approach to tackling suicide issues.

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1. Introduction

Youth suicide is a tragedy that negatively influences family members, friends, and wider communities. The tragic loss of young lives may leave significant others wondering what they could have done to save those young lives from choosing to take their lives. A number of efforts have been made in Australia to prevent young people from committing suicide; however, there still is a need for more efforts to help young people who are living in misery and seeing suicide as the only 'solution' to end their pain. What else can be done to reduce youth suicide? The current research aims to examine the feasibility of implementing peer-based strategy as a complement to existing efforts in Western Australia to prevent and intervene into youth suicide.

1.1 Current Statistics

In 2012, there were 2,535 deaths identified as suicide in Australia, which is a suicide rate of 11.2 persons per 100,000 (ABS, 2014). Of those, 324 deaths, or 12.78 per cent, were suicides of young people aged between 15 and 24 years. The number of suicide deaths dramatically increases after 15 years of age (Pfeffer, 2001a). Between 2008 and 2012, the age-standardised rate among children aged between 5 and 15 were 0.4 per 100,000 in both male and female (Mindframe, 2014). The suicide rate is higher among males aged between 15 and 19 years (9.3 deaths per 100,000 versus 8.3 deaths per 100,000), and between 20 and 24 years (17.4 deaths per 100,000 versus 6.4 deaths per 100,000; ABS, 2014).

The suicide rate is particularly higher in the Indigenous population (see Table 1 presented below). According to the Australian Bureau of Statistics (ABS, 2010), in 2001-2010 the age-standardised suicide rate in the Indigenous population aged between 15 and 19 years and between 20 and 24 years was much higher than the non-Indigenous population in both genders. The suicide rate of Indigenous males aged between 15 and 19 years during the period was 43.4 deaths per 100,000 while the suicide rate of non-Indigenous males in this age group was 9.9 deaths

per 100,000. Indigenous females in this age group had higher suicide rate (18.7 deaths per 100,000) than the non-Indigenous counterparts (3.2 deaths per 100,000, ABS, 2010). The suicide rate of Indigenous people aged between 20 and 24 years (74.7 deaths per 100,000 among Indigenous males, and 21.8 deaths per 100,000 among Indigenous females) was also higher than the non-Indigenous population in the same age group (19.2 deaths per 100,000 among non-Indigenous males, and 4.0 deaths per 100,000 among non-Indigenous females).

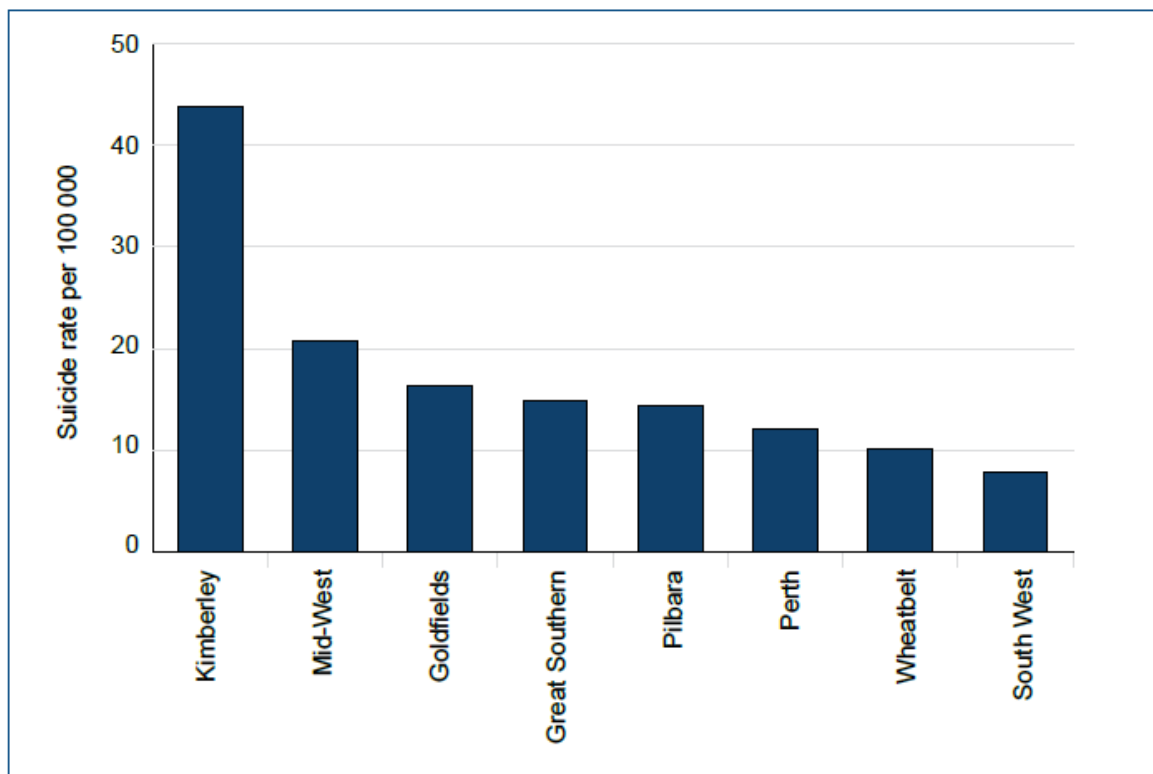
Table 1. Number of deaths and age-specific death rates by Indigenous status, sex, NSW, QLD, SA, NT, WA, 2001-2010 (ABS, 2010).

Age group (years)	Aboriginal and Torres Strait Islander		Non-Indigenous		Aboriginal and Torres Strait Islander		Non-Indigenous	
	Males	Females	Males	Females	Males	Females	Males	Females
	No.	No.	No.	No.	Rate(e)	Rate(e)	Rate(e)	Rate(e)
2001-2010								
15-19	106	43	483	148	43.4	18.7	9.9	3.2
20-24	148	42	967	196	74.7	21.8	19.2	4.0
25-29	147	30	1,056	254	90.8	18.1	22.1	5.4
30-34	120	22	1,288	300	75.0	13.1	25.0	5.8
35-39	88	25	1,307	343	60.1	15.7	25.4	6.6
40-44	57	11	1,340	354	44.7	7.9	25.2	6.6
45-49	27	8	1,196	344	25.5	7.1	23.3	6.6
50-54	15	5	960	315	18.3	5.6	20.3	6.6
55-59	8	—	720	241	13.6	—	16.2	5.5
60 and over	17	2	2,287	682	17.6	n.a	19.2	5.0
All ages(h)	748	198	11,633	3,189	33.0	8.7	16.5	4.5

In 2012, the suicide rate of Western Australia (14.8 per 100,000) was higher than national average (11.2 per 100,000) (the Office of the Auditor General Western Australia [OAG], 2014). The suicide rate in Western Australia has increased since 2006 (10.0 per 100,000; Department of Health, 2009). Suicide is one of the leading causes of death for people who are younger than 44 years of age in Western Australia, and the suicide rate is higher among people living in rural/remote areas (18.5 per 100,000 between 2006 and 2010; OAG, 2014) than that of Western Australia. The study conducted by Page, Morrel, Taylor, Dudley, and Carter (2007) which compared the suicide rates among metropolitan (capital cities and other metropolitan areas), rural (large and small rural centres and other rural areas), and remote (remote centre and other remote areas) regions found

that the suicide rate was particularly higher in remote areas (47.9 deaths per 100,000) than in rural areas (19.8 deaths per 100,000) and metropolitan areas (16.8 deaths per 100,000). The highest suicide rate was reported in Kimberley region (more than 40 per 100,000), followed by Mid-West and Goldfields, while the lowest suicide rate was reported in South West region (Figure 1). It is also reported that the suicide rate of Indigenous people in Kimberley region is seven times higher than that of non-Indigenous population (Victor, Victor & O'Reeri, 2009)

Figure 1. Average suicide rates per 100,000 in WA regions 2008-2012 (OAG, 2014).



It is important to note that those statistics may be underestimating the number of suicides, due to the difficulty in distinguishing accidents from suicides (Akiyama & Saito, 2002). Moreover, the statistical data do not reflect suicide attempts which 'fail'. It is estimated that as many as 30 failed attempts occur for every successful suicide (Lifeline, 2010).

1.2 Current efforts made in Western Australia

A variety of efforts on suicide prevention have been made by not-for-profit organisations in Western Australia. The Western Australian Suicide Prevention Strategy 2009-2013 (Department of Health, 2009) identified several higher risk groups in Western Australia, which include men, Indigenous Australians, migrants, people living in rural/remote communities, people who are in prison, people who are in contact with child protection or juvenile justice systems, people who have been exposed to suicide of family and/or friends, and same-sex attracted youth. The strategy, employing community development approach, aimed to promote a coordinated approach and collaboration of the government and communities, to build resilience in individuals and communities, improve the knowledge basis, target high risk groups, and implement standard and quality measures for suicide prevention strategies. The strategy sought collaboration from a range of non-government organisations in developing and carrying out innovative approaches to raise awareness, conducting research and evaluation, and providing education and training on suicide prevention in communities. The strategy also encouraged workplaces to build resilience in employees, and local agencies to identify and map existing efforts on suicide prevention and to promote new initiatives if needed. The Western Australian government has spent \$18 million on this strategy.

Those processes were reviewed by The Implementation and Initial Outcomes of the Suicide Prevention Strategy published by the OAG in May 2014. The report notes several benefits of the strategy, such as: de-stigmatisation of suicide and mental health issues; training that provided knowledge on how to deal with mental health issues; better understanding of suicide, warning signs and how to respond to those signs; and higher likelihood of help-seeking among people in need. However, the report also states that the strategy experienced difficulties in providing efficient services due to: inadequate planning; changes that were not communicated well; lack of guidance for funding proposal resulting in number of re-submission and delays which eventually caused loss of enthusiasm among community members; and lower likelihood of sustainability of the projects due to the limited capacity of the communities that participated in the strategy, such as lack of financial

resources, over-reliance on 'good-will' in communities, and lack of knowledge on how to make an sustainable impact on communities.

Based on the review of the strategy, the OAG recommends that future suicide prevention strategy should: 1) include more quantitative information together with qualitative information in order to measure the effectiveness of projects objectively; 2) develop a more collaborative implementation plan; 3) clarify the roles and responsibilities of each organisation/individual involved for better governance; and 4) collaborate with existing suicide prevention strategies rather than trying to implement a completely new project, as this will increase efficiency and probability of those efforts to be sustained.

In the Kimberley region, 'back-to-country' camps were held to provide culturally appropriate and safe places for Indigenous people to discuss mental health issues and suicide (OAG, 2014; Palmer, 2006; 2012). Walking in bush can physically isolate Indigenous youth from day-to-day issues while providing intimate time with other community members (Palmer, 2006). This process also gives voice to young people in their communities, and provides opportunities for young people to learn traditional Indigenous culture and their responsibilities in their communities (Palmer, 2006). People who participated in the camps stated that involvement of Indigenous people as central organisers of the activities was highly valuable, and that camps provided them with a place to discuss difficult issues more comfortably (OAG, 2014). In the same region, Beyond Blue has been collaborating with the Broom Saints Football Club to run a project called "Alive and Kicking Goals!" which aims to educate young male Indigenous people to be community gatekeepers (Tighe & McKay, 2012). The project has been successful in opening up discussions on suicide in their communities which can be a starting point for Indigenous youth to overcome the 'cycle of grief' as a result of multiple losses of people due to suicide (Tighe & McKay, 2012).

In the South-West region, the Understanding and Building Resilience Project has provided a multi-level suicide prevention in six communities (Jackson & Johns, 2009). The project provided: education for journalists on safe and sensitive reporting of suicide; a learning session on resilience building for community members; community gatekeeper training; and workshops to improve

accessibility of services for Gay, Lesbian, Bisexual, Transsexual, and Intersexual (GLBTI) communities.

Several not-for-profit organisations are providing state- or national-wide phone counselling services for those who are suffering from mental health issues and/or suicidal ideation or attempts, such as the Lifeline (2014), the Samaritans (2014), the MensLine Australia (2014), the Beyond Blue (2014) to name a few.

Those efforts have been made in school settings as well. For example, Mindmatters (SPA, 2010) is based in secondary school which promotes general psychological wellbeing. This approach includes training of school staff and provision of resources to promote an optimum environment for a whole school. KidsMatter is a similar program to Mindmatters which was implemented in 101 primary schools in 2007-2008 (SPA, 2010). The Youth Focus (2014) is currently running education program for high school students which aims to educate young people on symptoms of mental illness. The Samaritans (2014) is also running education program for wider community including schools to educate on warning signs, risk factors, and effective listening skills to support vulnerable individuals.

Youth Focus (2010) is currently running peer support program, which involves group work for individuals aged between 12 and 18 years who receive counselling services from the organisation. This program involves use of therapeutic, recreational and social activities which help youths improve their social and psychological wellbeing in peer environment. The peer support program is a self-help program which provides young people at risk of suicide with a place to meet with other young people who are experiencing similar issues (Sachmann, 2007). The program aims to assist young people to recognise that they are not the only ones who are struggling with their difficulties, and that support is available and positive change is possible (Sachmann, 2007). The organisation is also running a peer mentoring program, which involves training mentors (over 21 years of age) to act as positive role models for young people currently receiving counselling (Youth Focus, 2014).

The current suicide prevention efforts made in Western Australia are utilising a variety of

means, such as traditional activities, sports, and telecommunication technologies. Those efforts have been found effective in providing places for young people to discuss their difficulties. However, those programs have some limitations. Firstly, most of those programs are rather passive (i.e., not actively identifying young people who are at risk of suicide) and their effectiveness is dependant on willingness of at-risk youth to seek help. Secondly, the majority of suicide prevention programs in Western Australia do not involve young people themselves as active participants of suicide prevention strategies. Thirdly, most of the programs are located outside the schools, and accessibility of those programs is questioned especially among youth who do not have means of transportation. Fourthly, the current school-based programs in Western Australia are not focusing specifically on suicide, but rather on promotion of positive environments. However, suicide-specific strategies are required because prevention and intervention of suicide require suicide-specific skills (Stuart, Waalen & Haelstromm, 2003). Finally, suicide-specific programs which involve youth as active participants, such as suicide education programs, are provided by not-for-profit organisations and are not based in schools themselves, which means that even when young people are educated on how to identify and respond to their suicidal peers, they may not have good access to individuals who can provide supervision and support, and that availability of education programs can be influenced by a variety of factors such as lack of funding in schools and/or organisations, lack of availability of educators, and schedules of schools and organisations.

School-based peer-gatekeeper programs may overcome those limitations by educating young people on more proactive approaches for youth suicide (i.e., identifying and responding to suicidal peers), actively involving young people in suicide prevention strategies, increasing accessibility to suicide prevention program by implementing a suicide-specific program in school settings, and increasing availability of suicide education for students by implementing a suicide prevention program that is owned by and based in schools.

1.3 The Aim of This Research

The aim of this research is to investigate the possible barriers for implementing peer-gatekeeper program in Western Australian secondary schools. Using the peer-gatekeeper training logic model, this research aims to identify barriers for implementation and effective service delivery of school-based peer-gatekeeper program in the following five areas: rural/remote communities, Indigenous communities, Culturally and Linguistically Diverse (CALD) communities, secondary school settings, and youth involvement in suicide prevention strategy. This research then focuses on some limitations of gatekeeper programs and how peer-gatekeeper programs may be modified or collaborated with existing programs and/or some other strategies to maximise their effectiveness. Finally, this paper tries to identify some areas that require future research.

Based on the previous research, this paper suggests peer-gatekeeper program to be implemented in Western Australian secondary schools. Peer-gatekeeper programs have the potential to fill the gap between current efforts made in school settings to prevent and intervene into youth suicide by employing young people as active participants of the program, especially because youths at risk of suicide are more likely to be open and discuss their concerns with their peers than adults. Moreover, peer-gatekeeper programs can overcome problems such as the lack of time for staff training (SPA, 2010) and also, promote active participation of young people in the process of identifying and responding to their peers who are at risk for suicide. School-based programs also provide increased accessibility and availability of the service for secondary school students.

2. Previous Research on Suicide and Suicide Prevention Programs

2.1 Risk Factors

There are numbers of risk factors associated with suicide, and usually several risk factors co-exist to cause a suicidal behaviour (SPA, 2010). These factors can be classified into individual risk factors, social factors, and contextual factors (Table 2). Individual risk factors include mental illness, substance abuse, gender, previous suicide attempts, and self-harm. Social factors include childhood experience of trauma such as abuse, social exclusion, sexual assault, and family factors such as loss of parents and divorce. Contextual factors involve socio-economic status, rural environment, homelessness, being in prison or contact with police, and exposure to suicide. Pfeffer (2001a; 2001b) points out that availability of lethal method, neurological factors, and exposure to violence (i.e., witnessing violence) are also associated with higher rates of suicide.

Table 2. Youth Suicide Risk Factors.

Individual	Social	Contextual
Mental illness	Indigenous status	Rural and remote
Previous suicide attempt	GLBTI-identified	Socio-economic disadvantage
History of self-harm	Childhood adversities	Detention, contact with juvenile justice
Substance or alcohol abuse	Family dysfunction	Access to means of suicide
Physical ill-health	Restricted help-seeking	Homelessness
Male gender	Unemployment	Friends or family displaying suicidality

(SPA, 2010, p. 8)

2.2 Protective Factors

Protective factors that minimise the effect of suicide risk factors are shown below in Table 3 (SPA, 2010). The Suicide Prevention Australia argues that suicide prevention program should focus on fostering protective factors and mitigating risk factors simultaneously (SPA, 2010).

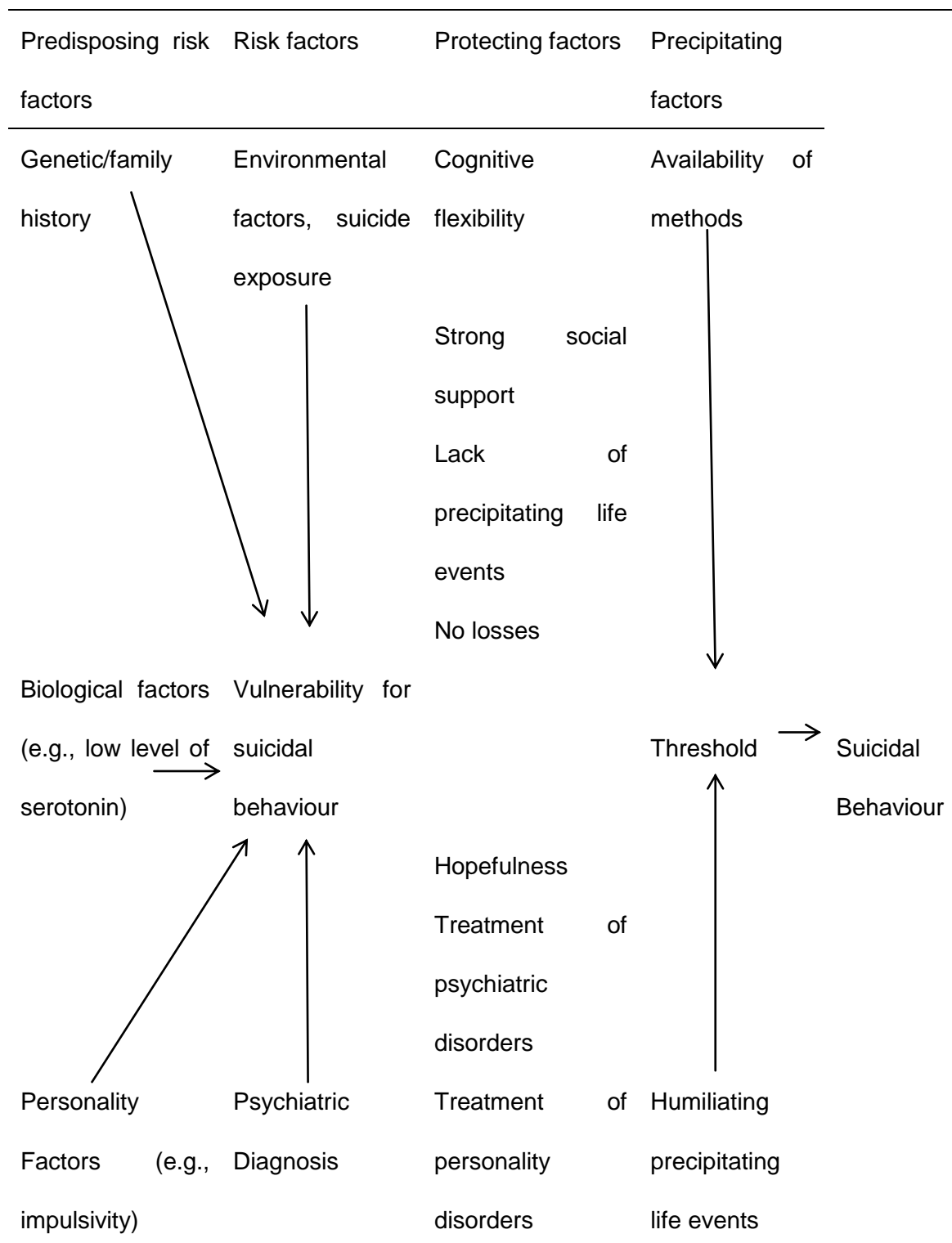
Table 3. Protective Factors.

Individual	Social	Contextual
Good coping skills	Family connectedness and support	Access to appropriate services
Personal resilience	Positive school environment	Economic security
Problem-solving skills	Social and community inclusion	Non-discriminatory environments
Optimism	Protection from adverse life events	Housing
Social and emotional wellbeing		
Ability and desire to seek help if necessary		

(SPA, 2010, p. 8)

Bulmental and Kupfer (1988, cited in Barlow and Durand, 2012) developed a threshold model for suicide behaviour. This model explains how different factors contribute to suicidal behaviours (Table 4).

Table 4. Threshold Model for Suicidal Behaviour.



(Bulmental & Kupfer, 1988; cited in Barlow and Durand, 2012, p. 252)

Of those risk factors mentioned above, there are some factors that are unable to be controlled by intervention strategies (e.g., gender, neurobiology). However, providing protective factors such as social support and treatment to improve mental health, or working with cognitive

flexibility and encouraging hope about the future, will provide positive effects to adolescents at risk of suicide.

2.3 Previous Research on Suicide Prevention Programs

There are mainly three types of prevention suicide prevention programs: universal, selective and indicative (Robinson et al., 2013). Universal programs target the whole population regardless of suicide risk factors and focusing on promotion of protective factors. Selective programs focus on individuals who are showing risk factors but not yet showing suicidal behaviour. Finally, indicated programs focus on individuals who are currently showing suicidal behaviour (Robinson et al., 2013).

Robinson et al. (2013) conducted research to compare universal, selective, indicated, and post-vention programs running in secondary school settings to assess their effectiveness. They used a bibliographic electronic database to search for literature on prevention or treatment of suicide-related behaviours and post-vention programs in secondary school settings, and found 15 studies on universal programs, 23 selective programs (12 gatekeeper programs and 11 screening programs), three indicated intervention programs, and two post-vention programs. They found that universal programs had positive outcomes; however, they recommended that universal programs should be used as a way of mental health promotion rather than a suicide prevention strategy. Selective programs were found to be effective. The authors suggest that a gatekeeper program and a screening program should co-exist and should include suicide screening. Indicated programs were questioned for their appropriateness in school settings. The authors suggest that indicated programs (i.e., therapeutic intervention) should remain in clinical settings. There was not enough evidence to claim the effectiveness of post-vention programs.

Pfeffer (2001a) points out the importance of direct assessment when individuals are diagnosing the risk of suicide. She argues that most screening strategies are effective in identifying young people who are truly at risk of suicide; however, those tools tend to involve a large

number of false positives, that is, identifying youth as being at risk of suicide who are actually not (Pfeffer, 2001b).

Wyman et al. (2008) conducted a research to assess the effectiveness of gatekeeper program. Their research involved 249 secondary school staff from 32 schools to assess the effect of gatekeeper program on their self-reported knowledge, effectiveness, and service accessibility. They found that the program offered increased perceived knowledge, increased perceived effectiveness of the service, and increased identification of suicidal behaviours among school staff. Similar findings were reported by Reis and Cornell (2008), who state that 165 school teachers and 73 counsellors who attended gatekeeper training demonstrated increased knowledge of risk factors than a control group, and reported greater confidence and active involvement in communicating with youth at risk for suicide. Mann et al. (2005) conducted a literature review of 93 published articles in 1966-2005 and found gatekeeper programs to be effective in reduction of suicidal behaviour, especially in those organisations which have solid roles for gatekeepers and good access to treatment such as the military; however, they also pointed out that previous research had not utilised good outcome measures such as referral rates and treatment rates. They also argue that it is not clear which components of educational interventions are actually producing desired outcomes, as those interventions tend to be multi-faced.

However, Wyman et al. (2008) found that more than 80 per cent of eighth and tenth grade students who had a recent suicide attempt would not talk to a counsellor or other adults at schools to seek for help. In fact, the inability and perceived difficulties of discussing about problems with adults and lack of closeness to adults at school were two of the major reasons reported by 854 high school students who participated in the research conducted by Cigularov, Chen, Thurber, and Stallones (2008). Wyman et al. (2008) argue that involvement of students as peer-gatekeepers and training on communication to increase openness of school staff may increase the chance of reaching out at-risk youths.

Youth specific issues will be best understood by people living in similar contexts. Youth gatekeepers have the capacity to identify and provide care for their at-risk peers (Nelson & Galas,

2006). Thus, inclusion of peers is important in youth suicide prevention programs. However, current peer support programs have some issues in terms accessibility, especially among youths who are living far from the organisation and do not have means of transportation.

Stuart et al. (2003) examined the effectiveness of peer gatekeeper programs on enhancing knowledge, attitude, and skills in suicide assessment of adolescents. A peer gatekeeper program was used to train 65 adolescents aged between 13 and 18 years, who had been participating as peer helpers. They used revised Suicide Intervention Response Inventory (SIRI-II) to assess the ability of adolescents identifying their at-risk peers. This research found significant increase in knowledge about suicide, significant improvement in supporting attitudes toward suicidal peers, and increased skills in addressing to at-risk individuals.

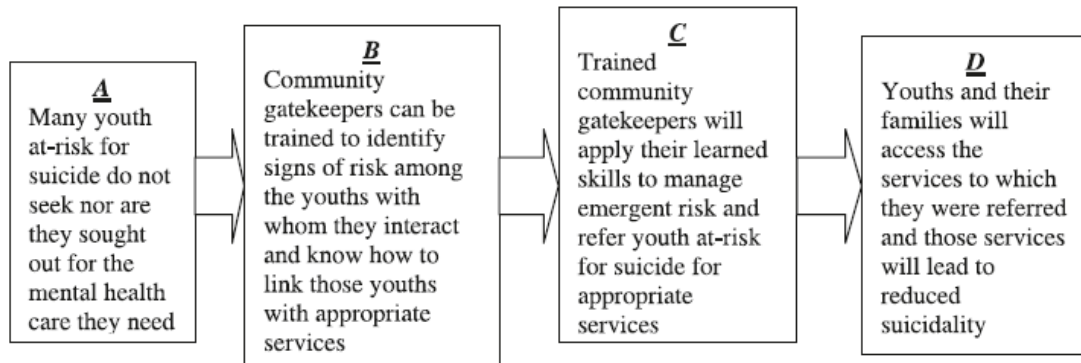
Eckert, Miller, Riley-Tillman, and DuPaul (2006) conducted a research in the Northeastern region of the United States to examine the perception of adolescents towards curriculum-based suicide education programs, staff in-service (gatekeeper) programs, and suicide screening programs. Their participants rated curriculum-based programs as the most acceptable, and suicide screening programs as the least acceptable and more intrusive. The research also found that participants perceived the staff in-service programs as less acceptable than curriculum-based programs. Eckert et al. (2006) argue that the reason why curriculum-based programs are more preferred by young people may be because adolescents are not comfortable with adult people assessing young people.

2.4 Gatekeeper Training Logic Model

The US Centers for Disease Control and Prevention (CDC, 1992, cited in Rodi et al., 2012) developed the gatekeeper training logic model which focuses on three components of gatekeeper programs: 1) learning of knowledge and skills to identify at-risk youths; 2) identification of at-risk youths using the knowledge and skills learned; and 3) referral and utilization of professional treatment on suicide (Figure 2). This model explains how gatekeeper programs may contribute to

the effort to reduce suicide.

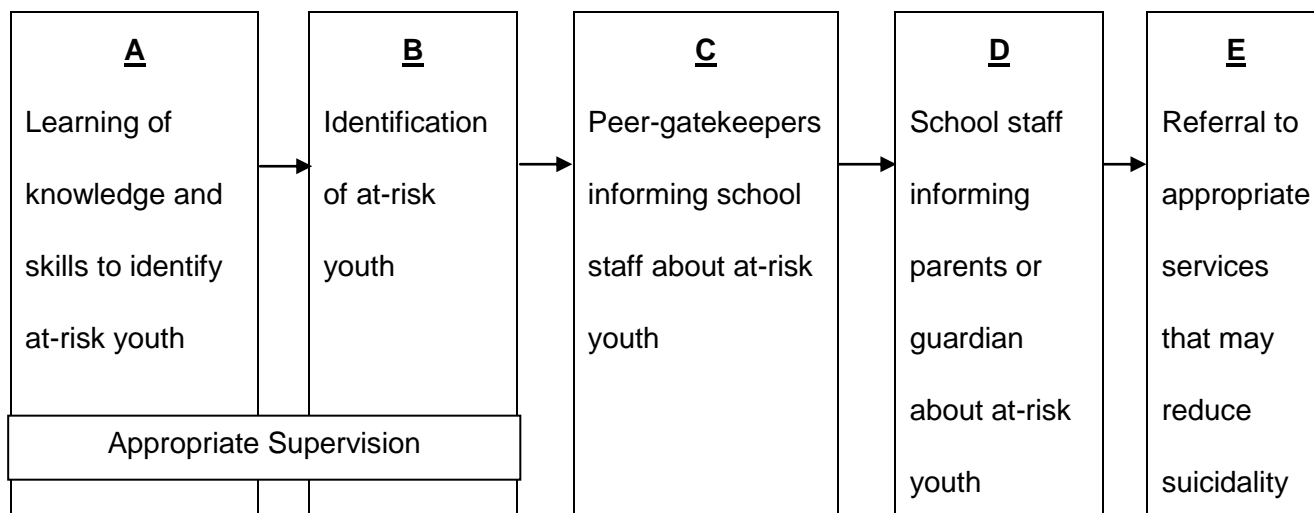
Figure 2. Gatekeeper training logic model (CDC, 1992; cited in Rodi et al., 2012, p.114).



However, the logic model for school-based peer-gatekeeper program works slightly differently from the logic model developed by the CDC. Firstly, in order for peer-gatekeeper programs to be effective, peer-gatekeepers need to inform school staff or guardians about the presence of risk so that adults are able to assist and supervise peer-gatekeepers, and to support at-risk youth to seek help and treatment from appropriate service providers. Secondly, when peer-gatekeepers are reporting at-risk peers to school staff, the school staff need to inform guardians/parents of the at-risk youth as soon as possible so that at-risk youth will be referred to appropriate mental health service/treatment. Finally, peer-gatekeepers may require appropriate supervision by professionals at school (e.g., school psychologists) during the learning and identification process, so that adolescents involved in the program are able to discuss their concerns and debrief. Therefore, the author argues that the logic model for school-based peer-gatekeeper programs should focus on at least five components: 1) learning of knowledge and skills to identify at-risk youths; 2) identification of at-risk youths using the knowledge and skills learned (under appropriate supervision); 3) reporting of at-risk youths to school staff made by peer-gatekeepers; 4) reporting of at-risk youths to guardians/parents made by school staff; and 5)

referral and utilization of professional treatment on suicidality (Figure 3).

Figure 3. Peer-Gatekeeper training logic model.



The peer-gatekeeper training logic model provides suitable areas of focus to identify possible barriers of implementing peer-gatekeeper programs. Therefore, the current research refers to this logic model to analyse possible barriers of implementing peer-gatekeeper programs in current Western Australian secondary school contexts. In the next chapter this logic model will be applied to investigate possible barriers of implementing the programs in different communities, including rural/remote areas, Indigenous communities, and CALD communities. In the third and final chapter, logic model will help identify areas which require further research.

3. Barriers for Successful Implementation and Effectiveness of Peer-Gatekeeper Program

This chapter focuses on the barriers for implementation and effectiveness of peer-gatekeeper programs in Western Australian secondary schools. It is important that the barriers to such programs are well understood so that effective programs can be designed and implemented. Some of the barriers, such as cultural beliefs on mental health issues, lack of familiarity with Australian systems and mental health services, are specific to certain communities, while other barriers, such as stigma attached to suicide and reluctance to seek help as a result of the fear of stigma, are universal to all communities examined in this study.

Some of the barriers identified in the present research, such as general reluctance to seek help for suicide and suicide-related issues due to fear of stigma, lack of culturally and linguistically appropriate services, and geographical inequality, are relevant to suicide prevention programs in general. On the other hand, some barriers, such as lack of empirical foundation on gatekeeper programs, school-based suicide prevention programs, and youth involvement in such programs, are specific to certain types of programs.

This chapter focuses on three communities which are identified as high risk of suicide by the Western Australian Suicide Prevention Strategy 2009-2013 (Department of Health, 2009): rural/remote communities; Indigenous communities; and CALD communities. It then focuses on barriers that are attributed to the school environment and issues on youth involvement in suicide prevention strategies, and finally, it focuses on previous research on gatekeeper programs to identify limitations of the programs.

3.1 Rural/Remote Communities

Barriers for successful implementation and effectiveness of peer-gatekeeper program in rural/remote communities are mainly related to: smaller populations in comparison to metropolitan

areas; stigma on mental health issues and suicide; gender identity and rural masculine ideal which may prevent at-risk youth from help-seeking behaviours; socio-economic factors; and lack of opportunities which may negatively impact family functions; and limited availability/accessibility of services. Difficulty in controlling access to firearms, although this is not directly related to the program, may also need to be noted because it is associated with a higher likelihood of completed suicide due to greater lethality of the method.

Young participants who were interviewed in the study conducted by Bourke (2002; 2003) stated that their friends and families were an important source of support. However, Bourke (2002; 2003) states that this social network can also be a barrier for help-seeking simultaneously. In rural/remote communities where community members tend to be exposed to higher social visibility than in urban areas, it is difficult to maintain confidentiality and anonymity (Pugh, 2007). This lack of confidentiality and anonymity may negatively influence the effectiveness of peer-gatekeeper program in several ways. In smaller communities where community members are more likely to know each other, informal witnessing of interaction and communication between already known persons may unintentionally breach their confidentiality (Pugh, 2007).

This higher visibility may increase the likelihood of at-risk youth avoiding contact with peer-gatekeepers and service providers to seek help, due to the fear of being witnessed by others. For example, a young unemployed participant residing in New South Wales stated that he was not receiving unemployment benefits because of the fear that other community members may witness him contacting to unemployment service, and the fear of stigma attached to unemployment (Bourke, 2003). Another participant in the study stated that she was hiding her mental health issues due to the fear of stigma attached to mental illness. Similar fears may be perceived by young people who identify as GLBT, single parents (Bourke, 2003), and those who are scared of the stigma attached to suicide (Judd et al., 2006), which can negatively influence their help-seeking behaviour and result in delaying effective intervention and treatment. The fear of stigma and higher visibility may also be associated with reluctance of parents/guardians to seek professional help for their children.

Moreover, even when at-risk youth are referred to professional(s) and start receiving

treatment, young people may not disclose their concerns or suicidality because of existing relationships between the youth and the professional (e.g., a counsellor can be a parent of a friend of the youth). Thus the lack of confidentiality, especially when it is combined with fear of stigma and being witnessed, can be a significant barrier for help-seeking behaviour.

Furthermore, this higher visibility may have negative consequences for peer-gatekeepers and their supervisors, especially due to the severity of the issues with which they may be dealing. Using child sex offenders as an example, Green (2003) argues that social workers in rural areas may be exposed to the dilemma between community expectations to share information that has potential negative consequences on the community, and their professional ethics to protect confidentiality. Peer-gatekeepers and their supervisors may experience similar dilemma. Green (2003) argues that proactive strategies that allow community members to prepare and be alert to potential dangers may provide solution for this dilemma.

Finally, the stronger ties of community members in rural communities may impact the willingness of teachers and other school staff to be involved in peer-gatekeeper program as an informant for parents/guardians or supervisor of peer-gatekeepers. For example, teachers who were interviewed by Bourke (2003) stated that although they would listen to their students who were seeking support, they were generally reluctant to perform counselling roles for their students because of their personal relationships with parents of their students. This reluctance of teachers may have negative impacts on the successful implementation of school-based suicide prevention programs in rural areas.

Young people who were interviewed by Bourke (2003) stated that choice of friends in rural community was limited, and that the hierarchy of social groups existed among young people based on whether or not they 'fit' into the 'cool' category. The choice of friends that young people are able to maintain daily contact with can be further restricted by lack of opportunities for higher education and employment in rural communities and out-migration to seek better opportunities (Bourke, 2002; Bourke, 2003; Baume & Clinton, 1997). Previous research has found that students in rural areas tend to have better coping strategies than young people who had left schools (Bourke, 2002), and

employed individuals tended to have higher self-esteem and higher life satisfaction than students and unemployed young people who had left schools (Bourke, 2003). These results show that young people who are at higher risk tend to be isolated from educational/occupational groups. In the US, analysis of a survey completed by 13,465 adolescents revealed that young people who are more isolated tended to have a higher suicide risk (Bearman & Moody, 2004). Young people who are at higher risk for suicide may be left unidentified by school-based peer-gatekeeper programs due to their isolated situation and/or lack of contact with schools or other organisations which may have the potential to identify those who are at risk.

Furthermore, decline in rural economy may have negative impact on family functioning, and as a result, isolated young people who are at risk of suicide may not be able to receive good support from their families. Alston (2012) analysed suicide among male farmers in rural areas. She argues that a decline in the production of crops due to drought and climate change has significantly negatively impacted rural farming families. The economic decline in agriculture has increased outmigration of young people for the sake of employment opportunities and further education, and closed down farming businesses. The loss of labour hands has been forcing farmers to deal with increased workload and stress (Alston, 2012). Moreover, rural males tend to cope with the stress by alcohol consumption which could lead to relationship issues (Alston, 2012). Increased incidence of domestic violence is also found in rural areas (Alston, 2012). Furthermore, an increasing number of wives of those farmers has been working in non-agricultural industries, and is often required to seek for employment in different communities due to economic decline in their own communities (Alston, 2012). Further decline in agricultural industry and increased stress, overwork, and higher risk of family dysfunction explained by Alston (2012) may have significant negative impact of family members to identify and support youth at risk for suicide, and may increase suicide risk of young people as family dysfunction has been identified as a risk factor for suicide (SPA, 2010).

Alston (2012) argues that one of the factors that prevents rural males from seeking help is rural masculinity which is characterised by stoicism and a strong focus on self-reliance. She

argues that this stoicism tends to lead rural males to attribute loss of farm productivity to individual failure, and they tend to be trapped into a cycle of self-blame for the circumstances which may be caused by factors that are beyond their control. This continuous self-blame and inability to seek help has significant association with higher rate of suicide among rural males. The avoidance in help-seeking behaviour among rural males is particularly more common among males aged between 18 and 29 years (Judd et al., 2006). Moreover, higher impulsiveness and aggression among young people, together with increased alcohol consumption, may be associated with more violent/lethal means for suicide attempts such as firearms (Baume & Clinton, 1997). Together with the characteristics of rural masculinity such as stoicism and strong self-reliance and tendency to consume alcohol for 'self-medication' to deal with personal issues (Alston, 2012), the higher impulsiveness and aggression and availability of lethal means within the reach of young people may be negatively associated with higher likelihood of completed suicide. Thus, rural masculinity can be a barrier for the effectiveness of peer-gatekeeper program by preventing at-risk youth from seeking help from their peers or adults.

At the same time, firearm restriction as a suicide prevention strategy in rural areas is difficult to implement, due to the widespread use of firearms in pest control and diseasing of live stock, and also because of the role of firearms in male culture and rural folklore (Judd et al., 2006). Moreover, even if firearm restriction is possible in rural areas, young people who choose to find their own solution rather than to seek help would look for alternative methods such as hanging (De Leo et al., 2003). Therefore, although limiting access to lethal methods may prevent the first suicide attempt from becoming a complete suicide, means restriction itself is insufficient to prevent youth suicide.

King (1994) states that the closing down of important community services in rural areas, such as finance, communications, and health and welfare services, is negatively contributing to the lack of ability and capacity of the communities to provide support to community members who are the most in need. Judd et al. (2006) argue that this is an important contextual factor which may be contributing to higher suicide rate in rural area. Moreover, out-migration of residents from rural

areas is further restricting the opportunity of community members to participate in community activities and organisations (Alston, 2012). This makes it difficult for any sort of community effort to be developed, especially when funding is limited and more volunteers are required.

Service accessibility may be further restricted by lack of access to private vehicles in rural areas, particularly among young people who do not own vehicles and youth who are too young to obtain licence. Moreover, rural environment may limit accessibility to services that are competent. Jackson and Johns (2009) argue that extra cost on travel and accommodation on top of training and education is limiting most service providers in rural areas from their professional development opportunities. Judd et al. (2006) state that general practitioners in rural areas are making lower rate of referral on psychological problems; however, they also state that it is not clear if this tendency is due to lower rate of recognition and treatment for mental health issues or due to different approaches rural general practitioners are utilising, despite the fact that suicide rate in rural areas is higher than in metropolitan areas. If the lower rate of referral is due to limited service accessibility/availability and/or limited opportunities for professionals to receive education and training, then suicide prevention efforts in rural area should include educational workshop for professionals (Jackson & Johns, 2009) and strategies to increase accessibility/availability of mental health services.

3.2 Indigenous Communities

Barriers for successful implementation and effectiveness of peer-gatekeeper program in Indigenous communities include the negative effect of past institutionalised discrimination and distrust/mistrust of governmental agencies and services providers; differences in culture; beliefs related to mental health; differences in expectations for services; privacy and confidentiality issues; reluctance in help-seeking due to fear of stigma and shame; and lack of culturally and linguistically appropriate services and accessibility.

The past policy and institutionalised discrimination against Indigenous community are

continuously affecting subsequent generations of Indigenous Australians (Vicary & Westerman, 2004). The lack of positive role models and support for those who have experienced removal from their parents has had a huge negative impact on the home environment in which Indigenous youth today have been growing (White, 2009). Moreover, the discriminative social climate against Indigenous youth today is fostering a marginalised identity among them (White, 2009). Indigenous youth today are overly problematised and the term 'Indigenous youth' is used almost like a synonym for social problems (Palmer, 1999). The negative view tends to ignore non-problematic aspects of Indigenous youth and places them under increased surveillance, rather than focusing on positive aspects of Indigenous youth and their lives (Palmer, 1999).

The removal of children from Indigenous community has imposed fear in many Indigenous women of approaching government agencies for assistance, and the fear is particularly associated with help-seeking for domestic violence and child abuse issues (Fan, 2007). This fear is occasionally misinterpreted by community workers working for organisations that are funded by or connected to the Department of Family and Community services as well; this misinterpretation causes the hesitation of mental health workers in inviting Indigenous people to utilise their services (Fan, 2007). Fan (2007) argues that a barrier for engaging with Indigenous people in mental health service is not only the fear and distrust held by Indigenous people, but also the negative beliefs perceived by non-Indigenous service providers that Indigenous people would not trust non-Indigenous service providers.

Indigenous people often see Western mental health system as suspicious (Capp, Deane, & Lambert, 2001) and fearful (Vicary & Westerman, 2004). Indigenous respondents who participated in the study conducted by Vicary and Westerman (2004) expressed this fear based on their experiences of witnessing family/community members who had been hospitalised and/or medicated, and became a 'different' person from what community members were familiar. Those experiences discourage Indigenous people from consulting Western mental health services, and often result in delayed treatment and higher likelihood of hospitalisation and utilisation of medical treatment, which further discourages Indigenous people from utilising mental health services (Vicary

& Westerman, 2004).

The mistrust/distrust and fear of mental health services may prevent Indigenous youth at risk for suicide from utilising services. In fact, an evaluation study conducted by Capp et al. (2001) observed a decline in intentions to refer at-risk individuals to mental health services among those who participated in community gatekeeper program, and a further decline was observed when the follow-up study was conducted two years after the training (Deane et al., 2006). This tendency may be because the training empowered Indigenous people and worked as an encouragement for self-help rather than utilising outside resources (Capp et al., 2001). This reluctance in seeking help from mental health professionals may have a negative effect on the effectiveness of peer-gatekeeper program in Indigenous community.

Indigenous communities, particularly traditional communities, are male-oriented and have a clear division between 'men's business' and 'women's business' (O'Malley, 1993). Any decisions made in the community require approval by male elders, and the male-oriented system and the process of obtaining approval can be challenging for community workers trying to work with the Indigenous community (O'Malley, 1993). This gender role difference should be considered when any sort of intervention program is implemented in Indigenous community. For example, Fan (2007) argues that it may be perceived as shame by Indigenous males to discuss their issues with female mental health workers, while Indigenous females may feel embarrassed to communicate with male professionals.

Moreover, Indigenous men are in general more reluctant to seek help due to their masculine ideals or strong sense of self-reliance (Sheldon, 2001; Vicary & Westerman, 2004). In this sense, the community-based peer-education suicide prevention program in the Kimberley region was successful in challenging this masculine ideal by involving football players (i.e., male who are engaging in masculine activities) and started to open up opportunities to talk about suicide (Tighe & McKay, 2012). Indigenous people are educated not to cry from early stage of their development due to the belief that crying makes them sick (Sheldon, 2001). Trained community-gatekeepers in the Kimberley region stated that it was difficult for them to share feelings

with individuals identified as at risk for suicide, due to avoidance of self-disclosure and sharing of feelings by at-risk individuals (Deane et al., 2006). Female-oriented community work based in central Australia, Western Australia, and Northern Territory has been successfully providing support to Indigenous women, including services for parenting, domestic violence, aged care, disability, petrol sniffing, health, and emotional and social well-being (Woods et al., 2000). Those successful programs imply that gender-specific intervention and services may be a key aspect for successful services for Indigenous people.

However, it is important to note that each Indigenous community is unique, and the effectiveness of gender-specific intervention can depend on the uniqueness of the community. For example, a health promotion project in north Queensland which targeted Indigenous men in rural communities found that Indigenous men were not always open to others, particularly with gay people (Tsey et al., 2003). Tsey et al. (2003) argue that consultation with organisers of the group and gay people in the community is essential to address this issue collaboratively.

Another challenging aspect for implementation of peer-gatekeeper program in Indigenous communities may be related to their greater tolerance for mental health issues, perceptions/beliefs about mental illness and treatment, and difficulty in sharing emotions. O'Malley (1993) pointed to the greater tolerance for petrol sniffing in Indigenous community. She argues that this tolerance is coming from their belief that it is inappropriate to interfere with the lives of others, resulting in lack of intervention in petrol sniffers. Similarly, Sheldon (2001) found that Indigenous children who were showing behavioural issues were rarely referred to mental health services.

Young Indigenous men who participated in the study conducted by Capp et al. (2001) left the following comments during discussion, "If you want to die that is their business, it is their life", "... He just hung there. I just sat there right through it (p. 319)". How to respect and accept the cultural belief of Indigenous people which considers interference into lives of someone else as inappropriate, and work towards suicide prevention without denying their cultural belief is a difficult but important issue to solve, in order for any suicide prevention strategies to be successful (Ife, 2002).

Indigenous people tend to see mental health issues differently. For example, depression

is not seen as a curable illness, but as a characteristic of the person (Vicary & Westerman, 2004). Depression becomes noticed only when it starts to influence behaviours of the depressed individuals, such as showing suicidal behaviours or frequent crying in public (Vicary & Westerman, 2004). Their treatment for depression involves strengthening personal resilience and wellness to fight against the evil spirits which is causing those behavioural abnormalities, rather than utilising medication or counselling (Sheldon, 2001). Traditional healers, called Ngungkari in central Australia, are responsible for providing culturally appropriate physical, psychological, and spiritual explanation of symptoms for Indigenous people (Sheldon, 2001). Participants in the study conducted by Vicary and Westerman (2004) stated that those traditional forms of treatment should co-exist with Western psychology to maximise the effectiveness.

Those cultural beliefs may negatively impact the process of identifying, informing of teachers/family members, and referral, particularly because of different perceptions of mental health issues, hiding of emotions which may influence the ability of peer-gatekeepers to identify at-risk individuals, and informing/referral process which may be perceived as inappropriate interference into the lives of Indigenous people.

Sheldon (2001) argues that both professionals and patients in remote Indigenous communities had limited English proficiency, and those who had a good command of English still preferred to speak in Indigenous English. Differences in pronunciation and use of words between Standard Australian English and Indigenous English must be recognised for effective communication with Indigenous people (Eades, 2000).

Apart from issues related to accessibility and availability of services in rural/remote areas, Vicary and Westerman (2004) point out process issues in Western psychology and its practice, which include; 1) occasionally, self-referral and written referral are required and third-person referral can be rejected; 2) treatment often lacks flexibility in time and therapy settings; 3) non-Indigenous workers try to engage with Indigenous clients without involving Indigenous mental health workers or individuals with good understanding of Indigenous culture; 4) therapeutic process occasionally lacks informed consent which leaves Indigenous clients unaware of the purpose and goal of the

intervention; 5) mental health workers may lack cultural competency/understanding; and 6) Indigenous clients prefer to have both professional and personal relationship with mental health workers, whereas Western psychology normally sees dual relationship as danger.

The study conducted by Deane et al. (2006) found that Indigenous clients generally preferred to consult to Indigenous professionals; however, both Vicary and Westerman (2004) and Fan (2007) argue that some clients preferred to see non-Indigenous professionals for maintenance of their confidentiality. Fear of stigma (Deane et al., 2006; Fan, 2007), lack of privacy (Capp et al., 2001), shame (Sheldon, 2001; Fan, 2007), and fear of being known (Vicary & Westerman, 2004; Fan, 2007) were major reasons why Indigenous people may avoid seeking help from Indigenous professionals. Lack of culturally appropriate services can negatively influence the effectiveness of referral and treatment for Indigenous people, if they decide to seek help from non-Indigenous mental health workers.

3.3 CALD Communities

Barriers for implementation and effectiveness of peer-gatekeeper program in CALD communities include: limited English proficiency and social disadvantage; isolation due to limited communication skills; diversity in migration process and negative influence of those processes; cultural values and beliefs; racism and its negative influence; lower rate of service utilisation due to lack of culturally and linguistically appropriate services; lack of familiarity with Australian systems; stigma and belief on mental health issues; and limited knowledge/understanding on effective intervention for suicide due to lack of research.

Lack of English proficiency can be a barrier for various aspects of life experience among CALD individuals. For example, it can be a major challenge for CALD youth when they are trying to fit into the school environment in Australia (Queensland Government, 2012). Limited English proficiency may cause difficulties in communicating with their peers, which may be associated with social isolation (Black Dog Institute, n.d.).

English proficiency may influence social disadvantage for CALD youth and their family which includes academic performance, employment opportunities, and socio-economic status (Queensland Government, 2012). The language barrier often prevents CALD individuals from accessing services and information (Blingnault & Haghshenas, 2005). Moreover, some languages may not have words/expressions which are equivalent to English, which may limit opportunities for CALD youth to discuss their concerns with their peers or family members (Black Dog Institute, n.d.).

The community-based suicide prevention project for the CALD community in Tasmania called CALD community connection identified illiteracy and the language barrier as major challenges for their service delivery (Department of Health, 2012). The project found it difficult to find interpreters who were competent with mental health issues. Moreover, inclusion of interpreters in discussions of sensitive issues can be problematic. When an interpreter is required in health service settings, health professionals need to choose the interpreter carefully based on the clients' preference of the interpreter's gender and cultural background. Particularly when clients and interpreters are both from the same small community, clients may not be able to express their concerns due to the fear that their confidentiality may not be maintained (Queensland Health, 2007). When CALD youth require intervention due to suicidality, lack of English proficiency can be a major barrier due to communication difficulties and possible social isolation, which may influence the process of identifying at-risk youth, reporting suicide risk of the youth to their parents to seek assistance and support from their family members, referral for treatment, and effectiveness of those treatments.

Current government attitudes towards refugees and asylum seekers are generally negative. Detention process includes strict surveillance, which place asylum seekers including children under a very restrictive and intrusive environment (Amnesty International, 2014). The government appears to be promoting the harsh treatment of asylum seekers as a means of encouraging them to return to their countries of origin and to deter others from unauthorised migration to Australia (Aly, 2014). As such, the psychological well-being of asylum seekers is a low priority, and suicide attempts by detainees are common (Refugee Council of Australia, 2014).

Refugees also suffer pre-migration traumas, which may include torture and sexual assault (Black Dog Institute, n.d.). Those traumatic experience and forced change of environment can make the acculturation process even more difficult for refugees and asylum seekers (Black Dog Institute, n.d.). Longer detention is reported as a risk factor for various negative psychological outcomes and suicidality (Ide, 2011). Refugees and asylum seekers are often exposed to negative stereotypes reported by media, during the time when they are trying to overcome those traumatic experiences of pre-migration and detention, and to deal with acculturation stress at the same time. Acculturation process itself can be very stressful for CALD youth. The process of assimilating to the host culture while maintaining their own cultural identity can be challenging for CALD youth (Goldston et al., 2008). Youth may need to face and overcome value conflict between themselves and their peers, and between themselves and their families (Black Dog Institute, n.d.).

Suicide risks related to acculturation process are likely to vary based on the background of immigrants and reasons for migration (Bhui, Dinos, & McKenzie, 2012). Those who have migrated for economic/academic opportunities are likely to have a different background from asylum seekers and refugees (Bhui et al., 2012). This diversity in migration experiences may be challenging for peer-gatekeepers who are trying to approach CALD youth at risk for suicide in terms of understanding and responding to the risks. Those who have suffered trauma may lack the ability and capacity to deal with suicidality of their children. Finally, those who have experienced trauma that was committed by authority figures such as government, police and military officers may have developed general distrust and fear of engaging with government agencies and officers (Queensland Government, 2010).

Goldston et al. (2008) points out that lack of familiarity with health service systems and cultural beliefs which emphasise family-oriented treatment are some of the reasons why migrants may not utilise mental health services. Lack of culturally and/or linguistically appropriate services (Black Dog Institute, n.d.) and distrust caused by previous experience of receiving culturally inappropriate service (Goldston et al., 2008) are also reasons why CALD individuals may avoid contacting mental health services. Black Dog Institute (n.d.) points out that differences between

Australian values/belief and those of CALD community can be a factor which prevents CALD youth from communicating their concerns, giving sex and sexuality as examples. They argue that in some cultures discussion on sex and sexuality may be considered taboo, and the same may apply to discussion on mental illness and suicidality. This cultural taboo may narrow down or completely close up the opportunity for CALD youth to seek help for those issues.

Colucci and Martin (2007a,b) reviewed 82 publication on youth suicide and ethnicity, race, or culture, focusing on suicide rate, means for suicide, risk factors, and precipitating factors. Their review (2007b) found that although some risk factors and precipitating factors appeared to be universal across different ethnic groups (e.g., previous exposure to suicide/suicidal behaviour), other factors may have a different influence on different ethnic groups (e.g., interpersonal factors). Goldston et al. (2008) point out that expression of distress may also vary among individuals from different backgrounds, and therefore, gatekeepers who are trying to identify individuals at risk for suicide should be cautious about those differences.

Lack of research and knowledge on suicide among different cultural groups has been pointed out by several researchers, and this could be a major barrier for developing an effective suicide prevention strategy for CALD youth. The CALD connection project in Tasmania faced a challenge due to lack of data on suicide among CALD individuals (Department of Health, 2012). Ide (2011) points out lack of information on suicide among second generation migrants who have been identified as being at greater risk of suicide, particularly because census data does not contain information on country of birth of individuals' parents.

Moreover, the lack of English proficiency may exclude the most disadvantaged CALD individuals from research because of the limited funding for inclusion of interpreters and preparing multi-lingual documents/apparatus (Blignault & Haghshenas, 2005). They argue that this exclusion of CALD individuals with limited language proficiency may limit generalisability of research results.

Furthermore, Lopez and Guarnaccia (2000) and Colucci and Martin (2007a,b) point out that cultural research on mental illness and suicide have not paid enough attention to the

heterogeneity of culture. Lopez and Guarnaccia (2000) argue that culture does influence the entire social context of cultural psychopathology research; however, other social factors, such as class, socio-economic status, and marginality, also have huge influence on our everyday lives. Colucci and Martin (2007a,b) argue that categorisation of participants based on race (e.g., 'Asian' or 'White' ignores ethnic diversity.

Goldston et al. (2008) argue that collaboration with CALD community is essential in order to develop effective and sustainable suicide prevention strategies, and perhaps such strategies should be developed by the community itself rather than being imposed on communities by external groups.

3.4 School Environment and Youth Involvement

Barriers for implementation and effectiveness of school-based suicide prevention programs and youth involvement in such programs include: concerns on confidentiality and stigma; lack of knowledge, resources and services to address youth suicide; geographic location of schools; lack of time and interest expressed by youth; and safety concerns.

When we consider a school as a small community, the same sort of issues as rural/remote communities may arise, such as lack of confidentiality and privacy, fear of stigma, fear of being identified as an at-risk youth, and fear of school gossip (Bourke, 2003; Green, 2003; Pugh, 2007). Interpersonal relationships within school settings, such as a limited choice of friends and social hierarchies that marginalise some students may influence interaction between peer-gatekeepers and youth at risk for suicide (Bourke, 2002; Bourke 2003). Moreover, school-based suicide prevention programs may not be sufficient when at-risk youth are not attending school for any sort of reasons, including bullying, physical/mental illness, involvement in anti-social behaviour, and child abuse/neglect.

Kalafat & Elias (1995) argue that school-based suicide prevention strategies need to focus on both broad and narrow contexts. Narrow contexts refer to the limited time frame and resources

available which may limit the amount of information and quality of educational components on suicide that need to be provided to teachers and students for effective intervention, prevention, and implementation of such programs (Kalafat & Elias, 1995). Broad contexts refer to school environments that may prevent youth identified as at risk for suicide from receiving help they need, such as: policies and procedures that provide guidelines for school staff on how to respond to suicidality; establishment of linkages with community; lack of accessibility or closeness to adults who can respond to at-risk youth in a culturally, timely, and psychologically appropriate manner; and school environments that foster help-seeking behaviours and support at-risk youth after they receive treatments/hospitalisation (Kalafat & Elias, 1995).

Lack of time and resources in schools can be a major factor which may prevent implementation of suicide prevention programs. Moreover, it is a barrier for school staff to be actively involved and respond to youth at risk for suicide (Kalafat & Elias, 1995; SPA, 2010). It is difficult for school staff to provide more services to their students when schools are not able to seek additional funding and resources (Gutierrez, Watkins, & Collura, 2004). Gutierrez et al. (2004) argue, based on their research on school-based suicide screening projects in the US, that participation in the project had a positive influence on promoting discussion on suicide and help-seeking behaviours, and changing school environment in positive ways. However, the projects required enormous effort from teachers and school psychologists, and support from university level researchers to: facilitate screening programs; analyse suicide risk and depression questionnaires completed by students; respond to youth identified as at higher risk for suicide/depression; and refer them to appropriate treatment and services. In the case of Western Australia, \$180 million has been cut from the school budget in 2014 and 500 education jobs have been made redundant (ABC News, 2014), decreasing the prospect that Western Australian secondary schools can accommodate such efforts and collaborations.

The other factor which influences effectiveness of school-based suicide prevention strategies is lack of knowledge on risk factors of suicide, lack of ability and skills to identify and respond to at-risk youth, and reluctance of teachers to be involved in such activities. Reis and

Cornell (2008) found a higher likelihood of school counsellors questioning and referring youth who are suspected of at risk for suicide than teachers, and they found that counsellors had a greater knowledge on suicide than teachers, indicating that increased knowledge and skills are important factors for suicide prevention activities.

Studies conducted in Adelaide (Leane & Shute, 1998), Victoria (Scouller & Smith, 2002) and North Queensland (Crawford & Caltabiano, 2009) found that Australian teachers had a limited amount of knowledge on suicide. Scouller and Smith (2002) found that knowledge on suicide risk factors among school teachers in Victoria was particularly limited. Crawford and Caltabiano (2009) found limited knowledge among teachers in North Queensland on risk factors, precipitating factors, and warning signs of suicide. Crawford and Caltabiano (2009) also found that inability of teachers to distinguish between youth at higher risk and lower risk for suicide. More disturbingly, Leane and Shute (1998) found no difference in the amount of knowledge on suicide between teachers and clergy in Adelaide who had received training on death dying and suicide, and those who had never received such training. The limited amount of knowledge is a major restriction for teachers in identifying and responding to at risk youth. Moreover, research conducted in Canada on peer-gatekeeper programs found that although peer-gatekeeper training could provide increased ability to respond to at-risk peers, young peer-gatekeepers tended to show weakness in identifying angry or frustrated youth at risk for suicide (Stuart et al., 2003). This weakness may leave those angry or frustrated youth isolated and unidentified by peer-gatekeepers.

The process of implementing school-based peer-gatekeeper programs may be challenged by various beliefs and attitudes held by school staff and community members, especially parents/guardians of students. The attitudes and beliefs of teachers, value differences among school staff, and belief that programs which aim to increase general well-being are more effective than suicide-specific programs can be barriers to implement school-based suicide prevention programs (Dyke, 1991), although suicide-specific training is required to respond to youth at risk for suicide (Stuart et al., 2003). The belief that discussion on suicide will increase the occurrence of suicide (Dyke, 1991; Kalafat & Elias, 1995) and denial (e.g., suicide is not a problem happening

here; Dyke 1991; Bourke, 2003) have also been pointed out as barriers to school-based suicide prevention strategies.

Moreover, even when school-based peer-gatekeeper programs are successfully implemented and identify at-risk youth, the geographic characteristics of Western Australia may limit the ability for young people and their parents/guardians to seek professional help, especially when young people are isolated from family members because their home communities are not equipped with secondary schools and young people are residing in school dormitories to attend to boarding schools. In those situations, referral and treatment may be delayed due to the need for consulting family members who live rural/remote areas, and finding adults in dormitories/schools who may be able to help refer at-risk youth to appropriate services. Furthermore, in those settings, at-risk youth may have limited attention from adults in their home environment and left alone when they require increased help and support.

Saggers et al. (2004) point out that youth participatory approach in local governments tend to experience problems in term of the difficulty in maintaining interest due to their perception that those involvements are 'uncool' and their busy life style. They also argue that youth participatory approaches are sending two contradicting messages to youth: they are trying to promote a better place for youth; however, they simultaneously restrict freedoms of youth. Will an implementation of peer-gatekeeper program be perceived by youth as a process of taking away their freedom by placing them under increased surveillance? This is a possibility.

There is also an argument against involving youth as peer-gatekeepers in suicide prevention strategies due to health and safety issues. Hazell and King (1996) argue that involvement of youth in the process of identifying and responding at-risk youth is placing a huge responsibility on young people. They argue that if an at-risk youth attempts or completes suicide, the negative effect of loss and the increased responsibility perceived by peer-gatekeepers on young people could be enormous.

3.5 Limitations of Gatekeeper Programs

The effectiveness of gatekeeper training on increasing knowledge and confidence has been reported by several researchers (e.g., Wyman et al., 2008; Deane et al., 2006; Reis & Cornell, 2008). However, Deane et al. (2006) found that prior intention to help others was associated with the likelihood of community gatekeepers to support suicidal individuals. Rodi et al. (2012) also found that the gatekeeper role was adopted more positively by some assigned to the role than others – for example, in some cases there were multiple gatekeepers working in a organisation, a specific gatekeeper in the organisation tended to make most of the referrals of young people, while other gatekeepers were not participating in the process. Isaac et al. (2009) argue that the need for suicide prevention strategies in communities and willingness to invest in such strategies is required to be perceived by community members in order for those strategies to be effective.

Wyman et al. (2008) and Isaac et al. (2009) point out that youth at risk of suicide tend to avoid talking to gatekeepers or school staff to seek for help. Those individuals may not accept referral and treatment (Isaac et al., 2009). The same tendency was found by Moutier et al. (2012) who conducted research in a medical school in University of California on the effectiveness of its suicide screening program. Their suicide screening program was operated via the website, and students whose scores on the web-based questionnaire indicated high risk of suicide received replies from the counsellor which invited students to the web-based dialogue where students could communicate with the counsellor and receive face-to-face counselling sessions. Their research found that of those students who were identified as at high-risk, 91 per cent viewed the response from the counsellor via the internet; however, only 17 per cent accepted referral. However, their research also found that of those 17 per cent of students who accepted referral, 71 per cent stated that the screening program and education on depression were the key factors which made them decide to seek professional help. Other studies on suicide screening programs have found that the majority of students identified as high risk for suicide sought help even after completion of the study, and that the program encouraged help-seeking behaviours for their peers (Gutierrez et al., 2004). Rodi et al. (2012) reported that of those youth who were identified by gatekeepers, 84 per

cent received treatment from services referred by gatekeepers within three months. Rodi et al. (2012) found a higher rate of accepting treatment among at-risk youth who were identified by mental health professionals.

Cigularov et al. (2008) identified barriers for help-seeking behaviour perceived by young people in Colorado. Their research found that factors that prevented young people from seeking help for themselves included not knowing what to say to parents/school staff about their issues, lack of closeness with school staff, fear of hospitalisation, lack of trust on school staff, (over)confidence on their ability to solve problems by themselves, feeling of embarrassment, and preference to be identified rather than seeking help. Factors identified in this study that prevented young people from seeking help for their at-risk peers included fear of making wrong judgements and negative outcomes on their relationship with their peers, underestimating the risk of suicide, lack of closeness with adults, inability to talk about the suicidality of their peers to adults, fear of hospitalisation of their peers, and fear of broken confidentiality by school staff.

Reluctance in help-seeking can be attributed to differences in perception between young people and adults around them. Bourke (2002; 2003) argues that there is a difference between young people and adults in perceiving interpersonal problems. In her study, one third of young people stated that the recent moment of feeling down was associated with interpersonal issues. In contrast, adults who participated in her study tended to see interpersonal issues as trivial. Bourke (2002) argues that such differences in perceived severity of issues may cause reluctance of youth in seeking help from adult people because young people may feel that their issues will not be understood by adults.

Hazell and King (1995) point out the fear of broken confidentiality perceived by young people. They state that youth who receive suicide education do not show greater likelihood of seeking help for their at-risk peers, and inclusion of youth in the process of identifying and responding to at-risk youth may reinforce their exclusive peer focus. This tendency was also found among Indigenous participants who participated in the study conducted by Capp et al. (2001) that gatekeeper training might foster stronger self-reliance within Indigenous community members

rather than seeking help from outside the community.

Eckert, Miller, Riley-Tillman, and DuPaul (2006) conducted research on the perception of students of suicide screening programs, gatekeeper programs, and suicide education programs among first semester college students in an introductory psychology course in the United States. Their research found that curriculum-based suicide education programs were most accepted by adolescents, gatekeeper programs were the second most accepted, and suicide screening was the least accepted. Their research also found gender difference in perception of those programs, with female students perceiving suicide education program and gatekeeper program as significantly more acceptable than male participants. Their findings suggest that young males, who are at higher risk of suicide, may not receive benefits of those programs compared to young females who are showing higher rate of suicide attempts. Eckert et al. (2006) argue that adolescents may perceive programs that actively involve youth as more acceptable than those which involve adults making judgements on behaviours of youth, and that gender-specific strategies may increase the effectiveness of suicide prevention programs.

Isaac et al. (2009) argue that the effectiveness of gatekeeper programs is dependant upon the availability of effective treatment, which is not always found in communities. Lack of availability of culturally, linguistically, and locationally available services in Western Australia have been noted by several researchers (Black Dog Institute, n.d.; Bourke, 2003; Vicary & Westerman, 2004; Deane et al., 2006; Judd et al., 2006; Goldston et al., 2008; Alston, 2012).

Finally, a lack of strong empirical foundation for the effectiveness of gatekeeper programs has been pointed out by several researchers. Miller, Eckert, and Mezza (2009) reviewed publications on school-based suicide programs published between 1987 and 2007 which focused on the effectiveness of those programs, included outcome data, and involved youth as participants. Their research identified 13 publications (10 universal programs, three selective programs, and no indicated program) and found that there was a very limited knowledge base on effectiveness of school-based suicide prevention programs. Isaac et al. (2009) state that it is not clear how much of the preventative aspect of gatekeeper programs is due to the program itself, because in most of

the studies they examined, gatekeeper program co-existed with broader programs. Moreover, they argue that it is unknown how many per cent of the population is required to complete gatekeeper training in order for gatekeeper programs to be effective and start reducing the number of suicides. Research is also required to assess the ability of young people to identify and respond to at-risk peers (Stuart et al. 2003), and to examine potential perceived barriers which prevent young people from seeking help (Cigularov et al., 2008). Research in those areas should be conducted within Western Australia to identify and examine factors which are specific to the Western Australian context.

4. Towards Development of Effective Suicide Prevention Strategies in Western Australia

4.1 Need for Community Consultation

The Department of Health and Aging sponsored suicide prevention project, titled Living is for everyone (LIFE) summarises essential components for community engagement which measure readiness of communities for implementation of suicide prevention projects (LIFE, 2013). The checklist involves eight components: 1) identification and election of community leaders and essential human resources; 2) understanding of suicide and related issues, as well as needs and history which are relevant to the specific community; 3) arrangement of participation from a diverse range of community members; 4) agreement in vision, goal, and decision-making processes; 5) agreement on the use and mobilisation of existing community resources; 6) collaboration and networking with existing organisations and projects; 7) organising sufficient amount of financial and human resources; and 8) having a good research and knowledge base. The OAG (2014), in the review of the Western Australian suicide prevention strategy 2009-2013 (Department of Health, 2009) recommends that collaborative implementation plans and collaboration with existing strategies should be included in future suicide prevention strategies in Western Australia. The implementation process of peer-gatekeeper programs, therefore, should include consultation with the community to identify participants and seek collaboration from a diverse range of stakeholders to: involve those stakeholders in decision-making process; examine the need of each community; and to evaluate if the community is equipped with sufficient funding, human resources and knowledge base.

School-based peer-gatekeeper programs require cooperation and collaboration with schools, parents/guardians, community organisations, funding bodies, and young people to determine if this approach towards suicide prevention in the specific community is appropriate, acceptable, and needed.

The collaboration process of implementing peer-gatekeeper programs allows the

community to build social capital (Community Tool Box, 2013). Lathouras (2010) argues that through work driven by members of the community, those members are able to build a sense of belonging to the community. Trust, better understanding of each other, and sense of belonging to the community are required for both implementation and effectiveness of peer-gatekeeper programs, because lack of trust and closeness with school staff are some of the reasons why young people would avoid talking to adults about their concerns (Cigularov et al., 2008; Bourke, 2002) and seeking help from professionals (Fan, 2007; Capp et al., 2001; Queensland Government, 2010; Ciglarov et al., 2008), and also because the process of implementation requires good team work to tackle suicide. Inclusion of community members who truly care about its members is important factor for sustainability of those efforts as well (Power, 2003).

4.2 Need for Community Education

Fear of stigma attached to suicide, mental health issues, and other issues related to suicide have been identified by several researchers as factors negatively associated with avoidance of help-seeking behaviour (Bourke, 2003; Vicary & Westerman, 2004; Fan, 2007; Goldston et al., 2008). Therefore, community education which aims to de-stigmatise suicide and related issues is important for the effectiveness of suicide prevention strategy. Although some researchers argue that normalisation of suicide may increase the likelihood of suicide (The Life Resource Charitable Trust, 2011), without disassociating suicide and related issues from negative perceptions such as shame, at-risk youth and their family members may not be able to seek for help actively. Therefore de-stigmatisation is one of the essential components for community education on suicide prevention. Education on de-stigmatisation is needed for teachers and the wider community as well, to promote an anti-discriminative and supportive environment for suicidal youth in order to protect them from social isolation.

Education which enhances knowledge on suicide and skills to approach at-risk youth effectively is another essential component of effective suicide prevention. Some areas that

previous research identified as not well understood by teachers, such as risk factors, precipitating factors, and warning signs of suicide (Leane & Shute, 1998; Scouller & Smith, 2002; Crawford & Caltabiano, 2009), need to be covered well in peer-gatekeeper programs. However, Leane and Shute (1998) found that their participants who had completed training on death, dying and suicide prior to the research did not show statistically significant difference in scores on Recognition of Suicide Lethality Questionnaire. They argue that development of more effective training and education on suicide prevention and intervention is needed. Role-play and direct observation have been recommended by King, Price, Telljohann, and Wahl (1999) in order to develop more effective education and training on suicide intervention skills.

When relevant education and training are provided to young people, it is important that education components are taught in the language that suits the language acquisition level of students. Currently, some not-for-profit organisations are running suicide prevention program for young people (e.g., the Youth Focus, 2014; the Samaritans, 2014). Development of suicide intervention education materials for peer-gatekeepers can be effective if collaboration with those organisations is conducted.

Gatekeeper programs should co-exist and the training should be provided to teachers and other school staff, especially because young peer-gatekeepers may struggle to identify at-risk youth showing frustration or anger (Stuart et al., 2003). School staff may be able to work collaboratively with peer-gatekeepers to identify and respond to at-risk youth.

Moreover, Cigularov et al. (2008) and Wyman et al. (2008) argue that education and training in communication skills are needed for both school staff and students. Wyman et al. (2008) argue that training in communication skills for school staff may equip them with the techniques to interact more effectively with youth at higher risk for suicide who are not open to adult people working at school. Cigularov et al. (2008) argue that education in communication skills for young people may provide important communication techniques for youth at risk for suicide who are not sure how to start conversations with adults to seek help.

Therefore, the education components for suicide prevention should include materials on

de-stigmatisation, risk factors, precipitating factors, warning signs, and communication skills, utilising role-play and observation as a part of the learning process. The education and training should target not only peer-gatekeepers and their supervisors, but also at-risk youth, parents/guardians of students, school staff, and wider community members.

4.3 Improving Accessibility and Availability of Services

Lack of accessibility and availability due to lack of linguistically and culturally appropriate services and locational disadvantage have been pointed out by several researchers as a barrier to suicide prevention programs (Black Dog Institute, n.d.; Vicary & Westerman, 2004; Deane et al., 2006; Sheldon, 2001; Bourke, 2003; Judd et al., 2006; Alston, 2012). Training to improve cultural competency (Fan, 2007), involvement of culturally competent individuals in therapeutic approaches (Vicary & Westerman, 2004), and training of interpreters who are competent with mental health issues (Department of Health, 2012) are needed to improve the capacity of treating individuals from diverse backgrounds. In rural/remote areas, more opportunities for professional development are required to provide good quality services to youth at risk for suicide (Jackson & Johns, 2009). Some researchers have identified the need for gender-specific approach for youth at risk for suicide due to gender differences in perception on suicide prevention strategies (Eckert et al., 2006), and embarrassment of talking about issues with opposite sex professionals (Fan, 2007). Eckert et al. (2006) suggests screening programs as a way to identify young males at risk for suicide because young males tend to find gatekeeper programs and suicide education programs more intrusive and less acceptable; however, past research shows that screening methods are not a popular method among American school psychologists (Eckert, Miller, DuPaul & Riley-Tillman, 2003), school principals (Miller, Eckert, DuPaul, & White, 1999) public school administrators (Scherff, Eckert, & Miller, 2005) and young people (Eckert et al., 2006). Inclusion of young males in decision-making processes is therefore important to find an effective way to reach out to at-risk young males.

Inclusion of the recent telecommunication technologies and their ability to overcome

locational inequality in accessing services has been researched and put into practice. Telephone counselling and crisis lines have been utilised by several organisations in Western Australia and nation wide (e.g., the Samaritans, 2014; the Lifeline, 2014; the MensLine Australia, 2014; the Beyond Blue, 2014). E-mail has also been used by some organisations to reach out to at-risk individuals. Moutier et al. (2012) used the web-based dialogue with counsellors in the effort of inviting at-risk American medical students who were showing serious concerns with confidentiality and fear of negative effects of stigma on their career. A similar attempt has been made in Australia (MensLine Australia, 2014).

More recently, twitter has been researched as a way to identify distressed individuals in the UK (Scourfield, 2014). This approach utilises a mobile phone application called 'Samaritans Radar' to detect signs of distress and alert any tweets from twitter accounts. Although this application is still underdeveloped and has some limitations such as inclusion of false positives and inability to distinguish geographical areas, the technology can be beneficial, as signs of distress are related to higher risk for suicide. Kaslow (2014) is currently developing a mobile phone application in the US which connects individuals who are at risk of suicide to professional service providers. Kaslow (2014) argues that social media are becoming place for young people to seek assistance, and therefore, professionals should focus on the effective use and inclusion of digital technologies into their efforts of preventing and intervening into suicide. Online phone counselling, which utilises Skype, has been offered in Australia to reach out to vulnerable individuals who are located in rural/remote areas of Australia (MensLine Australia, 2014).

The use of technologies in therapeutic settings may also provide one of the solutions to issues related to inclusion of interpreters in clinical settings. Lack of interpreters who are competent with mental health issues and dual/multiple relationships between clients and interpreters may be overcome by inclusion of telecommunication technologies and hiring of interpreters from different communities. However, this might also diminish the benefit of including local interpreters who have knowledge on community-specific issues.

Some limitations of utilising the internet-based telecommunication and digital

communication technologies include lack of internet connection in rural/remote areas of Western Australia, lack of access to computer/mobile phones, lack of computer literacy, and possible information leakage due to computer virus and hacking. However, those technologies may allow at-risk youth to feel less fear of being known and more confidentiality especially if they are utilising those services in their home environment, to have higher accessibility because of less need of travel, and provide them with opportunities to avoid dual/multiple relationships with mental health professionals particularly in smaller communities. Telecommunication and digital communication technologies may also allow youth from ethnic minority groups to find and communicate with professionals who have similar cultural and/or linguistic backgrounds.

Inclusion of multiple systems, including educational, health, mental health, recreational and faith-based institutions, is also an important aspect of effective suicide prevention strategies, as those institutions are all related to the daily functioning of young people (Power, 2003). For example, Leane and Shute (1998) found that clergy in Adelaide had higher likelihood of being sought by suicidal youth than teachers. Goldston et al. (2008) found that African American people tended to seek help from church for mental health issues than from mental health services. In Indigenous communities, their traditional healers are more likely to be sought for treatment of psychological symptoms (Sheldon, 2001). Those findings suggest that collaboration with different institutions is essential to increase access to at-risk youth.

Moreover, occasionally mental health services are insufficient to support youth at risk of suicide. For example, when a CALD youth is experiencing suicidality due to social isolation which is attributed to lack of English proficiency, the help they need can be referral to a language school to enhance their communication skills and peer-networks from other CALD youth experiencing similar issues, although mental health services may be able to provide help for suicidality of the CALD youth. King (1994) argues, "identifying youth at risk and providing help is likely to stop some suicide, but it is unlikely to stop people from becoming suicidal (p.4)". Suicide prevention strategies should collaborate with a range of services and organisations to enhance the capacity to deal with issues from which suicidality is attributed. In this sense, over-reliance on mental health

services to deal with youth suicide may be too narrowly focused. A diverse range of projects and services with a range of tools, such as arts, culture, religion, and sports, should be considered as a part of strategies to deal with suicidality of young people.

Those efforts of utilising different tools have been made in Australia. For example, the Yiriman Project is supporting young people for are suffering from substance abuse issues, and promoting better ways to take care of young people themselves by including young people in the traditional process of becoming an adult (Palmer, 2006; 2012). In Sydney, Hip Hop has been used to enhance self-esteem and stop young people from engaging in negative behaviours on the street, and to provide a non-violent ways to express their emotions (Redfernoralhistory, 2007a-e; Department of Education and Communities, 2013). The BighART project in the Kimberley region includes a variety of forms of arts, including music, video games, and movies to give voice to Indigenous youth, as well as to acquire skills such as computer literacy which help them to learn important skills for future opportunities (BighART, 2014).

Individual community members have been contributing to the effort of preventing suicide as well. For example, a man who lives near the cliff stopped numbers of people from jumping off the cliff by talking to suicidal individuals (Out of the Shadows, 2014). Those grass-root efforts and helpful hearts in communities have been saving numbers of people who are living in despair.

To address issues related to English proficiency and limited service utilisation rate among ethnic minorities, the Department of Immigration and Border Protection may be able to attach information packs to visas or related documents, which contain contact information of consulate and/or organisations that are providing services for migrants. The information packs should include both written and oral (or video clip) presentations for people who cannot read which are covering some places that migrants are able to seek help when they are in need.

Finally, it is required for professionals, particularly in rural/remote areas, to have opportunities for professional development. The Understanding and Building Resilience Project in the South-West region of Western Australia included this component by facilitating educational workshop for local professionals (Jackson & Johns, 2009). This sort of arrangement should be

organised more often to minimise locational disadvantage to the quality of services available for youth residing in rural/remote areas. The effectiveness of peer-gatekeeper programs is hugely dependant upon the availability and accessibility of treatment and other services, and therefore, capacity building in this area is essential (Isaac et al., 2009).

4.4 School System and Policy

Crawford and Caltabiano (2009) found that the majority of North Queensland teachers participated in their research did not have a good understanding of school policy on suicide prevention and intervention. Some research found that there was a lack of knowledge and skills among teachers about how to respond to youth at risk of suicide (Leane & Shute, 1998; Scouller & Smith, 2002; Crawford & Caltabiano, 2009; Reis & Cornell, 2008). However, a large number of teachers in Australia believe that they are in the position where they can contribute to suicide prevention strategies (Crawford & Caltabiano, 2009). The suicide screening project in the US observed a positive change of school environment after the project was launched in high school, where students started to seek help for themselves and their peers (Gutierrez et al., 2004).

Research indicates that good knowledge, skills, and tools to prevent and intervene in suicidal youth is needed, and to encourage help-seeking behaviour among youth, the positive environmental change which opens up discussion on suicide is a key factor for successful school-based suicide prevention strategies. However, this positive change in environment requires a lot of time, effort, and human resources. In this sense, the recent budget cut and reduction in jobs in the education sector (ABC News, 2014) is a major barrier for creating an environment where students are able to seek help freely. Although peer-gatekeeper programs fundamentally focus on young people themselves to seek help from their peers, the contribution from school staff in supervision and supporting of peer-gatekeepers is needed for both the safety of youth and the effectiveness of the program. Therefore, policy change is required to allocate more budget and human resources in school settings.

Governmental and political change is required in other areas. For example, Alston (2012) argues that policies are needed for farmers who are struggling to keep their agricultural business, which allows farmers to see a better future either by keeping their business or changing careers. She argues that those policies may need to include financial support for farmers to relocate themselves and/or seek for another career, and health and welfare services which are supporting farmers to make a good decision for themselves.

The detention system that places refugees and asylum seekers including children under strict surveillance is a direct result of government policies (Amnesty International, 2014). Efforts towards allowing the children of unauthorised arrivals to move out of detention into the community on Temporary Protection Visas are currently being examined, but will most likely lead to further problems, not least the separation of children from their parents (Australian Human Rights Commission, n.d.). In addition, political speech against refugees and asylum seekers creates negative stereotypes and prejudice which are creating more harmful social conditions for vulnerable migrants (Pederson, Fozdar, & Kenny, 2012). An alternative approach is required if the Australian government is serious about reducing the risk of suicide among refugees and asylum seekers.

Governmental intervention in Indigenous communities may need to include more voice from Indigenous people. For example, even when Indigenous people are concerned with substance abuse and domestic violence in their community, they generally dislike the approach of governmental intervention which is specifically targeting Indigenous people (GlobalPrison, n.d.) because it is promoting a stigma that Indigenous people are the ones with substance abuse issues, even though it is not always the case. This sort of approach is discriminative rather than supportive. Governmental intervention, therefore, should include Indigenous communities in the decision-making process and carried out in a way that respects their decisions.

The complexity of the social system is directly related to our everyday lives, and therefore, any suicide prevention effort should focus on an ecological approach which focuses on the society as a whole (Butler et al., 2010), rather than claiming that suicide prevention efforts are the responsibility of individuals, communities, and specialised services (LIFE, 2007). Suicide

prevention strategies should focus on creating positive environments which encourage help-seeking behaviour of vulnerable youth and work towards increased accessibility and collaboration with various supporting systems in order for at-risk youth to be able to seek for support that they need. Therefore, school-based peer-gatekeeper programs should be considered as an effort of including young people in a multi-layered approach towards suicide prevention and intervention, rather than an independent program that is based in schools.

4.5 Safety

Hazell and King (1996) argue that inclusion of young people in the process of identifying and responding to at-risk youth is placing a huge responsibility on young people for the lives of their peers, and if an at-risk youth attempts/completes suicide, the negative effect on peer-gatekeepers could be enormous. However, nearly half of 201 teachers in North Queensland who participated in a study conducted by Crawford and Caltabiano (2009) stated that they had had a student who had attempted or completed suicide within their class. The majority of young people in the United States responded that if they were considering taking their own lives and would like to seek help from others, they would choose to talk to their peers (Nelson & Galas, 2006). Kalafat and Elias (1992) found that 97 per cent of American high school students participated in their study had talked to a friend who was clearly at risk of suicide, and of those, 63 per cent tried to provide support to their peers, 24 per cent reported the risk of their peers to adult people, and 12 per cent did not take any action. As such, it might be argued that it is safer for young people to have knowledge and skills to respond to their at-risk peers than not knowing anything and fail to seek help, resulting in a loss of their peers.

To increase the safety of young people, peer-gatekeeper programs should educate youth on coping skills and help-seeking for their own, include supervisors who can provide professional assistance and debriefing, and build a safe environment for both peer-gatekeepers and at-risk youth to discuss their concerns freely, without worrying about negative responses and stigma

attached to suicide and related issues.

4.6 Areas of Focus for Future Research

As mentioned earlier, a lack of scientific foundation of gatekeeper program has been pointed out by several researchers, and the majority of research on the effectiveness of gatekeeper programs is conducted in the US. Firstly, to examine acceptability and demand of peer-gatekeeper programs in Western Australian secondary schools, different stakeholders including youth, their parents/guardians, teachers, school psychologists, other school staff, and wider community members, should be consulted. Their perception on peer-gatekeeper programs should be integrated throughout the development and implementation of peer-gatekeeper programs in Western Australian secondary schools, and post-implementation survey research should be conducted to examine if different stakeholders are seeing the program as acceptable (Bowen et al., 2009).

To measure the effectiveness of peer-gatekeeper training, pre-post research design to examine knowledge on suicide and skills to intervene into peers should be examined (Bowen et al., 2009) as well as self-reported confidence and satisfaction levels. For example, Stuart et al. (2003) examined improvement of suicide intervention skills among youth between 13 and 18 in Canada, using the revised Suicide Intervention Response Inventory (SIRI-II). The same method was recommended by Leane and Shute (1998). The SIRI-II is a questionnaire which contains 25 items to assess the ability of counsellors responding to at-risk individuals (Neimeyer & Bonnelle, 1997). The scores obtained prior to training will be compared with the score obtained from post-training to assess the effectiveness of the training.

Knowledge of suicide can be measured by the Adolescents Suicide Behaviour Questionnaire (ASBQ) developed by Scouller and Smith (2002). The ASBQ contains 39 true/false questions to examine the amount of knowledge on adolescent suicide held by participants in five areas: warning signs, precipitating factors, risk factors, demographics and statistics, and prevention

and treatment. Crawford and Caltabiano (2009) included two scenarios in this questionnaire which ask participants to assess if an individual is at high/low risk for suicide. Follow-up research on skills and knowledge of suicide should be conducted to assess the sustainability of the effect of training.

The effectiveness of peer-gatekeeper programs may be able to be assessed by using either the Suicide Ideation Questionnaire (SIQ) or the Suicide Ideation Questionnaire-JR (SIQ-JR). The SIQ is a questionnaire which contains 30 items that is designed to identify individuals who are experiencing suicide ideation (Pinot, Whisman, & McCoy, 1997). The SIQ-JR contains 15 items and shares the same characteristics as the SIQ (Reynolds & Mazza, 1999,). The SIQ is designed for children in Year 10-12, while the SIQ-JR is used for children between Year 7-9 (Reconnecting Youth, 2013). The SIQ and SIQ-JR can be used to assess if peer-gatekeepers are correctly identifying youth at risk of suicide.

Rodi et al. (2012) and Mann et al. (2005) recommended that evaluation research on referral patterns and treatment rates should be conducted. The evaluation research should collect data on to which treatment at-risk youth are referred, and how many of those referrals are accepted by at-risk youth (Rodi et al., 2012). Research should also focus on the barriers which may prevent young people from accepting those referrals (Cigularov et al., 2008). It may also be needed to examine feedback given by at-risk youth who are identified and referred to treatment, as well as feedback given by peer-gatekeepers after identifying their at-risk peers.

Ide (2011) pointed out that Australian census data has not collected any information on parents of second generation migrants. The Queensland Government (2012) pointed out that data on Maori and Pacific Islanders tended to be 'hidden' under data on New Zealanders because this group tended to migrate into Australia via New Zealand. Blignault and Haghshenas (2005) identified that information that had been collected by health services tended to include information on language and country of birth, and increasing number of data sets started to include information on religion; however, data on cultural belief should also be collected to examine beliefs on health and illness. Exclusion of CALD individuals with limited English proficiency has also been pointed

out by the same researchers (Blignault & Haghshenas, 2005) which may influence the generalisability of research findings to CALD communities. Research is needed to examine if peer-gatekeeper programs are perceived as an acceptable way to prevent suicide among CALD communities, as well as its effectiveness among migrants.

Isaac et al. (2009) pointed out that it is not clear what proportion of the population is required to be trained as gatekeepers in order for the program to be effective. However, Deane et al. (2006) pointed out that whether or not a gatekeeper would help at-risk individuals was dependant upon the intention of gatekeepers to participate in the process of identifying and responding to suicidal individuals. Therefore, it may not be cost-effective to provide peer-gatekeeper training to the whole student population.

Finally, it is difficult to examine effectiveness of suicide prevention programs, because of the difficulty of measuring the number of suicide which did not occur. In addition, suicide itself is a fairly rare event, and therefore, it is difficult to examine the effectiveness of the program based on census data or other data on suicide rates, particularly in smaller community where one single occurrence of suicide can dramatically influence the statistical data on the suicide rate. Therefore, the effectiveness research on suicide prevention programs may depend on more measurable data such as referral and treatment rates, reduction in SIQ or SIQ-JR scores, and reduction in suicidal behaviours.

The present research examined a possibility of implementing peer-gatekeeper programs in Western Australian secondary schools by focusing on barriers for the implementation process and the effectiveness of the program. The present research tried to present some of the ways to increase the possibility of implementing the program in secondary schools, as well as to maximise the effectiveness of the program. Peer-gatekeeper programs are one of the ways to prevent and intervene into young people who are at risk of suicide. However, peer-gatekeeper should be considered as an extra layer of suicide prevention strategies which contribute to the broader context of the society, rather than an independent program. The present study is simply focusing on published literature, and therefore, the findings of this research are not sufficient to examine the

actual potential of introducing peer-gatekeeper programs into Western Australia in a comprehensive manner. However, the author hopes that this research has highlighted some of the key issues that a study into the feasibility of such programs in Western Australia would need to address.

References

- ABC News. (2014, April 1). WA teachers' strike: Thousands rally in Perth to protest against school funding cuts. Retrieved from <http://abc.net.au>
- Akiyama, S., & Saito, Y. (2002). *Suicide Q & A: To Prevent Suicide*. Tokyo: Shibundo.
- Alston, M. (2012). Rural male suicide in Australia. *Social Science and Medicine*, 74(4), 515-522. <http://dx.doi.org/10.1016/j.socscimed.2010.04.036>
- Aly, W. (2014, July 11). Tony Abbott's harsh treatment of asylum seekers is the same old story. *Sydney Morning Herald*. Retrieved from <http://www.smh.com.au/>
- Amnesty International. (2014, August 19). Children in detention: Government takes a step in right direction [Web log post]. Retrieved from <http://www.amnesty.org.au/news/comments/35322/>
- Australian Bureau of Statistics [ABS]. (2010). *Aboriginal and Torres Strait Islander suicide deaths* (No. 3309.0). Retrieved from <http://www.abs.gov.au>
- Australian Bureau of Statistics [ABS]. (2014). *Causes of Death, Australia, 2012* (No.3303.0). Retrieved from <http://www.abs.gov.au>
- Australian Human Rights Commission. (n.d.). A last resort? – Summary guide: Temporary Protection Visas. Retrieved from <https://www.humanrights.gov.au/publications/last-resort-summary-guide-temporary-protection-visas>
- Barlow, D. H., & Durand, V. M. (2012). Disorders of mood. In, *Abnormal psychology: An integrative approach* (6th ed., pp. 204-255). Australia: Wadsworth.
- Baume, P. J. M., & Clinton, M. E. (1997). Social and cultural patterns of suicide in young people in rural Australia. *Australian Journal of Rural Health*, 5(3), 115-120. <http://dx.doi.org/10.1111/j.1440-1584.1997.tb00251.x>
- Bearman, P. S., & Moody, J. (2004). Suicide and friendships among American adolescents. *American Journal of Public Health*, 94(1), 89-95. <http://dx.doi.org/10.2105/AJPH.94.1.89>
- Beyondblue. (2014). Get immediate support. Retrieved from <http://www.beyondblue.org.au/get-support/get-immediate-support>

- Bhui, K. S., Dinos, S., & McKenzie, K. (2012). Ethnicity and its influence on suicide rates and risk. *Ethnicity and Health*, 17(1-2), 141-148. <http://dx.doi.org/10.1080/13557858.2011.645151>
- BighART. (2014). Current projects. Retrieved from <http://bighart.org/#art/current-projects/>
- Black Dog Institute. (n.d.) *Information for culturally and linguistically diverse young people and their families: Recognising the signs of depression and tips for young people in self-managing and seeking help*. Retrieved from <http://www.blackdoginstitute.org.au/docs/CALDpaper.pdf>
- Blignault, I., & Haghshenas, A. (2005). Identification of Australians from culturally and linguistically diverse backgrounds in national health data collections. *Australian Health Review*, 29(4), 455-468. <http://dx.doi.org/10.1071/AH050455>
- Bourke, L. (2002). "How can you deal with that?" Coping strategies among young residents of a rural community in New South Wales. *Journal of Family Studies*, 8(2), 197-212. <http://dx.doi.org/10.5172/jfs.8.2.197>
- Bourke, L. (2003). Toward understanding youth suicide in an Australian rural community. *Social Science and Medicine*, 57(12), 2355-2365. [http://dx.doi.org/10.1016/S0227-9536\(03\)00069-8](http://dx.doi.org/10.1016/S0227-9536(03)00069-8)
- Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., ... Fernandez, M. (2009). How we design feasibility studies. *American Journal of Preventative Medicine*, 36(5), 452-457. <http://dx.doi.org/10.1016/j.amepre.2009.02.002>
- Butler, H., Bowes, G., Drew, S., Glover, S., Godfrey, C., Patton, G., ... Bond, L. (2010). Harnessing complexity: Taking advantage of context and relationships in dissemination of school-based intervention. *Health Promotion Practice*, 11(2), 259-267. <http://dx.doi.org/10.1177/1524839907313723>
- Capp, K., Deane, F. P., & Lambert, G. (2001). Suicide prevention in Aboriginal communities: Application of community gatekeeper training. *Australian and New Zealand Journal of Public Health*, 25(4), 315-321. <http://dx.doi.org/10.1111/j.1467-842X.2001.tb00586.x>
- Cigularov, K., Chen, P. Y., Thurber, B. W., & Stallones, L. (2008). What prevents adolescents from seeking help after a suicide education program? *Suicide and Life-Threatening Behavior*, 38(1), 74-86. <http://dx.doi.org/10.1521/suli.2008.38.1.74>

- Colucci, E., & Martin, G. (2007a). Ethnocultural aspects of suicide in young people: A systematic literature review. Part 1: Rates and methods of youth suicide. *Suicide and Life-Threatening Behavior*, 37(2), 197-221. <http://dx.doi.org/10.1521/suli.2007.37.2.197>
- Colucci, E., & Martin, G. (2007b). Ethnocultural aspects of suicide in young people: A systematic literature review. Part 2: Risk factors, precipitating agents, and attitudes toward suicide. *Suicide and Life-Threatening Behavior*, 37(2), 222-237. <http://dx.doi.org/10.1521/suli.2007.37.2.222>
- Community Tool Box. (2013). Multicultural collaboration. Retrieved from <http://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/multicultural-collaboration/main>
- Crawford, S., & Caltabiano, N. J. (2009). The school professionals' role in identification of youth at risk of suicide. *Australian Journal of Teacher Education*, 34(2), 28-39. <http://dx.doi.org/10.14221/ajte.2009v34n2.3>
- Deane, F. P., Capp, K., Jones, C., de Ramirez, D., Lambert, G., Marlow, B., ... Sullivan, E. (2006). Two-year follow-up of a community gatekeeper suicide prevention program in an Aboriginal community. *Australian Journal of Rehabilitation Counselling*, 12(1), 33-36. <http://0-search.informit.com.au/prosperso.murdoch.edu.au/documentSummary;dn=746268538609672;res=IELHEA>
- De Leo, D., Dwyer, J., Firman, D., & Neulinger, K. (2003). Trends in hanging and firearm suicide rates in Australia: Substitution of method? *Suicide and Life-Threatening Behavior*, 33(2), 151-164. <http://dx.doi.org/10.1521/suli.33.2.151.22775>
- The Department of Education and Communities. (2013). Youth assistance strategies section: Sydney University settlement. Retrieved from <https://www.det.nsw.edu.au/eas/youth/publica/sydnuniv.htm>
- Department of Health. (2009). *Western Australian suicide prevention strategy 2009-2013*. Retrieved from http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/WA_Suicide_Prevention_Strategy.sflb.ashx
- Department of Health. (2012). CALD community connection. Retrieved from <http://www.livingisforeveryone.com.au/CALD-Community-Connections.html>

Dyke, R. J. (1991). System-entry issues in school suicide prevention education programs. In A. A. Leenaars, & S. Wenckstern. (Eds.), *Suicide prevention in schools* (pp. 41-49). Sydney: Taylor and Francis.

Eades, D. (2000). *Aboriginal English*. Retrieved from http://www.naalc.org.au/cb_pages/files/Aboriginal%20English%20in%20the%20Legal%20System%20-%20Diane%20Eades.pdf

Eckert, T. L., Miller, D. N., DuPaul, G. J., & Riley-Tillman, T. C. (2003). Adolescent suicide prevention: School psychologists' acceptability of school-based programs. *School Psychology Review*, 32(1), 57-76. <http://0-search.proquest.com.prospero.murdoch.edu.au/docview/219647502/citation/9430878768094236PQ/9?accountid=12629>

Eckert, T. L., Miller, D. N., Riley-Tillman, T. C., & DuPaul, G. J. (2006). Adolescent suicide prevention: Gender differences in students' perceptions of the acceptability and intrusiveness of school-based screening program. *Journal of School Psychology*, 44(4), 271-285. <http://dx.doi.org/10.1016/j.jsp.2006.05.001>

Fan, B. W. S. (2007). Intervention model with Indigenous Australians for non-Indigenous counsellors. *Counselling, Psychotherapy, and Health*, 3(2), Indigenous Special Issue, 13-20. http://www.cphjournal.com/archive_journals/V3_I2_Fan_13-20_2007.pdf

GlobalPrison. (n.d.). *Australian Aboriginal alcohol and drug misuse* [Video file]. Retrieved from <http://www.youtube.com/watch?v=jln00qCnoQs>

Goldston, D. B., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., & Hall, G. C. N. (2008). Cultural considerations in adolescent suicide prevention and psychological treatment. *American Psychologist*, 63(1), 14-31. <http://dx.doi.org/10.1037/0003-066x.63.1.14>

Green, R. (2003). Social work in rural areas: A personal and professional challenge. *Australian Social Work*, 56(3), 209-219. <http://dx.doi.org/10.1046/j.0312-407x.2003.00082.x>

Gutierrez, P. M., Watkins, R., & Collura, D. (2004). Suicide risk screening in an urban high school. *Suicide and Life-Threatening Behavior*, 34(4), 421-428. <http://dx.doi.org/10.1521/suli.34.4.421.53741>

- Hazell, P., & King, R. (1996). Arguments for and against teaching suicide prevention in schools. *Australian and New Zealand Journal of Psychiatry*, 30(5), 633-642.
<http://dx.doi.org/10.3109/00048679609062659>
- Ide, N. (2011). Suicide among immigrants in Australia: Directions for research and prevention. *Diversit-e*, 3, 19-20.
<http://www.dhi.health.nsw.gov.au/ArticleDocuments/1513/Ide.%20Diversite%203%202011.pdf.aspx>
- Ife, J. (2002). Change from below. In *Community development: Community-based alternatives in an age of globalisation* (2nd ed., pp.101-118). Frenchs Forest: Pearson Education Australia.
- Isaac, M., Elias, B., Katz, L. Y., Belik, S., Deane, F. P., Enns, M. W., ... The Swampy Cree Suicide Prevention Team. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.
<http://0-search.proquest.com.prospero.murdoch.edu.au/docview/222794379/abstract/7E94ABEB5BDE43E9PQ/7?accountid=12629>
- Jackson, B., & Johns, M. (2009). Community engagement for suicide prevention in South-Western Australia. *Proceedings of the 10th National Rural Health Conference held in Cairns, Australia, 17-20 May 2009*.
http://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Johns_Marina_D6.pdf
- Judd, F., Cooper, A., Fraser, C., & Davis, J. (2006). Rural suicide – people or place effects? *Australian and New Zealand Journal of Psychiatry*, 40(3), 208-216.
<http://dx.doi.org/10.1080/j.1440-1614.2006.01776.x>
- Kalafat, J., & Elias, M. (1992). Adolescents' experience with and response to suicidal peers. *Suicide and Life-Threatening Behavior*, 22(3), 315-321.
<http://dx.doi.org/10.1111/j.1943-278X.1992.tb00736.x>
- Kalafat, J., & Elias, M. J. (1995). Suicide prevention in an educational context: Broad and narrow foci. *Suicide and Life-Threatening Behavior*, 25(1), 123-133.
<http://dx.doi.org/10.1111/j.1943-278X.1995.tb00397.x>
- Kaslow, N. J. (2014). Speaking of psychology: Preventing suicide. Retrieved from
<http://www.apa.org/research/action/speaking-of-psychology/preventing-suicide.aspx>

- King, K. A., Price, J. H., Telljohann, S. K., & Wahl, J. (1999). High school health teachers' perceived self-efficacy in identifying students at risk for suicide. *Journal of School Health*, 69(5), 202-207. <http://dx.doi.org/10.1111/j.1746-1561.1999.tb06386.x>
- King, R. (1994). Suicide prevention: Dilemma and some solutions. *Rural Society*, 4(3/4), 2-6. <http://0-search.informit.com.au.prospero.murdoch.edu.au/documentSummary;dn=950605614;res=IELAPA>
- Lathouras, A. (2010). Developmental community work. In A. Ingamells, A. Lathouras, R. Wiseman, P. Westoby, & F. Coniglia (Eds.), *Community development practice: Stories, method and meaning* (pp. 11-28). Altona, Victoria: Common Ground.
- Leane, W., & Shute, R. (1998). Youth suicide: The knowledge and attitudes of Australian teachers and clergy. *Suicide and Life-Threatening Behavior*, 28(2), 165-173. <http://dx.doi.org/10.1111/j.1943-278X.1998.tb00636.x>
- Lifeline. (2010). Statistics on suicide in Australia. Retrieved from <http://www.lifeline.org.au/About-Lifeline/Media-Centre/Suicide-Statistics-in-Australia/Suicide-Statistics>
- Lifeline. (2014). Get help. Retrieved from <https://www.lifeline.org.au/Get-Help/>
- The Life Resource Charitable Trust. (2011). Normalising suicide raises the risk. Retrieved from <http://www.life.org.nz/suicide/suicidekeyissues/normalising-suicide-raises-the-risk/>
- Living is for everyone [LIFE]. (2007). *A framework for prevention of suicide in Australia*. Retrieved from http://www.livingisforeveryone.com.au/uploads/docs/LIFE_framework-web.pdf
- Living is for everyone [LIFE]. (2013). *The project approach to suicide prevention activities* [Fact sheet]. Retrieved from <http://www.livingisforeveryone.com.au/uploads/docs/LIFE-Fact%20sheet%2013.pdf>
- Lopez, S. R., & Guarnaccia, P. J. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, 51, 571-598. <http://dx.doi.org/10.1146/annurev.psych.51.1.571>
- Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., ... Hendin, H. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association*, 294(16), 2064-2074. <http://dx.doi.org/10.1001/jama.294.16.2064>

- MensLine Australia. (2014). Help, support and counselling services for men. Retrieved from <http://www.mensline.org.au/>
- Miller, D. N., Eckert, T. L., DuPaul, G. J., & White, G. P. (1999). Adolescent suicide prevention: Acceptability of school-based programs among secondary school principals. *Suicide and Life-Threatening Behavior*, 29(1), 72-85.
<http://dx.doi.org/10.1111/j.1943-278X.1999.tb00764.x>
- Miller, D. N., Eckert, T. L., & Mazza, J. J. (2009). Suicide prevention programs in the schools: A review and public health perspective. *School Psychology Review*, 38(2), 168-188.
<http://0-search.proquest.com.prospero.murdoch.edu.au/docview/219658471/A4A23F1B2DC94FE2PQ/3?accountid=12629>
- Mindframe. (2014). Facts and stats about suicide in Australia. Retrieved from <http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats>
- Moutier, C., Norcross, W., Jong, P., Norman, M., Kirby, B., McGuire, T., & Zisook, S. (2012). The suicide prevention and depression awareness program at the University of California, San Diego School of Medicine. *Academic Medicine*, 87(3), 320-326.
<http://dx.doi.org/10.1097/ACM.0b013e31824451ad>
- Neimeyer, R., & Bonnelle, K. (1997). The suicide intervention response inventory: A revision and validation. *Death Studies*, 21, 59-81.
<http://0-www.tandfonline.com.prospero.murdoch.edu.au/loi/udst20>
- Nelson, R. E., & Galas, J. C. (2006). Introduction. In *The power to prevent suicide: A guide for teens helping teens* (Updated ed., pp. 1-7). Minnesota: Free Spirit Publication.
- Office of the Auditor General Western Australia. (2014). *The implementation and initial outcomes of the suicide prevention strategy* (Report 7). Retrieved from https://audit.wa.gov.au/wp-content/uploads/2014/05/report2014_08-Suicide.pdf
- O'Malley, P. (1993). Empowerment, Aboriginal culture and crime prevention: Managing petrol sniffing among Aboriginal young people. In J. Bessant, S. Cooks, G. Coventry, D. Maunder, & J. Wyn. (Eds.), *Rethinking policies for young people* (pp. 184-188). Melbourne: University of Melbourne.
- Out of the Shadows. (2014). My story: Don Ritchie OAM. Retrieved from <https://www.outoftheshadows.org.au/Home/My-Story/Don-Ritchie>

- Page, A., Morrell, S., Taylor, R., Dudley, M., & Carter, G. (2007). Further increases in rural suicide in young Australian adults: Secular trends, 1979-2003. *Social Science and Medicine*, 65(3), 442-453. <http://dx.doi.org/10.1016/j.socscimed.2007.03.029>
- Palmer, D. (1999). Talking about the problems of young Nyungars. In White, R. (Eds.), *Australian youth subcultures: On the margins and in the mainstream* (pp. 110-119). Hobart: National Clearinghouse for Youth Studies.
- Palmer, D. (2006). Going back to country with bosses: The Yiriman project, youth participation and walking along with elders. *Children, Youth and Environment*, 16(2), 317-337. <https://prospero.murdoch.edu.au/articles/2022063.27640/1.PDF>
- Palmer, D. (2012). 'We got to look at our old people, use a different schools': The Yiriman Project, going back to country and bringing out stories across generations in the Kimberley. In Westoby, P., & Shevellar, L. (Eds.), *Learning and Mobilising for Community Development: A Radical Tradition of Community-Based Education and Training*, (pp. 41-54). UK: Ashgate Press
- Pedersen, A., Fozdar, F., & Kenny, M. (2012). Battling boatloads of prejudice: An interdisciplinary approach to activism with asylum seekers and refugees in Australia. In D. Bretherton, & N. Balvin (Eds.), *Peace psychology in Australia* (pp. 121-137). New York: Springer Science + Business Media.
- Pfeffer, C.R. (2001a). Diagnosis of Childhood and Adolescent Suicidal Behaviour: Unmet Needs for Suicidal Prevention. *Society of Biological Psychiatry*, 49, 1055-1061. [http://dx.doi.org/10.1016/S0006-3223\(01\)01141-6](http://dx.doi.org/10.1016/S0006-3223(01)01141-6)
- Pfeffer, C.R. (2001b). Youth Suicide: Prevention through Risk Management. *Clinical Neuroscience Research*, 1, 362-365. [http://dx.doi.org/10.1016/S1566-2772\(01\)00038-X](http://dx.doi.org/10.1016/S1566-2772(01)00038-X)
- Pinot, A., Whisman, M. A., & McCoy, K. J. M. (1997). Suicidal ideation in adolescents: Psychometric properties of the suicidal ideation questionnaire in a clinical sample. *Psychological assessment*, 9(1), 63-66. <http://dx.doi.org/10.1037/1040-3590.9.1.63>
- Power, T. J. (2003). Promoting children's mental health: Reform through interdisciplinary and community partnership. *School Psychology Review*, 32(1), 3-16. <http://0-search.proquest.com.prospero.murdoch.edu.au/docview/219647641/91818F56C0474D9BPQ/3?accountid=12629>

- Pugh, R. (2007). Dual relationships: Personal and professional boundaries in rural social work. *British Journal of Social Work*, 37(8), 1405-1423. <http://dx.doi.org/10.1093/bjsw/bcl088>
- Queensland Government. (2010). *Working with people from culturally and linguistically diverse backgrounds*. Retrieved from <https://www.communities.qld.gov.au/resources/childsafety/practice-manual/prac-paper-working-cald.pdf>
- Queensland Government. (2012). *Culturally and Linguistically Diverse (CALD) suicide prevention project: Older people and Maori and Pacific Islander young people* (Final Report). Retrieved from http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/docs/cald_suicide_prevent.pdf
- Queensland Health. (2007). *Working with Interpreters Guideline*. Retrieved from http://www.health.qld.gov.au/multicultural/interpreters/guidelines_int.pdf
- Reconnecting Youth. (2013). Tools for screening and assessment of suicide risk. Retrieved from <http://www.reconnectingyouth.com/>
- The Redfern Settlement Neighbourhood Centre [redfernoralhistory]. (2007, September 8a). *A place of peace: Part 1* [Video file]. Retrieved from <http://youtube.com/watch?v=Y9KEFQYA>
- The Redfern Settlement Neighbourhood Centre [redfernoralhistory]. (2007, September 8b). *A place of peace: Part 2 Composition* [Video file]. Retrieved from <http://youtube.com/watch?v=Oo5lZVhmCY>
- The Redfern Settlement Neighbourhood Centre [redfernoralhistory]. (2007, September 8c). *A place of peace: Part 3 Recording* [Video file]. Retrieved from <http://youtube.com/watch?v=4R8h-yfNcBs>
- The Redfern Settlement Neighbourhood Centre [redfernoralhistory]. (2007, September 8d). *A place of peace: Part 4 Countering racism* [Video file]. Retrieved from http://youtube.com/watch?v=1W2C_FlTcXg
- The Redfern Settlement Neighbourhood Centre [redfernoralhistory] (2007, September 8e). *A place of peace: Part 5 Launch* [Video file]. Retrieved from <http://youtube.com/watch?v=rNzs2kPGMV4>

- Refugee Council of Australia. (2014). Mandatory detention. Retrieved from <http://www.refugeecouncil.org.au/f/as-det.php>
- Reis, C., & Cornell, D. (2008). An evaluation of suicide gatekeeper training for school counselors and teachers. *Professional School Counseling*, 11(6), 386-394. <http://dx.doi.org/10.5330/PSC.n.2010-11.386>
- Reynolds, W. M., & Mazza, J. J. (1999). Assessment of suicidal ideation in inner-city children and young adolescents: Reliability and validity of the suicidal ideation questionnaire-JR. *School Psychology Review*, 28(1), 17-30. <http://0-search.proquest.com.prospero.murdoch.edu.au/docview/219658515/C56A158B3D3F4C4EPQ/5?accountid=12629>
- Robinson, J., Cox, G., Malone, A., Williamson, M., Baldwin, G., Fletcher, K., & O'Brien, M. (2013). A systematic review of school-based intervention aimed at preventing, treating, and responding to suicide-related behaviour in young people. *Crisis*, 34(3), 164-182. <http://dx.doi.org/10.1027/0227-5910/a.000168>
- Rodi, M. S., Garraza, L. G., Walrath, C., Stephens, R. L., Condron, D. S., Hicks, B. B., & McKeon, R. (2012). Referral patterns for youths identified at risk for suicide by trained gatekeepers. *Crisis*, 33(2), 113-119. <http://dx.doi.org/10.1027/0227-5910>
- Sachmann, M. (2007). *Peer group support weekends: Evaluation report (14-18 year olds)*. Retrieved from <http://youthfocus.com.au/wp-content/uploads/2011/03/Peer-Support-Research.pdf>
- Saggers, S., Palmer, D., Royce, P., Wilson, L., & Charlton, A. (2004). Youth practice in local government. In *Alive and motivated: Young people, participation and local government* (pp. 99-110). Canberra: National Youth Affairs Research Scheme.
- Samaritans. (2014). Help and service. Retrieved from <http://www.thesamaritans.org.au/Help---Support.aspx>
- Scherff, A. R., Eckert, T. L., & Miller, D. N. (2005). Youth suicide prevention: A survey of public school superintendents' acceptability of school-based programs. *Suicide and Life-Threatening Behavior*, 35(2), 154-169. <http://dx.doi.org/10.1521/suli.35.2.154.62874>
- Scouller, K. M., & Smith, D. I. (2002). Prevention of youth suicide: How well informed are the potential gatekeepers of adolescents in distress? *Suicide and Life-Threatening Behavior*, 32(1), 67-79. <http://dx.doi.org/10.1521/suli.32.1.67.22182>

- Scourfield, J. (2014). How suicide prevention app alerts you to signs of distress on Twitter. Retrieved from <http://theconversation.com/how-suicide-prevention-app-alerts-you-to-signs-of-distress-on-twitter-33648>
- Sheldon, M. (2001). Psychiatric assessment in remote Aboriginal communities. *Australian and New Zealand Journal of Psychiatry*, 35(4), 435-442. <http://dx.doi.org/10.1046/j.1440-1614.2001.00920.x>
- Stuart, C., Waalen, J. K., & Haelstormm, E. (2003). Many helping hearts: An evaluation of peer gatekeeper training in suicidal risk assessment. *Death Studies*, 27(4), 321-333. <http://dx.doi.org/10.1080/0748118039099082>
- Suicide Prevention Australia [SPA]. (2010). *Position Statement: Youth suicide prevention*. Retrieved from <http://suicidepreventionaust.org/wp-content/uploads/2012/01/SPA-Youth-Suicide-Prevention-Position-Statement.pdf>
- Tighe, J., & McKay, K. (2012). Alive and kicking goals!: Preliminary findings from a Kimberley suicide prevention program. *Advances in Mental Health*, 10(3), 240-245. <http://dx.doi.org/10.5172/jamh.2012.10.3.240>
- Tsey, K., Patterson, D., Whiteside, M., Baird, L., Baird, B., & Tsey, K. (2003). Indigenous men taking their rightful place in society? A follow up report. *Australian Journal of Rural Health*, 11(6), 285-286. <http://dx.doi.org/10.1111/j.1440-1584.2003.tb00554.x>
- Vicary, D., & Westerman, T. (2004). 'That's just the way he is': Some implications of Aboriginal mental health beliefs. *Australian e-Journal for the Advancement of Mental Health*, 3(3), 1-10. <http://dx.doi.org/10.5172/jamh.3.3.103>
- Victor, S., Victor, D., & O'Reeri, M. V. (2009). Speech at the Billard Summit. In Billard Learning Centre (Eds.), *Blank Page Summit on Suicide: Getting together for life held in Billard Learning Centre, Kimberley, Western Australia, 28-30 July 2009* (pp. 15-35). <http://www.nt.gov.au/lant/parliamentary-business/committees/ctc/youth-suicides/Submissions/Sub%20No.%2008,%20Robert%20Parker,%20Top%20End%20Mental%20Health,%20Part%2004,%2029%20Sept%202011.pdf>
- White, R. (2009). Indigenous youth and gangs as family. *Youth Studies Australia*, 28(3), 47-56. <http://0-search.informit.com.au/prosporo.murdoch.edu.au/documentSummary;dn=103550089085972;res=IELFSC>

- Woods, W., Wanatjura, E., Colin, T., Mick, J., Lynch, A., & Ward, N. (2000). Atunypa wiru malparara malparara: the strength of working together. In Weeks, W., & Quinn, M. (Eds.), *Issues facing Australian families: human service respond* (pp. 91-100). Sydney: Longman.
- Wyman, P. A., Brown, C. H., Inman, J., Cross, W., Schmeelk-Cone, K., Guo, J., & Pena, J. B. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76*(1), 104-115. <http://dx.doi.org/10.1037/0022-006X.76.1.104>
- Youth Focus. (2010). Services. Retrieved from <http://youthfocus.com.au/services-2/>
- Youth Focus. (2014). Mentoring. Retrieved from <http://youthfocus.com.au/services-2/mentoring/>