Attempted or Alleged* Suicide support guidelines

Purpose

Provide guidance to staff in remote Aboriginal Community Controlled primary health clinics to support clients, family & community following an attempted or alleged suicide.

This is a non-clinical document designed to provide holistic advice about how to respond to community & staff members affected by an attempted or alleged suicide.

Postvention support is an important part of preventing future suicide

A previous suicide attempt is the largest single factor indicating future suicide risk & death by suicide. Appropriate support following a suicide attempt can help to reduce the risk of subsequent attempts[i].

People bereaved by suicide have a higher risk of suicidal behaviour, mental health disorders & complicated grief which may also require support & intervention[ii].

Clinical & legal guidelines that provide additional information include:

1. If you believe that a person may be at risk of suicide:

   CARPA clinical guidelines for Suicide Risk

   St John's Ambulance Clinical Practice Guidelines (see 'Suicidal Patient' pp 240)

2. If a person has attempted:

   CARPA clinical guidelines for Mental Health Emergency

   CARPA clinical guidelines for Near Hanging

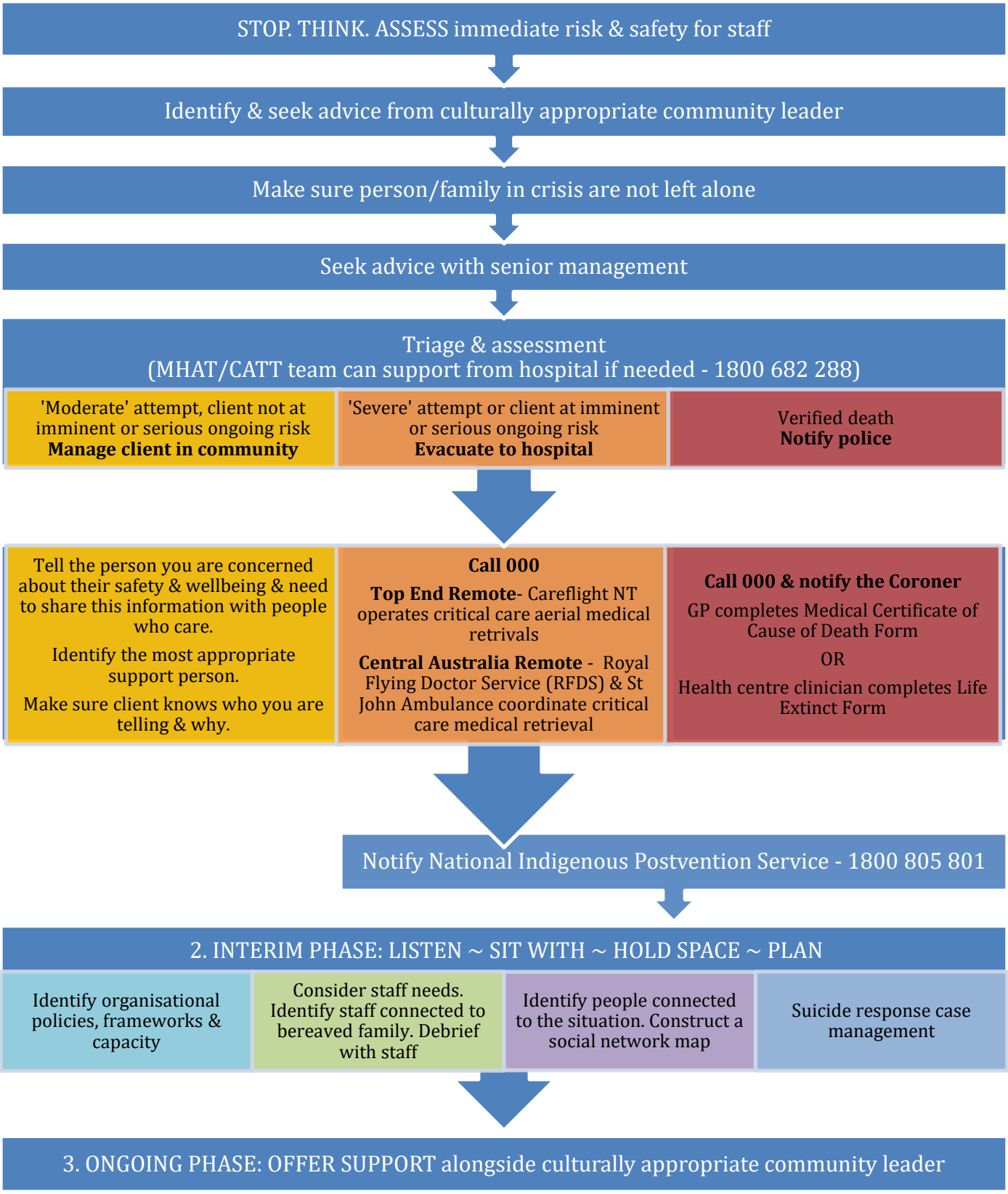
3. If a person has died from an alleged suicide:

   Coroners Act NT - Information

   NT Government - What to do if someone dies

* The term 'alleged suicide' is used throughout this document to indicate when a person is suspected to have died by suicide. All alleged suicides are referred to the coroner to confirm cause of death. To avoid presenting suicide as a desired outcome, don't say 'successful' or 'completed' suicide. For more on language & suicide refer to Appendix 4.

1. Immediate phase: Establish Safety



2. Interim phase: Listen ~ Sit with ~ Hold space ~ Plan

Identify the most culturally appropriate community leader to support the individual and/or family. Staff should work alongside, and be guided by this leader at every step.

Checklist: Organisational framework & planning

☐ Identify cultural safety protocols & staff wellbeing policies in your organisation

☐ Identify the training, skills & knowledge in your workplace & consider the kinds of support you can really offer

☐ Identify & reach out to other agencies & community groups who you can collaborate with in providing support to the client & family (refer to contact list on page 5-6)

Checklist: Staff needs

☐ Provide opportunities for professional & peer debriefing

☐ Encourage self-care practices (some examples are provided below)

☐ Continue to check-in & monitor staff wellbeing

Adapted from: Olga Phoenix Project. Healing for Social Change

Checklist: Social network mapping

☐ Construct a social network map to identify:

1. the positive social supports that can help to keep a person strong moving forward; &
2. people within the family or community who are also at risk & in need of support.

Consider the person's family, friends, romantic relationships & the connections they might have through school, work, sports, church or other social services.

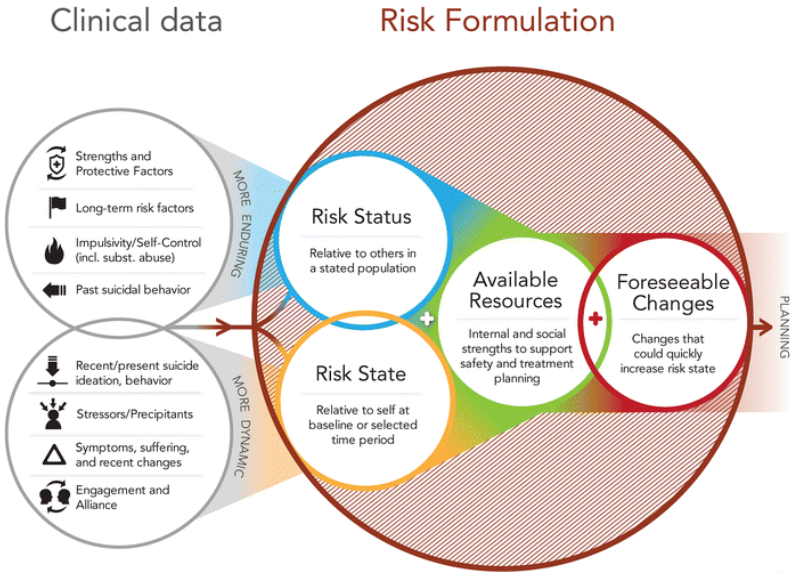
Factors that lead to suicide often relate to social context, relationship, social behaviours & informal support systems. Within our social environment we have both positive & negative influences on our wellbeing & resiliency.

To construct your social network map you may want to use this simple online tool developed by Columbia University for use by social workers & human service, health or mental health workers.

Checklist: Case planning

☐ Comprehensively assess risk & protective factors associated with suicidal behaviour.

You may want to consider this prevention-oriented risk formulation from SafeSide Prevention. This approach does not aim to predict future behaviour, but to promote communication & collaboration among professionals, patients, & families to reduce risk in the short & long term.



☐ Use findings from the comprehensive assessment to complete a care plan.

The care plan should clearly articulate roles, responsibilities & timeframes, including a planned date for reassessment. Planning should consider actions & supports that need to be in place immediately (today); in the short-term (next 7 days); & longer term (next 28 days).

3. Ongoing phase: Offer support

Make sure it is clear which staff member/organisation/agency is coordinating ongoing support and managing any care plans that have been put in place.

Checklist: Support for the client & family

☐ Consider the mode(s) of support that the individual or family would find most helpful & which you are equipped to offer. Consider whether support can be delivered at the family's home, somewhere outdoors, at a clinic site, one on one, or in a group.

The mode of support should be guided by what the individual &/or family feel most comfortable with. If they indicate that it is not the right time to engage, staff members should offer to make contact again at a later agreed time, & if this is refused, contact details should be provided in case they want to seek support later.

Mode of support	Examples of self-identified needs
Practical	Access to food & basic essentials
	Support to care for children
	Support organising a funeral
	Navigating the health/social service system
	Connecting client & family with traditional healers
Social, Emotional & Cultural	Building a sense of connectedness with: trusted support people, elders, family, community & Country.
	Identify & support engagement with appropriate cultural practice
	Supporting a sense of empowerment, autonomy & agency in decision-making
Psychological	Stabilising distress
	Identifying & recognising the contribution of past trauma
	Create opportunities to make meaning of trauma & grief
Physical	Responding to immediate medical needs
	Managing AOD misuse
	Reducing or eliminating exposure to violence
	Limiting access to means of physically harming
	Identifying a safe space to go if having suicidal thoughts

(Adapted from Black Dog Institute: What can be done to reduce suicidal behaviour[iii])

Checklist: Support for community

☐ Use a social support network map – like this simple online tool – to identify everyone in the community who is connected to the person who has attempted or died by suicide. Use this map to guide you in identifying people who are at risk & reach out to offer them support.

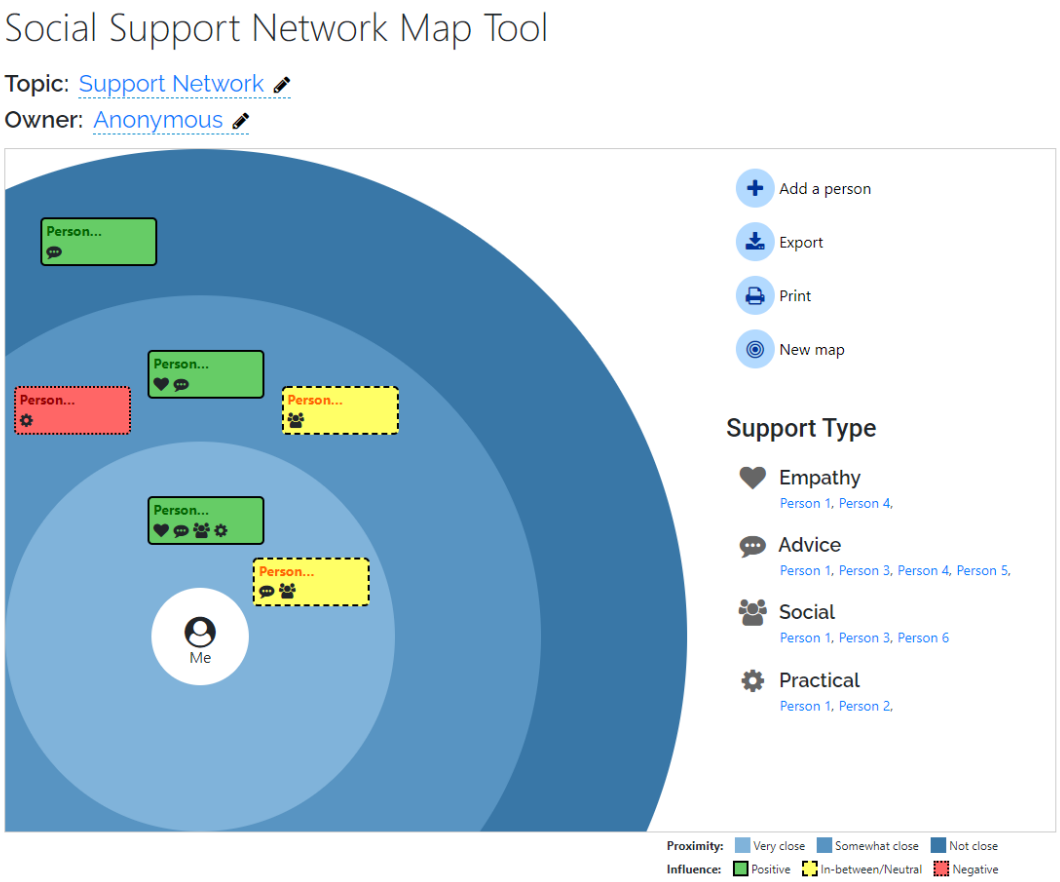


Image 1: Snapshot of a Social Support Network Map Tool, developed by Colombia University & available free online at: https://ssnm.ctl.columbia.edu/

NOTE: It is important to remember that ACCHSs represent the community. Sometimes the communities' wishes & families' wishes may not align.

While it is important to try to build trust & work with the family, if they refuse this help, there is still an obligation to work with the broader community to prevent any further harms.

In some more complex situations, it may be the case that family are not open to support because additional risk factors are present e.g. bullying, sexual abuse, neglect, domestic violence. If you are unsure how best to respond to these kinds of complex cases, seek guidance from your management, clinical supervisor, and culturally appropriate community leaders.

Who can help?

1. Culturally appropriate leaders, healers & 'natural helpers'[iv]

Culturally appropriate leaders are people who live in the community & are already well known as a reliable support person to reach out to during a time of crisis. They are often older adults who are able to provide a warm, non-judgmental & welcome space for sharing & healing.

It is important to identify these leaders in your community & work alongside them. Options for more formal recognition & resourcing for people in these roles should be considered where appropriate. Support should also be offered to these 'natural helpers' reduce risk of burnout & vicarious trauma.

2. Community-specific resources

Be aware of local community groups who you may be able to work, such as: Women's & Men's Groups; Suicide Prevention networks; Community Suicide Prevention Grant Recipients

3. Service and training providers

Service	What they do	Contact
Postvention support services		
National Indigenous Postvention Service (NIPS)	Coordinates support to Indigenous individuals, families, & communities affected by suicide. Can travel to provide face to face support if invited by family.	24 hours, 7 days per week Call: 1800 805 801 More information
NT Mental Health Line	Hospital-based phone line that provides assessment of alleged suicide & can play a coordinating role in the postvention response	24 hours, 7 days per week Call: 1800 682 288
StandBy Support	Provides face to face & telephone support to people impacted by suicide. Run locally tailored community awareness & training workshops.	24 hours 7 days per week Call: 0418 575 680 More information
Support for staff		
AMSANT	Provides supervision & workforce support. Delivers Culturally Responsive Trauma Informed Care Training.	8:30-17:00 Mon to Fri Call: (08) 8944 6667 More information
Employment Assistance Scheme Australia (EASA)	Provides free, confidential, telephone, skype or face to face counselling for Health Care staff	8:30-17:00 Mon to Fri Call: 1800 193 123 More information

CRANAplus Bush Support services	Provides free & confidential telephone counselling service for rural & remote area health professionals.	24 hours, 7 days per week Call: 1800 805 391 More information
Training/Community education		
Suicide Story	The Suicide Story Program uses both-ways learning to guide understanding, reduce stigma & equip participants with the skills, knowledge & confidence to respond to suicide risk in remote Aboriginal communities	Mon – Fri 8:30am-4:30pm Call: 08 8946 4800
Anglicare NT	Suicide Intervention & awareness training (ASIST & SafeTALK)	Mon – Fri 8:30am-4:30pm Call: 08 8946 4800
Royal Flying Doctor Service (RFDS) Mental Health Team	Has trainers able to provide a suicide prevention workshop for interested communities	Call: 08 8958 8490
Mental Health Association of Central Australia (MHACA)	Provides a range of accredited training courses for professionals	Mon – Fri 8.30am–4.00pm Call: 08 8950 4600
Lifeline Central Australia	Community education & training in suicide awareness & prevention	Mon – Fri 9am-4:30pm Call: 08 8953 1250
Remote mental health services		
Relationships Australia	Provides specialist counselling services for children & families. Face-to face sessions are available in Darwin, Katherine & Alice Springs & phone or video sessions for people all over the Territory.	Mon - Fri 8:30am to 5pm Call: 1300 264 277
Royal Flying Doctor Service (RFDS) Mental Health Team	Treatment of mild to moderate mental illness. Visits one week per month to nominated communities in the Barkly & Central Australia	Call: 08 8958 8490
Central Australian Mental Health Service	Specialist clinical mental health services to clients in Central Australia & Barkly regions.	Call: 08 8951 7710
Top End Mental Health Service	Specialist clinical mental health services to clients in the Top End, Katherine & East Arnhem regions.	Call: 08 8999 4988

Further reading and useful references

The Little Red Threat Book – A community response to Suicide as a threat, developed in Central Australia through community workshops, coordinated by the Mental Health Association of Central Australia.

Brief Wellbeing Screener – developed by the NT Remote AOD Workforce Program to help guide discussion & assessment by health centre staff

Grieving Aboriginal Way – A description of grief from an Aboriginal perspective in simple language with images. Developed by Indigenous Psychologist Tracy Westerman in 2011.

Finding our way back – A resource for Aboriginal & Torres Strait Islander Peoples after a Suicide Attempt, developed by Beyond Blue.

Postvention Australia Guidelines – A resource for organisations & individuals providing services to people bereaved by suicide developed by the Australian Institute for Suicide Research & Prevention in 2017.

Trauma & Loss - Guidelines for providing mental health first aid to an Aboriginal or Torres Strait Islander Person, developed by Mental Health First Aid Australia in 2012.

What can be done to reduce Suicidal Behaviour – Paper by the Black Dog Institute from 2020 that delivers a series of evidence-based recommendations to guide suicide prevention initiatives.

Reconsidering self-care – Journal article that proposes an approach to self-care based in relational models & a recovery orientation

Self-care toolkit – Resource from the Aboriginal Health & Medical Research Council of NSW

Preventing Suicide among Aboriginal Australians – In Working Together: Aboriginal & Torres Strait Islander mental health & wellbeing principles & practice

Evaluation of Suicide Story - Findings from an evaluation completed by Batchelor Institute in 2019 to assess Suicide Story, a culturally safe & Aboriginal-led suicide prevention program.

The Elders' Report into Preventing Indigenous Self-harm & Youth Suicide - The Report describes interviews held between 2012-2014 with 31 Elders & Community representatives from over 17 communities, asked about the causes of suicide & their identified solutions.

Contextual aspects of suicide in Australian Aboriginal communities – 2020 article exploring suicide in Aboriginal communities as a ways of executing violence or retaliation, & a response to lack of choice in the face of an historical context of intergenerational trauma, grief & loss.

Reformulating Suicide Risk Formulation: From Prediction to Prevention – 2016 article with a suicide risk formulation that moved from prediction to a prevention model.

Appendix 1: Three phases response to trauma & grief

A key factor in enabling recovery is working with the client to help them find & maintain a sense of hope. This involves the person believing in themselves & feeling optimistic about their future. Recovery is a journey. It takes time, looks different for every person & is a non-linear process.

Developed from the work of Judith Hermann & adapted from Coade et. al. Yarning up on trauma[v], the following table identifies 3 key stages & phases of healing which reflect an individual's personal journey towards recovery & maintaining hope.

- Ensuring physical emotional & physical safety.
- Establishing safety & security in life circumstances
- Creating safe places & spaces
- Developing safety & trust within relationships
- Maintaining existing healthy relationships that are safe
- Maintaining connections to culture & country
- Creating safety within communities (safe places & community healing work)
- Developing a capacity for self-regulation, & a sense of safety in the body

- Parents, carers & workers skilled & ready to listen & hear stories of trauma & grief
- Sharing stories within safe & trusting relationships
- Developing language to describe thoughts & feelings
- Exploring/ making meaning of the trauma & grief: creative arts, play, make a story book
- Exploring family trauma/ intergenerational trauma (understanding trauma): individuals, families & communities
- Create opportunities to explore grief & loss i.e. separation from family, culture & community
- Trauma & grief is able to be talked about not hidden or secret or shamed.

- Individuals & families reconnecting with wider community & families
- Integrating the trauma & grief story & moving on with a sense of hope & direction for the future
- Strengths based working with individuals' families & communities (build on skills, talents & values)
- Finding a mission e.g. peer mentoring/ community work
- Community building: e.g. developing places & opportunities for community to come together to celebrate & share. Strong in culture together

Appendix 2: Suicide risk factors

Risk Factors

Previous suicide

A previous suicide attempt is the largest single factor indicating future suicide risk & death by suicide.

Adverse Childhood Experiences

The ACES study indicates that individuals exposed to 4 or more traumatic events during childhood are 4 times more likely to experience depression, & 12 times more likely to commit suicide[vii].

The AIHW identifies 'child abuse & neglect' as the leading behavioural risk factor for suicide & self-harm[iix].

Violence

For females, the AIHW identifies 'intimate partner violence' as the second greatest contributor suicide & self-harm[iix].

AOD misuse

In males, the AIHW identifies 'alcohol use' & 'illicit drug use' as the second & third leading risk factors contributing to suicide & self-harm[iix].

Relationship issues

After previous suicide, 'problems in relationship with spouse or partner' & 'disruption of family by separation & divorce' are the most frequently occurring psychosocial risk factors identified in coroner-certified suicide deaths[ix].

A note on suicide 'clusters'

Cases of suicidal behaviour & deaths that appear to become socially 'contagious' within a community or region over a limited period of time have been recorded in Aboriginal & non-Aboriginal Australian communities in recent decades[x].

Deep connections between the deceased & surviving immediate family, kin & friends should be recognised as a risk factor, requiring postvention preventative measures.

Factors common to clusters which have been recorded include:

- High levels of alcohol & drug misuse
- Widespread community unemployment & limited opportunities for young people
- Exposure to suicidal threats, attempts & suicide within the family or close associates
- Constant state of mourning, grief & bereavement from the cumulative impact of funerals & grieving rituals, which can overwhelm the normal recovery process[x].

Appendix 3: Suicide Prevention

"…the desire to end one's personal story abruptly, prematurely & deliberately can be seen to stem from the complex interplay of historical, political, social, circumstantial, psychological & biological factors that have already disrupted sacred & cultural continuity; disconnecting the individual from the earth, the universe & the spiritual realm—disconnecting the individual from the life affirming stories that are central to cultural resilience & continuity[vi]."

Protective Factors

Strong early childhood development

Extensive research has demonstrated that intervention in early childhood, including family support & parenting programs, can improve long-term health, wellbeing & resilience outcomes[xi].

Cultural continuity

Research from Canada has shown that communities with more 'cultural continuity' factors had lower rates of suicide among their young people. These factors include:

- a measure of self-government;
- have litigated for Aboriginal title to traditional lands;
- a measure of local control over health, education, policing & child welfare services;
- community facilities for the preservation of culture[xii].

Community healing

Healing initiatives aimed at strengthening positive identification with culture & enabling social & economic participation in community life, has been found to be a key recovery feature of communities where high rates of suicide & other self-destructive behaviours have been reduced[x].

Connectedness

Connections to body, mind & emotions, family & kinship, community, culture, land & spirituality are all recognised as essential to the maintenance of social & emotional wellbeing for Aboriginal people[x].

Appendix 4: Language and Suicide

Certain ways of talking about suicide can alienate members of the community, sensationalise the issue or inadvertently contribute to suicide being presented as glamorous or an option for dealing with problems.

Preferred language

People who are vulnerable to suicide, or bereaved by suicide, can be particularly impacted by language. Below is a summary of preferred language to use when communicating about suicide.

Do say	Don't say	Why?
'non-fatal' or 'made an attempt on his/her life'	'unsuccessful suicide'	To avoid presenting suicide as a desired outcome or glamourising a suicide attempt.
'took their own life', 'died by suicide' or 'ended their own life'	'successful suicide'	To avoid presenting suicide as a desired outcome.
'died by suicide' or 'ended his/ her own life	'committed' or 'commit suicide'	To avoid association between suicide and 'crime' or 'sin' that may alienate some people.
'concerning rates of suicide'	'suicide epidemic'	To avoid sensationalism and inaccuracy.

We need to ensure we are not "too afraid" to talk about suicide as a community, while respecting & understanding the risks in certain situations.

Talking about suicide

Suicide is an important issue of community concern and needs to be discussed. However, there is often confusion about what is meant by "discussing" or "talking about" suicide, & confusion about the evidence.

Everymind has developed world-first resources to support community conversations about suicide. The online Conversations Matter resources assist communities to talk about suicide in ways that break down the stigma and increase understanding & support for those thinking about suicide, or those affected by suicide.

A series of resources have also been developed by Aboriginal leaders and organisations in NSW, to help support conversations about suicide

Appendix 5: Principles of practice for mental health & suicide risk screening & assessment for Aboriginal people

The Royal Australian & New Zealand College of Psychiatrists have developed a framework referred to as Understanding the Dance of Life for culturally competent assessment.

This framework provides information about the traditional, historical & contemporary contributors of mental health & suicide for Aboriginal people across five dimensions (physical, psychological, social, spiritual & cultural). It also identified gaps in knowledge & solutions across these five dimensions.

Culturally competent assessment involves a commitment by the practitioner to self-exploration, critical self-reflection & recognition of the implications of the power differentials inherent in the role of clinicians & clients

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The Royal Australian College of General Practitioners & NACCHO have developed a National Guide to a preventative health assessment for Aboriginal & Torres Strait Islander people, which makes a series of practice recommendations on screening for suicide risk (pp 122-123).

This includes the following advice about asking about suicide:

Box 4. Ways of asking about suicide

Have you ever felt like this before?

Have you ever felt so bad that you've hurt yourself or tried to kill yourself?

Many people when they feel this bad have thought about hurting themselves or even killing themselves. Has this happened to you?

Other people with similar problems sometimes lose hope. Has this happened to you?

Have you thought about how you would kill yourself?

Have you made any plans?

What stops you from doing that?

And as a follow-up question to many of the others: *Can you tell me more about that?*

Asking about suicide intent does not make it more likely

The Commonwealth Department of Health has developed a set of National Practice Standards for the Mental Health Workforce 2013. This includes Standard 4: Working with Aboriginal & Torres Strait Islander people, families & communities which identifies the responsibility of mental health practitioners in actively & respectfully reducing barriers to access, providing culturally secure systems of care, & improving social & emotional wellbeing.

References

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