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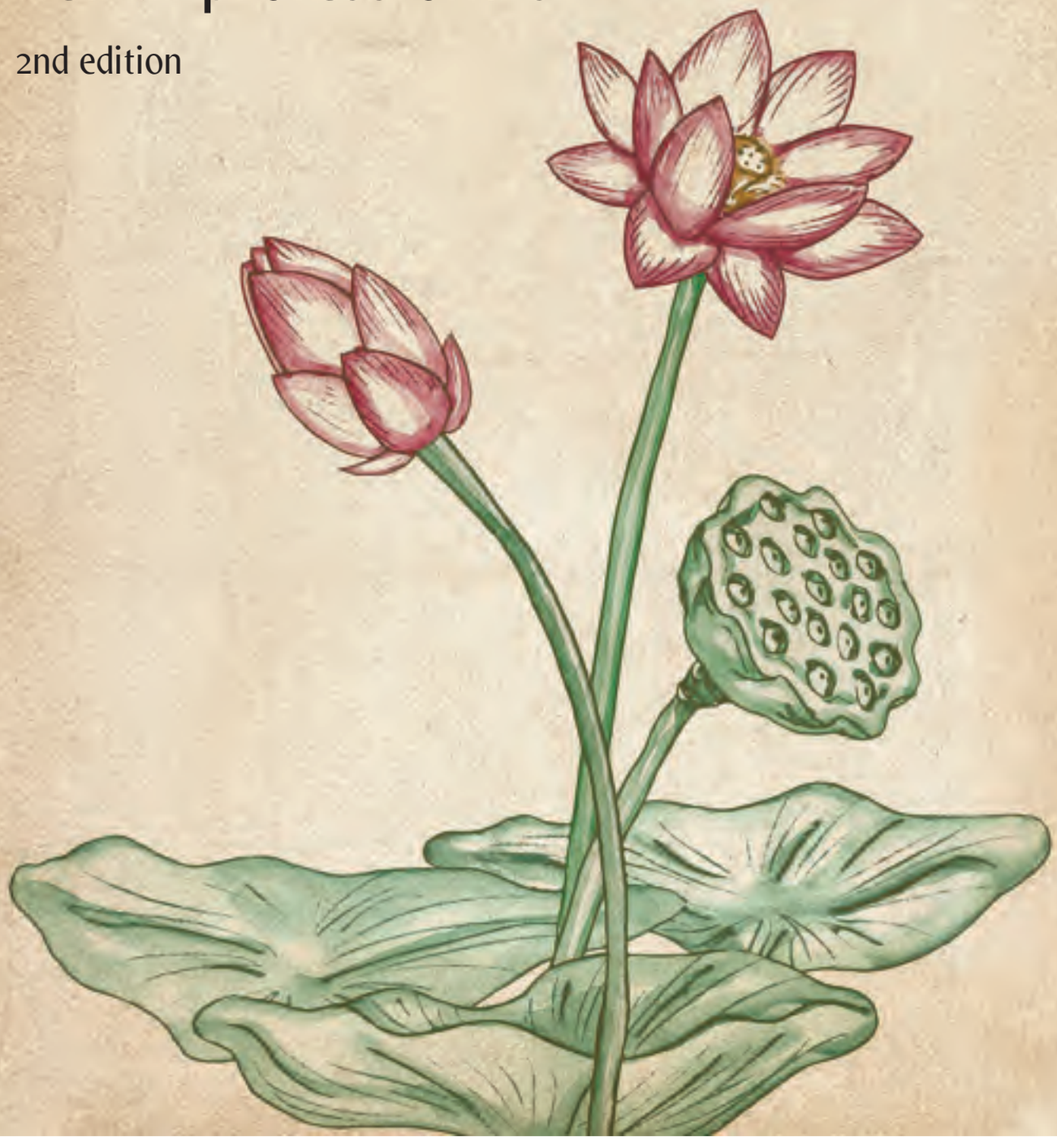
# Suicide Prevention and Recovery Guide

## A resource for mental health professionals

2nd edition



# Suicide Prevention and Recovery Guide

## A resource for mental health professionals

## Contents



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**The SANE Australia Suicide Prevention and Recovery Guide aims to help mental health professionals support people who are experiencing suicidal thoughts and behaviours – through the prevention of suicide, and in crisis management.**

This guide is unique because it examines suicide prevention through the lens of recovery. This is particularly relevant as the management of suicide risk, especially when it leads to involuntary hospitalisation, may be perceived at times to conflict with recovery principles encouraging services to support consumer choice and decision-making. The guide helps workers to reflect on how they address suicide in their workplace, and in what ways they can support the individual's recovery during this time. An important part of recovery-focused suicide prevention is to talk to clients when they are well, about what they would like to happen when they are not. How mental health professionals can instil a sense of hope and encourage individual responsibility, while still upholding their duty of care for consumer and community safety, is central to this guide.

The guide is suitable for mental health professionals including mental health support workers, peer workers, mental health nurses, psychologists, psychiatrists, social workers, general practitioners and occupational therapists working in both community and hospital settings. Although workers in different settings may focus on different aspects of care, recognising and responding to people experiencing suicidal thoughts and behaviours is relevant to all. It is just as important that those working in a community setting are confident to address the issue of suicide as it is for clinicians to think of suicide in terms broader than pathology and treatment of an illness.

The majority of mental health professionals work hard with their clients to improve mental health and reduce the likelihood of suicide. This guide is intended to be a broad overview of how suicide can be approached from a recovery perspective to help them continue their essential work. It is not a 'how to' book on preventing suicide, but it is intended to provide a useful resource, encouraging a holistic and inclusive view that puts the consumer at the centre of care.

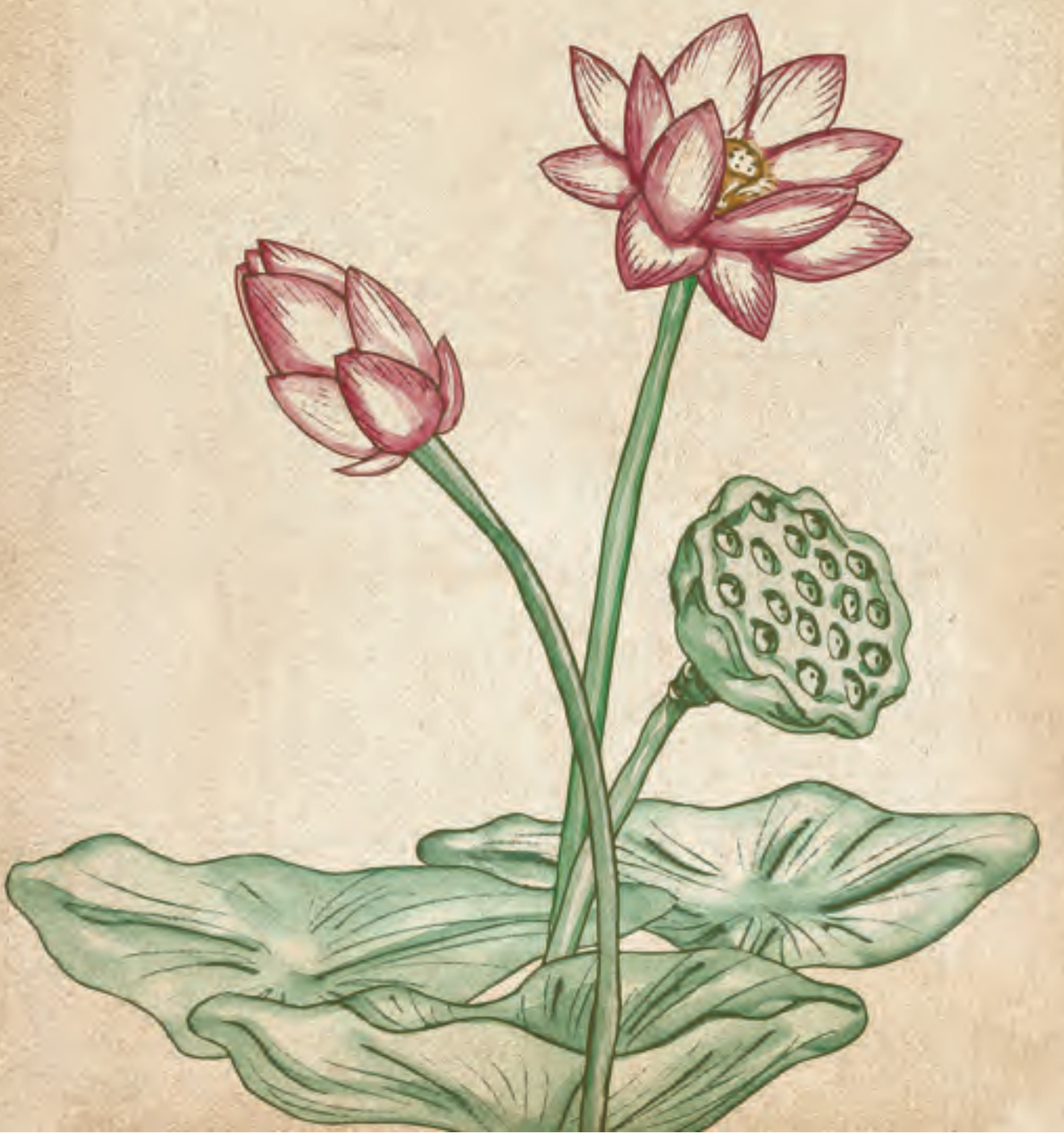
Although we acknowledge that the term 'consumer' may not be preferred by everyone, we have chosen to use this term when referring to people who come into contact with mental heath services based on the feedback from those who reviewed the guide.

The guide has undergone a review process by a range of mental health professionals across different service settings as well as consumers and carers. For a full methodological outline please contact info@sane.org.

The SANE *Suicide Prevention and Recovery Guide* encourages mental health professionals to work on:

- Building a positive working relationship with the consumer
- Considering risk assessment in a way that fully engages with the consumer
- Working collaboratively with family and friends
- Supporting the consumer's independence and decision-making
- Supporting the consumer in times of transition between services and discharge
- Promoting recovery and building resilience
- Communicating respectfully when talking about suicide and mental illness
- How to provide support to families and friends after suicide
- Staying healthy themselves by engaging in self-care and distress tolerance
- Continued professional development and training in suicide prevention.

# Recovery and the Mental Health System



# Recovery and the mental health system

## What is recovery?

Recovery in mental health is a concept that stemmed from deinstitutionalisation and the physical disability movement in America in the 1980s and 1990s. The idea of recovery was conceptualised by people who had first-hand experience of mental illness, yet achieved fulfilling lives despite being told that their situation would never improve. At its core, a recovery approach encourages people to take control of their lives and nurtures hope that they can achieve their goals despite the presence of mental illness.[1]

The recovery approach has been promoted both in Australia and internationally as a key component to a fair and progressive mental health system, but a challenge with the concept is that it means something different to the traditional definition of 'recovery' – that is, relating to a cure from an illness. Rather, recovery from mental illness is a process by which people regain hope and move forward with their lives with or without the symptoms of mental illness. Whether one is 'recovered' is highly subjective.[2]

Although it is recognised that recovery is a unique personal journey, the literature identifies a number of common factors that facilitate recovery. These have been summarised by the NSW Mental Health Coordinating Council [3] as: individual responsibility, acceptance, hope, identity, empowerment, and advocacy. Many people writing about recovery emphasise hope as perhaps the single most important of these factors. For example:

> *Many recovery stories describe the devastating effects of having been told by mental health professionals that prospects for recovery were slim or non-existent . . . those who feel they have recovered generally find ways to maintain, regain or create hope that somehow, someday, things will be better.* [4] (p. 246)

The National Mental Health Commission's first *Report Card* [34] (2012) recognised the importance of the recovery perspective; its very first recommendation was that people with a mental illness be at the centre of decision-making about all services that affect them.

The NSW Mental Health Coordinating Council in partnership with the NSW Consumer Advisory Group has developed a comprehensive resource for services: the *Recovery Oriented Service Self-Assessment Tool* (ROSSAT).[5] Resources such as these are useful in helping services think about recovery and its application, but often do not explicitly talk about the management of suicide. If services are to embrace recovery across all dimensions of service delivery, the concept must be examined in light of one of the most challenging aspects of care – suicide prevention.

## Is recovery the way forward?

Although recovery is widely promoted within the Australian mental health sector, and indeed forms the core of many State Government mental health reforms currently under way,[6] the model has been criticised for putting additional pressure on services, building false expectations for consumers and their families, and failing to address the issue of risk.[7, 8] These are important issues to consider when thinking about how services can operate within this framework.

Services may feel pressure from many competing areas that make being fully engaged with recovery seemingly difficult. For example, the emphasis on the reduction of bed stays within in-patient units, the lack of time staff have to build effective working relationships, the emphasis on reporting against clinical outcomes as opposed to recovery-based outcomes, and the problems with objectively measuring recovery [9] are all potential obstacles. However, advocates argue that recovery is a process in which a person with mental illness works to figure out how to manage and live with their symptoms of mental ill health and:

> *It is not a fad, an added burden, or a new and as yet unproved practice imposed on already stretched providers. As such it is neither something services can do for people with mental illness, nor is it something that can be promoted as separate from treatment and other clinical services. Recovery should be the ultimate goal of mental health services and this should not be conceptualised as an add-on to already existing services* [10] (p. 643)

It is argued by some that promoting recovery is giving false hope to consumers and their families, particularly if they believe recovery equates with being free from mental illness. However, supporters of the recovery paradigm argue that for a long time consumers and their families have been given a false sense of hopelessness, and that the focus needs to shift to a much more positive outlook.[11] Further, it is argued that recovery aims to set up realistic expectations about what a person can achieve. It focuses on building a person's strengths and supports, and making the consumer the expert in their own experience. This is a big shift from previous ways of operating where clinical experts worked to bring about compliance to treatment, often with little regard to the consumer's perspective and in many cases leading to disempowerment and dependence on the mental health system.

Another commonly expressed concern about recovery involves questions of ethics and risk. Mental health professionals may ask how recovery can be relevant to someone experiencing an acute episode of psychosis or mania, as surely a person in that situation would need to get better before recovery can be discussed. Similarly, staff may question the focus on strengths, hopes and dreams when a person is faced with urgent needs such as safety, shelter and stabilisation. What sense does it make to honour the choices of someone who is acutely unwell, potentially leaving them to reject treatment and risk self-harm?[22]

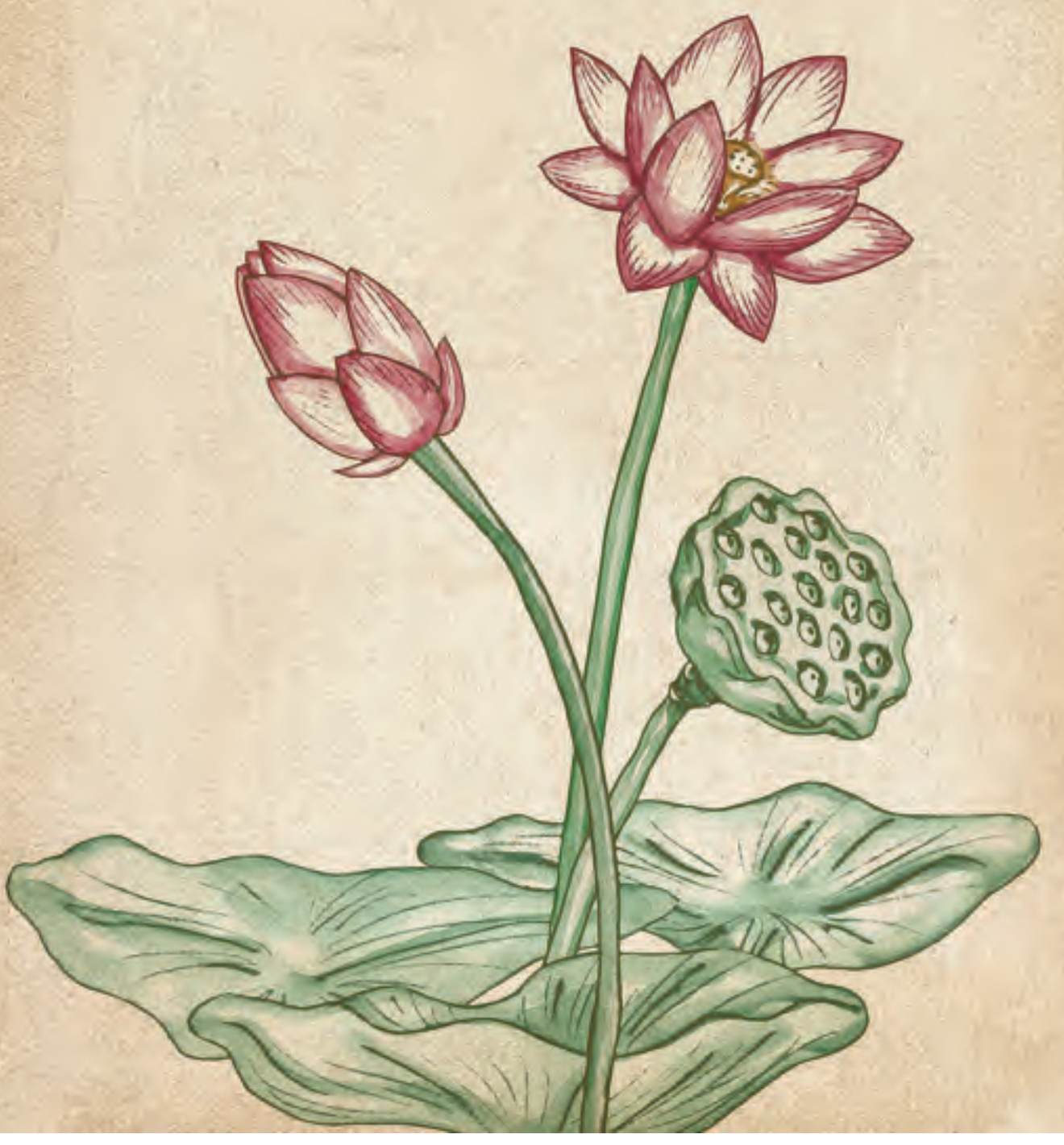
Davidson et al argue that if a person is experiencing a crisis, recovery doesn't start after the episode resolves, and it cannot be put on hold while the person receives treatment. From the person's perspective, the crisis has temporarily disrupted the ongoing process of recovery, and care during this time can support or undermine that process.

> *Recovery requires reframing treatment from the professional perspective to the person's perspective. The issue is not what role recovery plays in treatment but what role treatment plays in recovery.* (p. 643)

Many people described as being in recovery from mental illness do not think or talk about the term 'recovery' at all. They talk about getting a job, making friends, living independently and generally getting their lives back.

Choice, self-determination, and personal responsibility are key themes in recovery-oriented practice. However, as the mental health system is obligated to protect the individual from self-harm and the community from possible harm also, there are exceptions to this rule. In cases where there are serious risks involved, and a person's judgement is temporarily skewed, just as in emergency medicine, the issue of informed consent and permission to treat are temporarily suspended to perform life-saving measures.[12]

# Suicide prevention in the mental health sector



# Suicide prevention in the mental health sector

**Preventing suicide is a core function of what mental health services do, and although not everyone with mental illness will experience suicidal thoughts and behaviours, they are strongly associated.**

Schizophrenia, Borderline Personality Disorder (BPD) and mood disorders such as depression and bipolar are particularly linked to increased risk of suicide.[13,14] A 2010 study looking at the lives of people living with psychotic illness reported that half (49.5%) of the participants had attempted suicide at some point in their lifetime compared to 3.7% of the general population.[15] People with mental illness are at greatest risk of suicide in the first year after being discharged from hospital, especially during the first five weeks.[16] Sexual abuse as a child is strongly associated with heightened risk of developing a mental illness and of suicide. The rate of suicide of those abused is between two to 11 times greater than the general population according to a 2013 survey of the literature by the Australian Institute of Family Studies.[50] Transitions between mental health services can also be a time of upheaval and increased vulnerability. Risk of suicide is further increased when combined with misuse of drugs and alcohol and previous suicide attempts.[17] Despite mental illness being a contributing factor for the majority of people who take their own life, many people experiencing suicidal thoughts and behaviours do not have mental illness. Such people may have reactionary suicidal thoughts and behaviours related to negative life-events such as loss of employment or a relationship break-up.[18]

Not all mental health workers have a clinical treatment-focused relationship with consumers, rather many focus on addressing risk factors that can increase vulnerability. For example, community-based services work hard to reduce the impact of social isolation, help with financial and legal issues, encourage treatment, and provide psychosocial rehabilitation or supported accommodation, which all contribute to suicide prevention. Initiatives such as PARCS (Prevention and Recovery Care Service) also aim to keep consumers out of acute settings by providing step-up care when people's symptoms are escalating, or conversely, provide step-down care when their symptoms are improving. This is another example of a program working to reduce the risk of suicide, especially in times of transition.

Although there are some effective community-based suicide prevention programs, the outcome for many people who reach crisis point is admission to hospital. This process can sometimes be involuntary and often involves crisis assessment, emergency departments and/or police. Such a process can be traumatising, demoralising, and can undermine recovery. There are few alternatives to hospital care when people are in crisis in Australia, but Beaton 2009,[19] has researched alternatives that have been developed in other countries. This research shows the effectiveness of community based 'safe houses' where people can find refuge and are supported by health professionals and in some cases, volunteers with lived experience, to 'find and create a life worth living'. Although such alternatives to suicide care are currently not available in Australia, it is important that workers in both hospitals and community-based services consider how they can help to instil this sense of hope despite the limitations of the systems in which they work.

## Assessing suicide risk

There is general consensus within the suicide prevention field that there is no reliable method to accurately predict suicide. However it is known that there are both warning signs and risk factors that help us to determine when someone may be at risk. Warning signs are things that may lead to suicide in the immediate future – for example, having a plan to die, resolving financial affairs, or feeling an extreme sense of hopelessness. Whereas risk factors are associated with a heightened risk of contemplating suicide over the long term – for example, having previously attempted suicide, being socially isolated, having depression or being abused as a child – it is thought that it is the combination of warning signs and risk factors that increase a person's risk of suicide.[20]

Protective factors, on the other hand, are those things that mitigate the risk of suicide, such as love for one's family or children, community support, problem solving skills, a sense of belonging and identity, cultural, spiritual and religious connections and effective medical care. Recognising protective factors can encourage hope among persons at risk, however the presence of protective factors does not reduce the risk associated with the presence of severe warning signs. Instead, these factors can be used to support and encourage the person and can be highlighted as reasons why life is worth living.[20]

The assessment of suicide risk is a process based on the identification and appraisal of warning signs as well as risk and protective factors [21] (Rudd et al 2006). A potential problem with risk assessment tools is if they are used as a substitute for engaging in a deeper conversation about the person's state of mind, or when the assessment focuses only on one aspect of risk, such as warning signs, but not longer-term factors, such as a history of previous attempts, or psychosocial factors, such as connection to social supports.

The reliability of risk assessments to determine suicide has been examined in a meta-analysis by Large et al.[22] This study shows that 60% of in-patients that died by suicide in the first year after discharge were assessed as being at low risk. This highlights how time-specific risk assessments are, as they only give a snapshot at a certain moment in time of the risk of suicide. Mulder argues that it is a dangerous practice for mental health workers to rely solely on risk assessments and that:

> *Risk assessments should be used where appropriate and be a consensual process with the patient and clinician striving towards a realistic conceptualisation of the risk and then deciding how to manage it.*[23] (p 606)

Research by SANE Australia [24] indicates that mental health services tend to focus their efforts for suicide prevention on people who have been assessed as being at moderate or high risk of suicide. However, the unreliable nature of risk assessments highlights the importance of universal strategies that direct suicide prevention activities towards everyone who comes into contact with mental health services.[25]

## Working with suicidal people

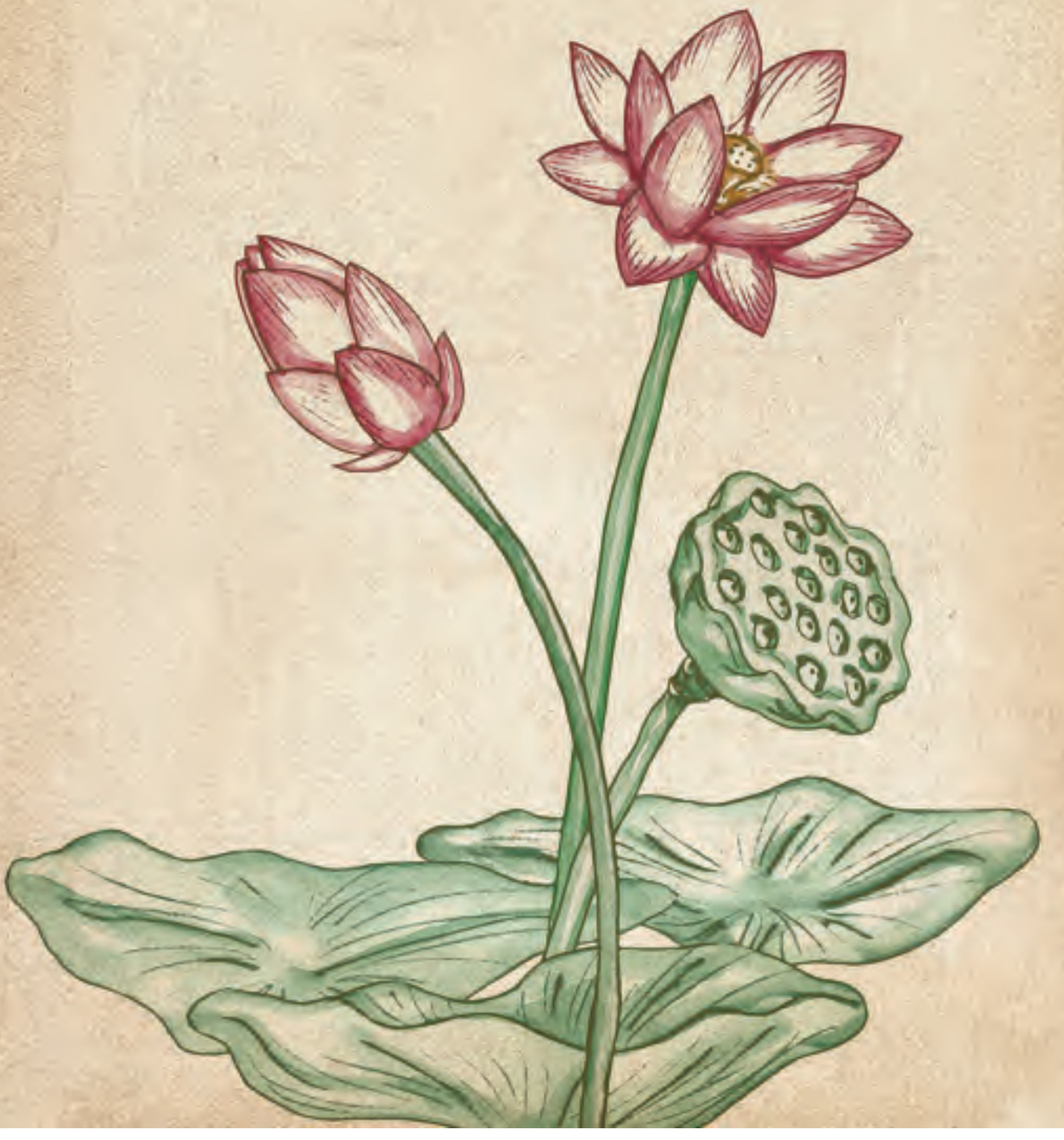
The experience of working with suicidal people has been identified as one of the most stressful parts of a mental health worker's job. Most workers feel a great deal of responsibility in helping to support potentially vulnerable people and they endeavour to provide effective care. However, there is evidence to show that the issue of suicide is sometimes avoided or inadequately addressed. Neimeyer & Pfeiffer [26] found that health professionals had a tendency toward superficial reassurance, avoidance of strong feelings, professional distancing, inadequate assessment of suicidal intent, failure to identify precipitating problems, and passivity.

One further issue that can be problematic for mental health workers is when consumers repeatedly present with suicidal ideation sometimes leading to ambivalent feelings from staff and an underestimation of the seriousness of the person's suicidal intent. People with chronic suicidally may have an underlying mental health condition, be frustrated with the progress of interventions or treatment, or use suicidality as a way of communicating distress.[20]

Working with a person who engages in repetitive suicidal behaviour can provoke frustration, however understanding your own personal views on suicide is important to help maintain a caring, respectful and non-judgemental attitude, while understanding the perspective of the person at risk can aid in developing more meaningful, person-centred interventions[20]

Unfortunately, sometimes workers may feel uncomfortable, ill-equipped or lacking in time to talk about suicide in a meaningful way. A common reaction then is to move people on and concentrate on things the worker feels comfortable with rather than dealing with the underlying cause of the suicidal ideation. In such cases, it is important for health professionals to seek assistance or supervision to develop an appropriate response, or to refer the person on to someone with the skills necessary to help. How people are treated during a period of crisis and in what ways services can work to uphold principles of recovery are of particular interest here. So what are some of the things workers can do to support people experiencing suicidal thoughts and/or behaviours in a recovery-oriented manner?

# Addressing Suicide in a Recovery-Orientated Manner



# Addressing suicide in a recovery-oriented manner

The guide now outlines some approaches that mental health workers can use to maintain a broad and recovery-focused outlook in their suicide prevention and intervention work. Not all of the sections will be relevant for each mental health worker – some relate more to hospital settings and some are more relevant to people working in community settings. Even so, it is worth reading the guide as a whole in order to reflect on approaches that are relevant for different workers.

When considering the suggestions in this guide in relation to your own work practices, it may be useful to use the action box checklists. Note those things that you only sometimes, or never do, and reflect how you might include these ways of working in the future.

# 1 Build a positive working relationship with the consumer

If someone is experiencing a suicidal crisis, a positive relationship with a mental health worker is of paramount importance. Listening closely to a person's story and displaying a genuine and caring attitude can make a huge difference in helping them through. A group of clinicians writing about the importance of a positive working alliance have developed guidelines for clinicians in meeting the suicidal person.[27] They stress the importance of a narrative style of interviewing which allows the person to explain their suicidal feelings in the context of their life-history. The guidelines suggest that:

- the mental health worker's task is to reach a shared understanding of the person's suicidal thoughts and behaviour
- the mental health worker should be aware that most suicidal people who experience mental pain or anguish can be very vulnerable
- the mental health worker's attitude should be non-judgemental and supportive
- the interview should start with the consumer's self-narrative. For example, 'Tell me, in your own words, about your suicidal thoughts and feelings . . .'
- the ultimate goal is to engage the person in the therapeutic relationship.

The outcome for many people who are experiencing a suicidal crisis is admission to the in-patient unit of a hospital. This process can be a traumatising experience, even if voluntary. Research by Samuelsson et al [28] suggests that people can feel a sense of shame and failure mixed with relief when hospitalised for suicidal behaviours. It is important for workers to recognise this and acknowledge the confusing feelings and trauma that a person may experience.

Sometimes it may be difficult to engage with a person, especially if they are unwilling to disclose their suicidal feelings. Establishing a good therapeutic rapport can improve the working relationship and the way that questions are asked can help convey a sense of empathy and help the person feel more comfortable. One approach is to let the person know that it is not uncommon for people to think about suicide when in distress, and then ask them if that is how they feel. The person may then feel reassured that they are not alone in their feelings, and that the clinician is there to listen and provide support.[20]

| | When working with someone around the issue of suicide I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 1.1 Work with the person to reach a shared understanding of their suicidal behaviour | | | |
| 1.2 Am non-judgemental, genuine and caring | | | |
| 1.3 Use a narrative approach to elicit the person's story | | | |
| 1.4 Acknowledge any trauma experienced during admission to hospital | | | |
| 1.5 Support the person over time to make sense of the crisis | | | |

A difficulty in establishing a trusting working relationship with a consumer is when, as often happens in in-patient settings, there is an ever-changing flow of workers attending the person. This puts an added burden on staff and consumers. Evidence by Samuelsson et al [28] shows that people feel distressed and disrespected when asked to continually retell traumatising events. This is a problem that individual workers may have little control over; however, it can be eased by good communication between staff about the consumer's circumstances and care taken, wherever possible, to have the same staff member attend the consumer and work on developing a trusting relationship.

Michel at al [29] argue that it is necessary to use an approach that does not see consumers as objects displaying pathology but rather as individuals who have their own reasons to perform an act of self-harm or suicide. Building a positive working relationship will help to keep the individual and their perspective central. Such a relationship can also help support the person over time to make sense of the crisis and foster hope for the future by discussing:[30]

- How did the crisis arise?
- What is good and bad about it?
- What can we learn from it?
- What skills and supports does the person have that we can draw on to help prevent such a crisis recurring?
- What plans, goals or support skills will the person need in the future? [21]

## 2 Consider risk assessment holistically

Risk assessments are an important tool used by workers to help gauge a person's risk of suicide at a precise moment in time. They can be useful as they help to remind us of significant warning signs and risk factors to ask about. There are four key questions that form the basis of assessing suicide risk. These centre on a persons suicidal thoughts, access to method, previous attempts and any plans made to end their life. The Australian Institute for Suicide Prevention and Research has produced a Framework of a Suicide Risk Screening Tool [52] that describes the questions to ask.

Risk assessment tools are also an important way to start a conversation that considers the individual holistically within their historical and psychosocial context, with emphasis on empowering them to access help, reducing their distress and maximising protective factors.[31,32] For example, if a middle aged man came in who was socially isolated, had recently lost his job, and had a history of suicide attempts, an experienced mental health worker would press further to find out if he had any current thoughts of suicide and to discuss what to do should these thoughts recur in the future.

However, if risk assessments are used as a substitute for developing a deeper understanding of a person's state of mind, they can fail in their purpose. There are many risk assessment tools available, and it is important to remember that they can only gauge suicidality at a particular moment in time, and they should not replace a meaningful discussion with the individual. For example, a consumer who reviewed this guide put it well when she said:

> *The most effective assessments I had (where I was actually honest about my suicidal thoughts and plans) were with people who did not have a checklist of questions in front of them but rather had a discussion with me, where each question built on previous responses.*

Individuals will have particular characteristics that may influence how you support them around the issue of suicide. Considerations such as cultural background, stage of life, the presence of disabilities or sexual orientation can all impact how a person views suicide, their relative risk of suicide and your own reactions and assumptions. Understanding, empathetic and non-judgmental approaches that respect the person's privacy are essential. It is crucial that mental health professionals draw on all resources necessary to support an individual's needs and thoroughly assess suicide risk.

| | When working with someone around the issue of suicide I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 2.1 Recognise that risk assessments cannot predict suicide by themselves | | | |
| 2.2 Use risk assessments as a way to start a deeper conversation about the person's state of mind | | | |
| 2.3 Use a risk assessment that asks questions about warning signs and risk factors | | | |
| 2.4 Ask the person about their social supports and history of suicidality | | | |
| 2.5 Draw on other resources, such as interpreters or specialists, to support the individual's needs | | | |

For example, mental health workers need to be aware of cultural norms, values and beliefs and their potential influence on suicide. In some cultures for instance, suicide is considered taboo and is neither acknowledged nor discussed. In other cultures suicide is believed to be caused by evil spirits, the actions of ancestors or a previous bad life. Strong stigma can be attached to suicide and the families associated. This creates a challenge not only for mental health workers, but also for the person who may be struggling with suicidal thoughts but feel unable to talk about it with members of their ethnic community.[20]

The best strategy for working with people from different cultures is to have someone from the same culture who they trust there with them, to help translate not only the language, but also the various cultural differences that may exist51. Further information about working with people from Culturally and Linguistically Diverse communities can be found at Mental Health in Multicultural Australia: www.mhima.org.au.

# 3 Work collaboratively with family and friends

Working with significant family members, friends, or other carers is an important part of mental health care that is promoted within Australia's Fourth National Mental Health Plan.[33] It is recognised that carers play a vital role in the support of people with mental illness, and that carers are subject to high levels of stress and may have mental health difficulties themselves. Carers need support and education to help them manage their own and their relatives' needs, especially when suicide is a risk. Significant family and friends are often traumatised by the experience of someone's attempted suicide, and terrified of the likelihood of it happening again.

Qualitative research by Leggatt & Cavill describes the concerns that carers have about their dealings with mental health services when someone was suicidal.[35] Of particular concern to families was that *their* assessment of the person's risk of suicide was not heeded. It was also reported that interventions were felt to be too brief to be of benefit and that the focus appeared to be on discharge from hospital in order to free up beds. Carers reported feeling excluded from all aspects of care while the person was in a psychiatric unit, and their own psychological needs were not assessed or supported.

It is vital that services listen to carers as an important source of information regarding the consumer's suicidal intent, current life stressors, behavioural changes and available social supports. Although the person with mental illness needs to agree to involve carers, it should be a priority for services to encourage carer involvement in order to gain a deeper understanding of the person's health and social context.

> *One of the best strategies that we have found (in suicide prevention) is to work with families and carers so that they are equipped and skilled to intervene and support the consumer, and refer them to the right place. We need to improve supports around the person and reduce isolation. It's wrong to put it all back on the person who is unwell.*
> (NGO worker)[10]

Mental health workers can play a crucial role in educating carers about a consumer's mental health, directing them to carer resources, and providing them with tools to help support the unwell person. This is particularly important if the suicidal person is discharged back into the care of family or friends who may feel ill-equipped to provide adequate support through subsequent crises. Mental health services need to acknowledge the traumatic circumstances that carers often live with.

| | When working with someone around the issue of suicide I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 3.1 Listen to carers as an important source of information | | | |
| 3.2 Pay close attention to carers' concerns about suicidal intent | | | |
| 3.3 Provide education to carers about how to support the consumer | | | |
| 3.4 Provide referrals to carers so that they can access support for themselves | | | |
| 3.5 Assess and support the carers' own mental health needs | | | |

Working with carers is not about giving them control over treatment, but rather it involves education, skills training, and support so that carers feel more confident in knowing how to support the suicidal person and look after themselves.

**Referrals for families and friends:**

**MHCAA** (Mental Health Carers Arafmi Australia): offers a wide range of services, respite and support for people with relatives with mental illness. www.arafmiaustralia.asn.au.

**MI Networks:** A network of community services run by the Mental Illness Fellowship of Australia providing support and information for people with mental illness, their families and friends. 1800 985 944.

**SANE Australia Helpline:** A national freecall telephone and online service providing information and advice on mental illness and related issues. 1800 18 7263. www.sane.org.

**COPMI:** Providing support for Children of Parents with a Mental Illness and their families www.copmi.net.au.

**Guiding their way back:** A resource for helping people who are supporting someone after a suicide attempt. www.beyondblue.org.au/thewayback

**The SANE Guide for Families:** Caring for someone affected by mental illness. www.sane.org/bookshop/carers

**The SANE Carers Forum:** Provides an anonymous online space for us to share our stories and help each other. www.saneforums.org

# 4 Support the consumer's independence and decision making

In order to support recovery it is important, as much as possible, not to undermine the individual's independence, decision making and sense of personal responsibility. This is especially the case if the person is receiving treatment at an in-patient unit. Some techniques that mental health workers can use to support independence in this setting are:

- keep the person's everyday life on the go, ensuring mail is collected, pets are fed, dependents cared for and bills paid, etc
- consider the personal items that can be taken into the in-patient unit and where possible allow the person to keep things that help them stay connected or are important to them
- ensure the person has access to peer support and/or consumer advocacy if they require it
- identify who comprises the person's support network and what their roles are, and encourage them to visit and offer ongoing support.

Another important method for minimising loss of personal responsibility and increasing decision-making power is the use of advance directives. Advance directives are documents that set out a person's preferences for future medical treatment. They are also called advance statements, or care plans, and they give consumers the opportunity to work with health professionals to decide, when they are well, on the type of treatment they would like to receive in a time of crisis.

Advance directives may outline the care of children or other dependents while a person is receiving treatment. The development of advance directives can also be useful for family and friends to be involved in, as it allows reflective discussion that can identify the role that they will play.[36] An important process for advance directives to work successfully is a clear and identifiable path of communication so that all involved, the consumer, carers and mental health workers, know of its existence and can access it in a time of crisis.

| | When working with someone around the issue of suicide I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 4.1 Keep the person's everyday life on the go | | | |
| 4.2 Provide advocacy | | | |
| 4.3 Encourage visitors from the person's support network | | | |
| 4.4 Promote the use of advance directives | | | |
| 4.5 Learn about pathways to effectively use advance directives | | | |

Although an advance directive may stipulate a person's wishes in regards to the type of treatment that they receive – for example, whether or not they agree to have ECT – there is a potential dilemma when the advance directive rules out treatment which a doctor believes is in the person's best interest. Currently in Australia, mental health legislation can over-ride an advance directive. Nevertheless, clinicians are coming under increasing pressure to explain their actions in regards to advance directives and must give good reason if the wishes of the person are not followed. Thus, they are important documents because even if a person does not receive the treatment that they stipulated, the advance directive encourages communication about why things did not turn out the way the person had hoped and what can be learned for the future.

Although it is not standard in mental health care to develop advance directives with consumers, they are becoming central to the mental health reforms being pursued in some States within Australia and it is likely that they will be increasingly used.[18] An important part of recovery-focused suicide prevention is to talk to clients, when they are well, about what they would like to happen when they are not. More future planning such as this will go a long way to minimising loss of self-autonomy and supporting independence and decision-making.

# 5 Support the consumer in times of transition

It is essential that mental health services follow-up with patients who are discharged from an in-patient unit or who move between mental health services. The time after discharge, and around transitions, is a period of extreme high risk when many suicides occur. Active outreach at this time and continuity of care between services, have been found to be an effective way of reducing re-admissions and suicidal behaviour.[37,38] Following up with consumers and communicating with other services involved is an important way of helping to improve outcomes.[39]

Further, family and friends have raised concerns that consumers are often discharged home either alone or without carers being informed.[32] In in-patient settings, people are often seen as separate from their community and social supports, and are sometimes discharged back into the community without health professionals having a good understanding of what they are going back to. An important part of discharge planning is that carers are informed about when and where the person is being discharged and what their role will be in the continued support of their relative or friend.

Discharge from or transition between services may involve a range of professionals and organisations, from hospitals to NGOs, supported accommodation, alcohol and other drug services, psychiatrists, general practitioners, and psychologists. With such a varied range of services involved it is essential that communication is maintained and all relevant people are informed about what their roles are in the continued support of the consumer. This is a time when it is easy for people to 'slip through the cracks' and the outcome of suicide is a real danger if this occurs.

| | When working with someone around the issue of suicide I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 5.1 Actively follow up with the person after discharge or transition between services | | | |
| 5.2 Communicate with carers about the discharge plan and their role in continued support | | | |
| 5.3 Communicate with other services and health professionals about the discharge plan and their role in continued support | | | |
| 5.4 Ensure that people are discharged to a supportive environment | | | |

## Useful referrals and resources to share with consumers for support around the issue of suicide

**Finding your way back:** A resource for people who have attempted suicide www.beyondblue.org.au/thewayback

**The SANE guide to staying alive:** A resource for people with mental illness who feel suicidal at times www.sane.org/bookshop/suicide/product/27-sane-guide-to-staying-alive

**SANE forums:** An Australian service for people living with mental illness. It provides an anonymous online space for us to share our stories and help each other. www.saneforums.org

**Lifeline Australia:** National 24-hour telephone counselling service. Lifeline also operates a suicide helpline and callers can be referred through to this specialist telephone line. 13 11 14. www.lifeline.org.au.

**Suicide Call Back Service:** This national suicide call back service provides professional online and telephone counselling for people who are suicidal, their carers, or those bereaved by suicide. 1300 659 467. suicidecallbackservice.org.au.

# 6 Promote recovery, build resilience

One of the best ways of reducing the likelihood of a crisis is by helping people develop self-management skills such as the ability to recognise triggers and respond to symptoms of mental illness. Such skills lead to an increased sense of empowerment, control and resilience to cope with setbacks.[28]

There are a number of strengths-based programs that aim to help consumers work on their self-management skills. One of the most commonly-used and positively-evaluated is the Wellness Recovery Action Plan (WRAP).[40,41] Participants of WRAP learn to identify the early warning signs or 'triggers' of distress. People are empowered to take control of their own wellness with a focus on personal responsibility, education, hope, self-advocacy, peer support and future planning. WRAP includes a specific section on the development of advance directives and it imparts important skills that can assist consumers to help avoid crises: www.mentalhealthrecovery.com/wrap.

It is important to note that programs such as WRAP are more than simply crisis planning. Crisis plans are used by services to set out what to do if a crisis occurs. Such plans are usually developed by mental health workers and not always with the consumer's collaboration. Strengths-based programs such as WRAP focus much more on the consumer taking the driver's seat to develop the skills that they need to prevent crisis, as well as helping them to know what to do if a crisis occurs.

Another recovery-focused strategy that services can implement is to increase risk literacy. Risk literacy is the capacity for critical understanding of risks and risk taking. Positive risk taking is a model of practice that promotes the taking of risks within the context of strengths and opportunities. Mental health workers and consumers work in partnership to develop a shared understanding of risk and assess and manage it.[42] Such programs provide the opportunity to discuss risk in relation to issues such as self-harm or suicidal behaviours, and plan ways to reduce or manage those risks.

It is essential in recovery-focused suicide prevention that services focus on building a person's strengths and reducing social isolation. Social isolation is thought to be a risk factor that is strongly associated with suicide, [43] and unfortunately people who come into contact with mental health services are often socially isolated with few community supports. Encouraging people to develop supportive relationships with peers, informing them of what community support services are available and involving family are all important ways of helping to reduce social isolation and the risk of suicide.

| | When working with someone around the issue of suicide I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 6.1 Work with consumers to identify early warning signs of a crisis and a plan of what to do if this occurs | | | |
| 6.2 Help consumers to recognise their strengths and supports | | | |
| 6.3 Adopt a recovery-focused strengths-based program such as WRAP | | | |
| 6.4 Talk with consumers about risk-taking and adopt a positive risk-taking approach | | | |
| 6.5 Encourage consumers to engage with carers and peers to reduce social isolation | | | |

# 7 Communicate respectfully

The way in which mental health workers talk with people experiencing mental health problems can have a powerful impact – it can foster hope and optimism, or conversely, it can be condescending, stigmatising and contribute to feelings of shame and hopelessness. Ashcraft and Anthony are two leading recovery writers in the US who have written about alternatives to certain terms often used within the mental health sector.[44] They argue that the use of generalising words such as 'non-compliant' and 'low-functioning' can cause people to feel stigmatised. Communicating respectfully is an important way of keeping the focus on the individual and their story, rather than thinking and responding in clinical terms that may be misinterpreted and create a barrier to developing a positive working relationship.

Beaton et al discuss the importance of taking care when communicating about suicide.[45] Certain terms such as 'commit suicide' are no longer appropriate as they imply criminal activity and suicide is no longer illegal in Australia. Using the term 'successful suicide' implies the positive resolution of an undesired outcome, and similarly 'failed suicide attempt' suggests the inability to complete an act that we are working to help people avoid.

**When speaking of suicide, it is better to say, 'the person died by suicide', or 'took their own life', that the person 'attempted to end their own life' or that it was a 'non-fatal suicide attempt'.**

The NSW Mental Health Coordinating Council has published a *Recovery Language Guide*[46] with useful suggestions about using appropriate language. A summary of part of this document is reproduced below:

| | |
|---|---|
| **Do put people first:**<br>Say 'a person with mental Illness' or<br>'a person diagnosed with . . .' | **Don't label people by saying:**<br>'he or she is mentally ill'<br>or by defining a person by their struggle or distress |
| **Do emphasise abilities:**<br>'You're a great listener'<br>'You are the expert in what you are going through'<br>'You've got a really clear way of explaining things'. | **Don't equate the persons identity with a diagnosis,**<br>for example, by saying, 'a schizophrenic' |
| **Do focus on the person's strengths, skills and passions:**<br>'I admire the effort you've put into your writing, it's inspirational'<br>'Can you tell me more about your job, what do you enjoy about it?'<br>'There is so much that you can teach me'. | **Don't emphasise limitations and what you think is wrong** |
| **Do use language that conveys hope and optimism:**<br>'You've come such a long way'<br>'Things will get better'<br>'There are lots of things that we can work on to get you to the place you want to be'<br>'I believe you can do it'. | **Don't use condescending, patronising, tokenistic, intimidating, or discriminatory language** |
| **Do enquire how a person would like to be addressed.**<br>(For example, as a consumer or client) | **Don't use confusing jargon or short-hand clinical terms**<br>such as DTO (danger to others), DTS (danger to self) |
| **Do ask for clarification.**<br>Is the person taking it all in and are they happy with the language you are using? | |

# 8 Provide support after suicide

Research tells us that people bereaved by suicide may be at higher risk of taking their own lives,[47] so intervention at this stage is an important, and often overlooked, suicide prevention strategy. Information and support are essential in helping family and friends cope after someone takes their own life. In many cases the friends of the person who died may be other clients of the mental health service, and workers have a role in offering extra bereavement support to this vulnerable group. Bereaved family and friends can feel confused, guilty and angry, but having their grief acknowledged, and where possible questions answered, can aid the process of understanding and living with the death of someone close.

SANE Australia has been working to help services improve how they support the family and friends of people who have died by suicide. The *SANE Bereavement Guidelines* are a useful resource for services to use and can be downloaded from www.sane.org. The guidelines discuss how to support family and friends; what issues may arise during contact with the bereaved; who within the service should make contact, and how will affected staff be supported. The guidelines also include an action plan that encourages services to adopt a policy on how they address the issue of support after suicide.

A further resource that services can use when working with bereaved individuals is the best practice standards developed by Lifeline and collaborating organisations in 2009, *Towards Good Practice: Standards & Guidelines for Suicide Bereavement Support Groups* [48] which articulates the need for specific training relating to suicide intervention, prevention and suicide bereavement, and the need for debriefing and supervision support.

| | When providing support after suicide I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 8.1 Acknowledge the grief that bereaved family and friends experience | | | |
| 8.2 Communicate as much as possible with the family about what happened | | | |
| 8.3 Offer ongoing counselling and support | | | |
| 8.4 Refer to grief and bereavement services | | | |
| 8.5 Support other consumers who may be affected by the loss | | | |

When supporting the family and friends of people who have died by suicide it is important to:

- acknowledge the grief and loss that families and friends are experiencing
- where possible, answer questions about the suicide and clarify the processes that will take place, for example, in relation to internal enquiries or a coronial inquest
- offer ongoing support and counselling
- refer family and friends to grief and bereavement services
- offer extra support to other consumers who may be particularly affected by the loss.

SANE Australia also offers ½ day workshops to mental health services around Australia to help staff and managers learn about the issue of suicide bereavement, implement policy change and increase knowledge of support agencies and resources for those bereaved by suicide. For further information about the workshops contact info@sane.org or call 03 9682 5933.

# 9 Stay healthy yourself

When mental health workers see people who talk about suicide and trauma, some may experience vicarious traumatisation. In other cases, the sheer workload and stress of supporting vulnerable people can cause workers to 'burn-out'. Symptoms can include anxiousness, irritability, not feeling safe, trouble sleeping, thinking about the person for much of the time, difficulty regulating emotions or emotional exhaustion.[49] A risk is that workers may become desensitised and disengaged as a coping strategy.

Workers may also be negatively affected, and in some cases traumatised, when a consumer takes their own life. This can be particularly pertinent for peer workers who may have mental health difficulties themselves, and such workers may require additional support to stay healthy. Supporting workers so that they themselves do not become unwell is something that mental health services need to be committed to by providing adequate debriefing and supervision opportunities, reasonable workloads, and Employee Assistance Programs.

It is understandable that when people are working close to pain and suffering, they may attempt to keep some distance in an attempt to avoid traumatisation, but there are other ways of protecting oneself from burning out, for example:

- Ensure that you have good regular supervision with a professional who can discuss your workload and difficult situations that you may be experiencing with clients
- Access an Employee Assistance Program to get support in managing your workload and any life-stressors you are experiencing
- Foster self-awareness to help understand your own reactions. The earlier you notice something getting to you, the easier it is to prevent bigger problems
- Balance your personal needs with the demands of your work. Make sure that each day includes breaks for meals, physical activity, and rest
- Utilise informal support networks with colleagues and friends. Take time out to socialise, debrief and have a good laugh
- Reflect on why you do your job, how you measure success in your work, and what are the costs and rewards. This can help give you perspective and impact on how you handle difficult situations
- Contact a Crisis Helpline if you need to talk a matter over further – this might be particularly useful if you feel uncomfortable discussing the situation with work colleagues. The Suicide Call Back Service offers support to professionals on 1300 659 467.

| | In order to support my own health I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 9.1 Have regular debriefing or professional supervision | | | |
| 9.2 Maintain awareness of reactions to traumatic stories from clients | | | |
| 9.3 Balance the demands of work with personal needs | | | |
| 9.4 Access informal supports such as talking with colleagues and friends | | | |
| 9.5 Use crisis support lines such as the Suicide Call Back Service on 1300 659 467 | | | |

# 10 Enrol in additional suicide prevention training

There is a huge range of staff with diverse backgrounds in education and experience to support people who may be affected by suicidal thoughts or behaviours. The training these workers received when gaining qualifications, as well as 'on the job' training, varies considerably. It cannot be assumed that people gain adequate (or any) suicide prevention skills in their professional training.

SANE Australia undertook a scoping study to assess the suicide prevention training required of mental health staff.[10] The study showed that 65% of clinical services and 47% of non-clinical services surveyed required all staff to have a minimum level of training in suicide prevention. The most commonly-mentioned training was Livingworks ASIST (Applied Suicide Intervention Skills Training) (42%), followed by in-house service-specific training (36%) and clinical risk assessment training (8%). The most frequently-used training, ASIST, is designed to increase people's confidence and ability to work collaboratively with someone at risk of suicide in ways that increase their immediate safety and identify options for further help. ASIST is a well-evaluated suicide intervention training program for community and mental health workers. It is designed to complement the knowledge and skills participants already bring, but does not address specific issues related to complex mental health needs. However, ASIST can form an important part of a wider training plan for those working in mental health.

Unfortunately there is no Australia-wide suicide prevention training used within the mental health sector. Some services do have in-house training for their staff, and skilled supervision goes a long way to help workers support suicidal people, but because good training is somewhat dependent on where you work, not all mental health workers will have the skills and confidence to address suicide effectively. It is important that mental health services consider how staff can gain the skills needed to assist suicidal people, and that this is reinforced through ongoing training and embraced by the whole organisation.

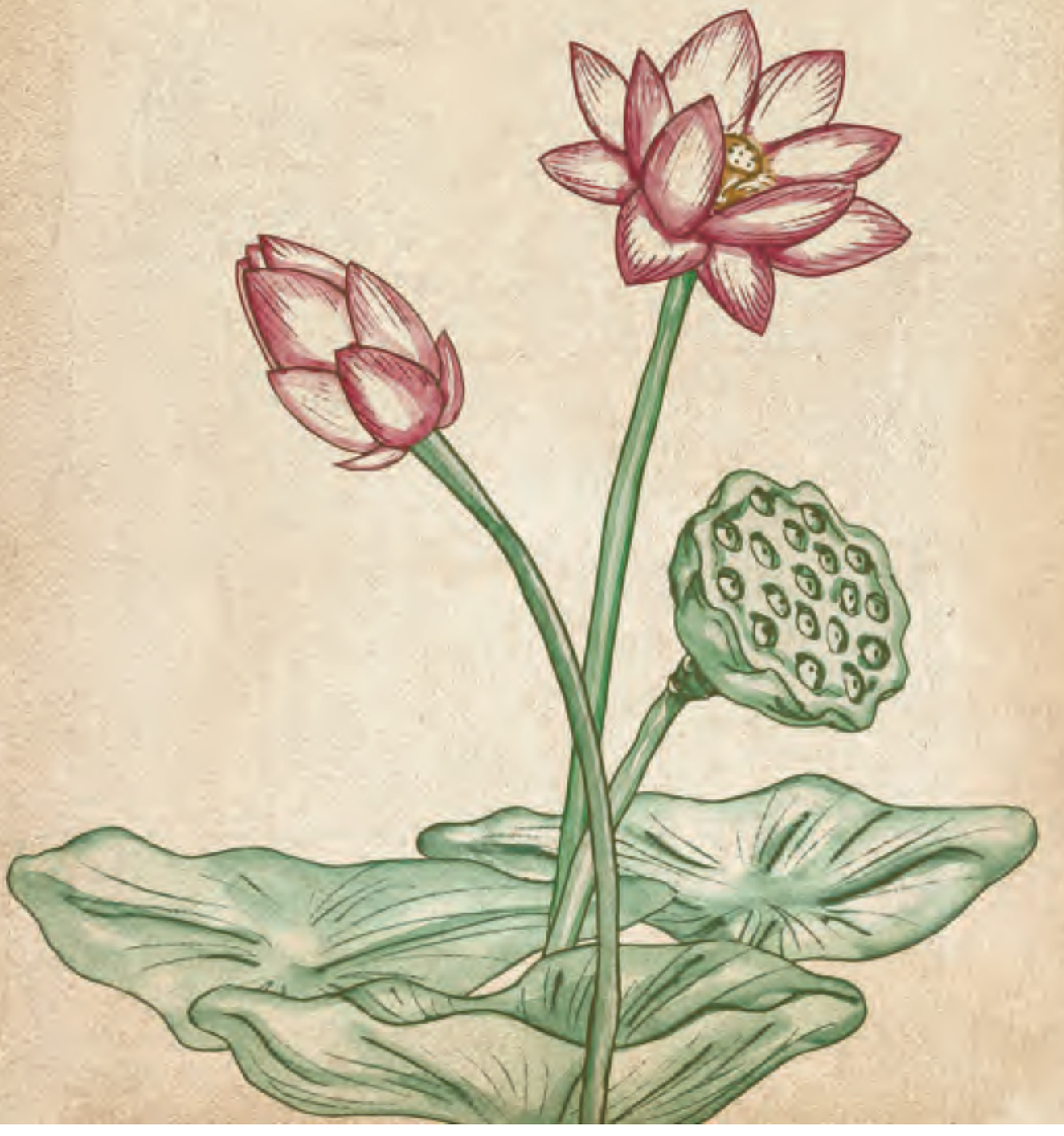
Training that focuses on suicide prevention for the mental health sector includes:

- **ASAP (Advanced Suicide Assessment Program):** Developed by Western Education & Training Cluster, Victoria, (Program Development and Lead, Bendigo Health – Psychiatric Services Professional Development Unit). This training is a guide to suicide risk assessment and management processes, designed for mental health professionals.
  - westerncluster@mh.org.au.
- **Applied Suicide Intervention Skills Training (ASIST)** ASIST is a two day, interactive, skills developing workshop that prepares caregivers in providing life assisting, first aid intervention for people at risk of suicide. Based on adult learning principles, the workshop helps prepare participants to identify and connect with people having thoughts of suicide, understand the person at risk's story, conduct a safety assessment and develop a plan that will keep the person at risk safe-for-now.
  - www.livingworks.com.au
- **ATAPS (Access to Allied Psychological Services) Suicide Prevention Professional Development Training:** The Australian Psychological Society (APS), with funding from the Australian Government, Department of Health and Ageing, has developed this professional development training package. Training is free for ATAPS providers. For non-ATAPS providers, the training fee is currently $165.
  - www.psychology.org.au/Events.
- **The Kimberley Way: Indigenous Suicide Prevention Training:** The Australian Psychological Society (APS), with funding from the Australian Government, Department of Health and Ageing, has developed a professional development training package around Indigenous suicide prevention for allied health professionals working in the Kimberley region. Training is free for health professionals working in the Kimberley region; for professionals not in the Kimberley region the cost is $165.
  - www.psychology.org.au/Events.

- **Australian Institute for Suicide Research and Prevention (AISRAP):** AISRAP's Suicide Prevention Skills Training Workshops provide a complete knowledge and skills-based approach to suicide prevention training across prevention, intervention and postvention. Training workshops can be tailored to specific organisational requirements and vary from half, one or two day workshops. AISRAP frequently run workshops and seminars on suicide prevention and also offer postgraduate programs in Suicidology.
  - www.griffith.edu.au/health/australian-institute-suicide-research-prevention.
- **Suicide, questions, answers and resources (SQUARE):** is an educational resource for primary health care and community specialists and any individuals working with people who are at risk of suicide. It is a set of resources that is both a standalone educational resource and a support package for training and systems change in suicide risk assessment, intervention and follow-up. It supports a suicide and self-harm primary health care model.
  - www.square.org.au.

| | When thinking about my own training needs I . . . | | |
|---|---|---|---|
| **Action Points** | **Always** | **Sometimes** | **Never** |
| 10.1 Engage in regular professional supervision | | | |
| 10.2 Update my skills by enrolling in appropriate suicide prevention courses | | | |
| 10.3 Talk to management about professional development and how they can support me in acquiring the skills I need | | | |
| 10.4 Ask colleagues or experts from other organisations to share information about suicide prevention | | | |

# Conclusion



# Conclusion

Supporting people who are experiencing suicidal thoughts and behaviours can be a challenging and daunting task.

Mental health workers try hard to support people experiencing mental health difficulties and in helping to prevent suicide. To assist with this work it is worthwhile taking a step back and reflecting on practices and attitudes.

It is beneficial for both staff and consumers if suicide prevention is focused on the individual, with emphasis on building a meaningful, caring and genuine relationship that values the individual as unique, and works to build a shared understanding of the goal to prevent suicide.

Continued Professional Development

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Acknowledgements

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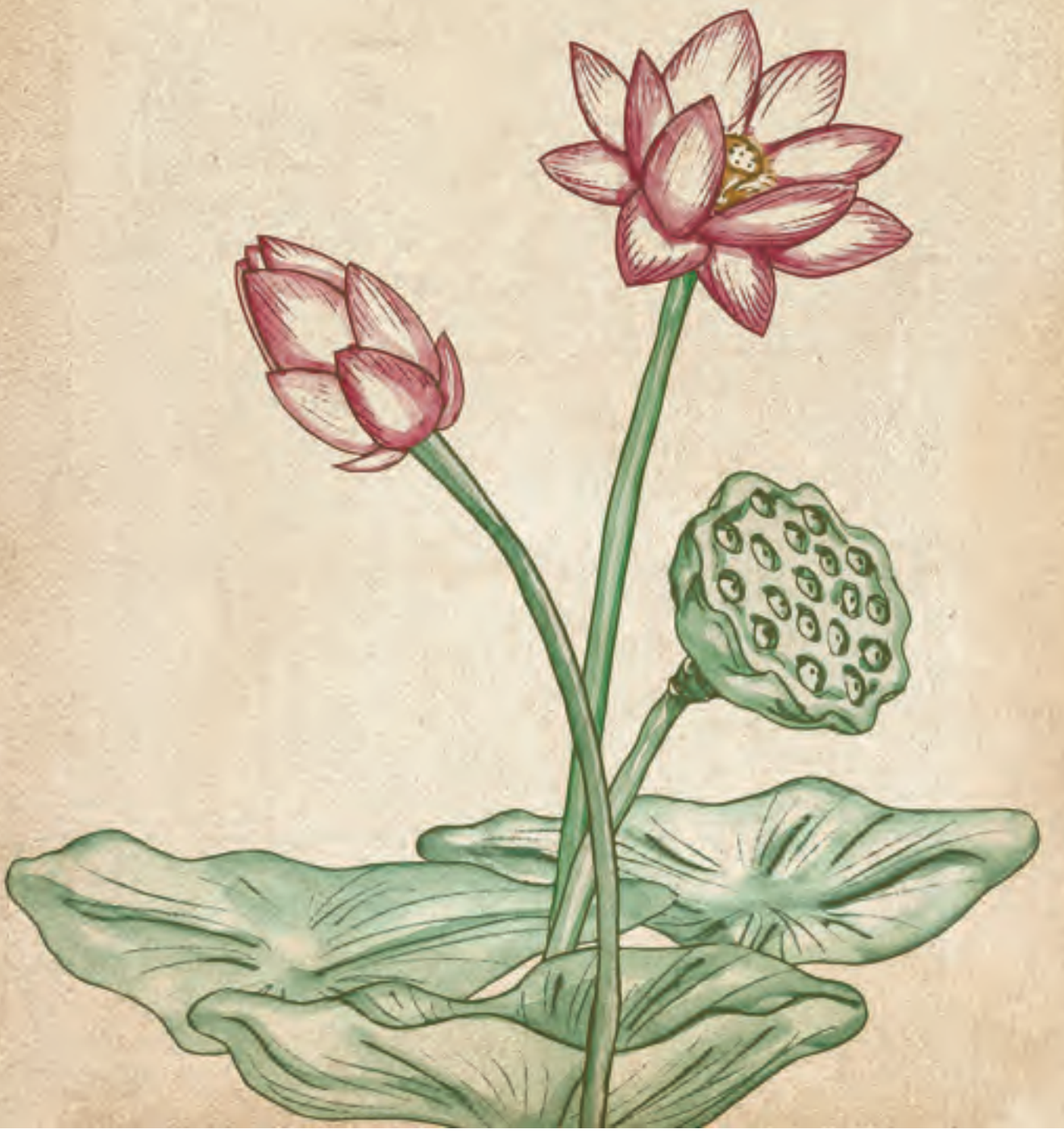

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# Continued Professional Development

This resource has been designed for continued professional development (CPD). SANE has developed an online version of the resource and free online assessment to test your knowledge of the issues covered in this guide. Having completed the online resource, you will receive a certificate of completion, and are eligible to claim two hours of CPD points. Go to www.sane.org/images/SPRG/index.html to access the free online assessment.

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