Summary of the Literature for Discussing Suicide

Outcomes Report:
Summary of the Literature for Discussing Suicide

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About the review

1.1 Background

The slogan "suicide prevention is everyone's business" has been used in a number of settings worldwide. However, if suicide prevention is everyone's business, then how does the general public talk about suicide in a way that is appropriate, healthy, helpful, competent and importantly, not harmful?

In 2010 the NSW Ministry of Health released the *NSW Suicide Prevention Strategy 2010-2015*. The aim of the strategy is to work with the community to reduce the rate of suicide and suicidal behaviour in NSW by strengthening the capacity of individuals, families, educational institutions, workplaces and the local community to work together and share responsibility in supporting each other and the whole community. Strategic Direction 3 is dedicated to 'Improving community awareness, strength, resilience and capacity in suicide prevention'[1]. The government committed to the development of 'whole of government, whole of community guidelines for dealing with and discussing suicide and attempted suicide within families, schools, workplaces and communities'[2].

Due to stigma, discrimination, fear and ignorance the topic of suicide has been commonly considered taboo. Most western cultures have been socialised to avoid the topic of suicide and our discomfort and lack of knowledge perpetuates this situation. Recent efforts to introduce a public health approach to suicide prevention challenges us to reconsider the potential 'cost' of avoiding discussions about suicide. It also, however, means being realistic about the potential 'costs' of inappropriate or misguided discussions about suicide.

While much has been written about the need to talk more about suicide, there are very few evidence-based resources to guide such discussions across community settings. Most of the literature related to the topic of discussing suicide over the past five decades has pertained to the domain of news and information media[3] [4]. However, much less research has been undertaken to investigate how to have a conversation about suicide within the general population.

1.2 Purpose and scope

The Hunter Institute of Mental Health has been contracted by NSW Health to review the evidence, consult with various stakeholders and develop guidelines for discussing suicide and attempted suicide. The first phase of this project was to conduct a Literature Review.

The Hunter Institute worked with a consultant to search, review and analyse the research evidence, as well as source and analyse existing resources and program approaches to identify and provide evidence-based recommendations on the proposed content and format for the development of Community Guidelines for Discussing Suicide. This review was conducted in two simultaneous streams, as outlined in Figure 1 below.

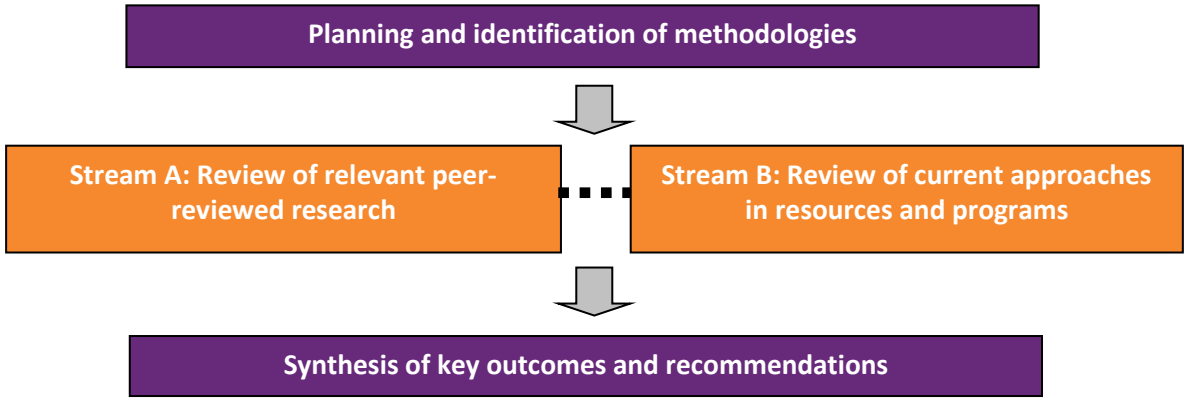

Figure 1. Flowchart to reflect process for conducting the literature review

Given the broad scope of the project to develop guidelines across a range of settings with relevance to a range of target groups, the literature review was conducted in a way to find research evidence and current resource examples related to:

i) the focus of the discussion (prevention, intervention or postvention);

ii) the format of the discussion (one-on-one, small group, or wide-scale);

iii) the setting (educational settings, workplaces, families, communities, online);

iv) the target group for the discussion (e.g. young people, Aboriginal people).

Note: This paper is the result of an evidence scan of peer-reviewed research looking at community discussion of suicide across identified settings and target groups. This does not represent a critical review of the evidence and was accurate as of June 2012.

This is a summary of the literature review. A more extensive review, covering other related areas, was developed for use in resource planning for the NSW Ministry of Health.

1.3 Method

Databases & search methodology

The following online academic databases were searched in January and March 2012 with existing meta analyses, key reviews and peer reviews prioritised for selection: COCHRANE REVIEWS / MEDLINE; PSYCHLIT; COMMUNICATION ABSTRACTS; ERIC; DISSERTATION ABSTRACTS; APAIS; PUBMED; and Google Scholar advanced search.

The following key search terms were identified by the project team and Boolean searches were conducted. Key term 1 (including truncated search terms*): 'suicid*', 'prevent*/interven*/postvention' + key term 2: 'discuss*', 'communicat*', 'talk*', 'convers*', 'forum', 'dialogue', 'spe*', and 'debate'.

Study selection

The initial database search returned 16,324 published English-language abstracts. Given the broad search terms used, most of these articles were not specifically relevant to the project topic. One of

the researchers screened the abstracts and excluded studies that did not relate to community discussion/conversation about suicide. This resulted in 91 potentially relevant studies.

An additional 101 studies were located through hand-searching the reference lists of reviews and key papers found through the initial search and which were considered to relate to the topic under consideration. The 192 abstracts and articles were reviewed, with key articles identified.

While the collation of key reviews and meta-analyses has been prioritised where possible, the apparent unavailability of literature of this kind has necessitated the inclusion of some individual papers and single-studies.

Coding of studies

Each of the 192 studies were coded using a pre-formulated rating sheet according to the following characteristics: Author name; year published; publication details; date of issue; country (location of study); classification of research; focus of discussion (prevention, intervention, postvention); format of discussion; setting for the discussion; and target group for the discussion. Table 1, below, provides more details about how the focus, format, setting and target group were further defined and coded.

Table 1: Fields of enquiry for the literature review (selected)

Fields	Components	Rationale
Focus of the discussion	(1) Prevention; (2) Intervention; (3) Postvention.	It is well understood that approaches in suicide prevention (including conversations) will be different depending on whether the intention is about prevention, intervention or postvention. *For example, what someone may say generally about suicide, may be quite different from what they could or should say if intervening in an individual's suicide risk and different again if they are talking about a suicide that has already occurred.*
Format of the discussion	(1) One-on-one; (2) Group presentations; (3) Community wide.	There are potentially different implications and impacts of discussing suicide across formats with varying levels of evidence. *For example, in some settings there is evidence of positive outcomes of one-on-one conversations, but contradictory evidence about group presentations or media reporting.*
Setting for the discussion	(1) Educational settings; (2) Workplaces; (3) Families; (4) Communities; (5) Online.	It is possible that the evidence would suggest different approaches and impacts across the five settings specified in the project brief. A review of the evidence tried to identify any differences or similarities from the peer-reviewed evidence.
Target group for the discussion	(1) Carers; (2) LGBTI; (3) Young people;	Any differences from the literature about considerations or discussing suicide with or within different target groups were identified and forms part of the recommendations.

	(4) Older people; (5) Aboriginal people; (6) CALD background; (7) People with mental illness; (8) Rural/remote; (9) Men; (10) Bereaved by suicide.	
Communication issues	(1) Stigma; attitudes & beliefs about suicide; (2) Interpersonal setting of conversation; (3) Communication skills.	There exists some pervasive social constructs which may impact on the community's potential reception and willingness to adopt the guidelines. Evidence for the personal, interpersonal, social and cultural settings which may provide barriers or enablers to the implementation, acceptance, dissemination and uptake of these Guidelines will need to be investigated.

Note, while the review was conducted across all fields outlined above, the current summary document only includes an overall summary of the literature in relation to prevention, intervention and postvention conversations about suicide. The evidence related to the setting of the discussion, target groups for discussion and other related literature about stigma, campaigns and conversation theory have been completed for in-house planning but do not form part of the summary for public dissemination.

General overview of literature

2.1 Summary of evidence

There is remarkably little research which has investigated the utility and impact of community level conversations about suicide.

In general, assertions made about the benefits or risks of talking about suicide are not supported, nor denied, by any scientific research findings.

There is very little research which has investigated the nature, extent or impact of community level conversations about suicide. Most of the research conducted has investigated the impacts of asking someone one-on-one about suicide risk. There has been very little research directed towards broader prevention-focused conversations and conversations that occur following a death.

Three previous reviews have been conducted looking broadly at this issue of conversations or discussions about suicide. The first was conducted in New Zealand in 2002[5], the second was conducted in Scotland in 2007[6] and the third was conducted in Canada in 2010[7].

Both the New Zealand and Canadian reviews focused almost entirely on conversations that ask about suicide risk, whereas the Scottish review also included a review of public education (wide-scale) messages. The only other review of evidence conducted has been dedicated to media reporting of suicide, led by Australian researchers[8].

A summary of outcomes from existing reviews are outlined below.

2002 review: New Zealand

In 2002 a study to investigate '*Does asking about suicidal ideation increase the likelihood of suicide attempts?*'[9] was commissioned in New Zealand. Despite their best efforts, the investigators could not locate any extant literature examining this question. They stated that they found strong and broad support from professional guidelines for health professionals that no risk exists when asking about suicidality, but they could not find research evidence to either support or refute the assertion.

2007 review: Scotland

The review conducted under the Scottish government's *Choose Life* Suicide Prevention Strategy[10] was broader in focus, looking at both individual level conversations and broader public education. One aim of the review was to '*Identify whether encouraging people to talk about suicidal feelings is associated with any known/identified positive or negative outcomes*'[11]. The researchers found several articles referring to suicide and the belief that talking with a person about suicide will give that person the idea to kill themselves, but this assertion was not supported, nor denied, by any scientific research findings. The authors wrote the following:

> "*There is a lack of available evidence to suggest that encouraging people to talk about suicide has any known positive effect on outcomes. It appears that most of the comment made in the literature is based on conjecture rather than evidence-based. This would suggest that either it is not possible to measure whether talking about suicidal feelings has any effect on outcomes, or studies have not included a measure for this.*"[12]

The Scottish review also included literature relating to general public education campaigns, aiming to '*Identify any similar/relevant suicide prevention awareness raising/social marketing campaigns and their impact'*[13]. This part of the review also found assertions about the benefit or risks of campaigns, with very little empirical evidence to support claims.

Authors have argued that exposure to suicide material may increase awareness, but it may also normalise suicidal behaviour, making it more acceptable in the process[14 15 16 17].

Research has found that general public education campaigns aimed at improving recognition of suicide risk and increasing help-seeking have had very limited effects[18]. Most studies have shown only a modest effect on attitudes regarding the causes and treatment of depression, but no detectable effect on targeted outcomes of decreasing suicidal behaviour or increasing levels of treatment seeking[19 20 21 22 23].

For example, evaluation across several years of a Suicide Prevention Week social marketing campaign in Quebec, Canada, revealed that knowledge of suicide facts and resources had improved during the campaign period, however, attitudes or intentions to seek help had not; nor was there any effect on the number of suicide attempts or completed suicides[24].

2010 review: Canada

A 2010 literature review "*Talking About Suicide, Asking the Question"* by the Centre for Suicide Prevention in Calgary (Canada) provides a useful summary of literature on this topic[25]. The first section articulates research evidence for reasons why people may be reluctant to talk or ask about suicide. These cluster around:

1. Fear of suggesting or planting the idea of suicide (11 studies);
2. Normalising of suicidal behaviours or desensitization (2 studies);
3. No obvious reason to ask (2 studies);
4. Uncertainty of how to respond and inadequate training and knowledge (5 studies);
5. Reluctance to disclose any issues of confidentiality (2 studies).

The second section of the 2010 review revealed literature relating to 'why even ask and talk about suicide'. Research in this section showed:

1. Asking provides relief (7 studies);
2. Increasing public and personal awareness of warning signs and services (3 studies);
3. People already know about or have considered suicide (3 studies);
4. Not asking may increase suicide risk once intent has been communicated (2 studies).

A small number of studies suggested that if given the opportunity, or asked directly, individuals would provide information about their suicidality, even though they may find it difficult[26].

2010 review of news media: Australia

While not directly related to community conversations about suicide, the question of whether media portrayals of suicide can lead to imitation has been debated for over two centuries; however, scientific studies on this subject have only been conducted in the last 50 years or so. A critical review conducted in 2010 considered studies of news and information media, both traditional (newspapers, television, books) and modern (electronic media such as the Internet)[27]. In total, 97 international studies were reviewed against indicators of a causal association. Similar to a 2001 study[28], it was concluded that presentations of suicide in news and information media can influence copycat acts in

particular circumstances. These circumstances generally related to reporting details of the method or location of death, presentation of celebrity suicides, repetitive coverage of a suicide death and coverage that in some way glorifies or sensationalises suicide or presents it as an option for solving problems.

2.2 Further literature related to prevention focused conversations

Little research has looked specifically at the impact of broader conversations about the issue of suicide. Much of the research in this area related to public education, impacts of training and exposure to suicide prevention programs. Even the well-studied area of media reporting, has generally overlooked studies relating to broader discussions, instead focussing on the impact of reports about suicide deaths.

Some authors[29] have argued that despite the persistent belief that simple exposure to suicide-related content may inadvertently increase risk for suicidal behaviours, particularly among distressed individuals, there exists a remarkable dearth of research investigating the validity of these concerns[30]. That is with the exception of studies which have shown an association between media presentation of suicide and increases in suicidal behaviour following those presentations[31].

Other authors[32] have argued that exposure to suicide material may increase awareness of suicide, but may also normalise suicidal behaviour in the process. This may mean that, despite the knowledge that suicide is an adverse outcome, talking about it may make it appear more normal and thus, more acceptable[33 34].

Some examples from the literature include the following:

- In a sample of 9th and 10th grade students with prior suicide attempts, exposure to a suicide prevention program resulted in no change in maladaptive views on suicide, although there was some evidence to suggest these at-risk students had a more negative reaction to the intervention than their peers[35].
- Following participation in routine suicide education as a part of the U.S. Air Force Suicide Prevention Program's video-based community briefing, a sample of young active duty airmen demonstrated small decreases in positive emotional states and larger decreases in negative emotional states, especially among suicidal females. No evidence of iatrogenic effects (i.e. unintended adverse effects) was observed among suicidal or suicide bereaved subgroups when compared to controls. Results supported the use of video-based media as a safe educational strategy that could serve to decrease emotional distress among vulnerable subgroups[36].
- Some studies have demonstrated a variety of positive outcomes such as improved awareness of suicide warning signs and enhanced helping attitudes[37 38]. These results suggest that exposure to suicide-related content framed within the context of help-seeking behaviours may actually have a positive effect on those most at risk for suicide.
- General public education campaigns aimed at improving recognition of suicide risk and increasing help-seeking have had very limited effects[39]. Most studies have shown only a

modest effect on attitudes, but no detectable effect on targeted outcomes of decreasing suicidal behaviour or increasing levels of treatment seeking[40 41 42 43 44].

The research suggests that norm-based persuasive communications have the best effect when descriptive and injunctive normative messages work in tandem. Descriptive norms relate to 'what people typically do' and injunctive norms relate to 'what people typically approve or disapprove of'. Cialdini wrote the following:

> *"… There is an understandable, but misguided, tendency to try to mobilize action against a problem by depicting it as regrettably frequent. Information campaigns may emphasize for example that alcohol and drug use is intolerably high, that adolescent suicide rates are alarming, and that rampant polluters are spoiling the environment. Although these claims may be both true and well intentioned, the campaigns' creators have missed something critically important. Within the statement "Many people are doing this* ***undesirable*** *thing" lurks the powerful and undercutting normative message "Many people* ***are*** *doing this." Only by aligning descriptive norms (what people typically do) with injunctive norms (what people typically approve or disapprove) can one optimize the power of normative appeals. Communicators who fail to recognize the distinction between these two types of norms imperil their persuasive efforts"* and may inadvertently cause harm."[45]

2.3 Further literature related to intervention focused conversations

Asking about suicide

Most suicides occur among people who are not in contact with mental health services which emphasises the important role of families, friends and colleagues in suicide prevention[46]. Previous research has shown that a majority of people who attempt suicide communicate their suicidal ideas and intent, either directly or indirectly, to members of their social network prior to the act[47 48 49]. A review of psychological autopsy studies found that between one-third and one-half of people who took their own lives had explicitly communicated suicidal intent to those around them in their final few months. This figure rose to be between 60 and 80 per cent when indirect suicide communications were also included [50 51].

There is a lack of scientific evidence suggesting that talking to someone about their suicide risk is either helpful or harmful. A handful of studies have reported that there were either infrequent, small [52 53] or no [54] negative impact on mood states in general, at the time the suicidal ideation assessment was conducted . Authors have also argued that asking about suicide can provide an opportunity for open discussion and relief at being heard, recognised, accepted, and understood[55 56 57 58 59].

There is concern that asking about suicidal thoughts can be a barrier to the development of empirical evidence that informs research on how to safely conduct these assessments. In a survey of ethics committees about conducting suicide research, the most commonly cited concern was whether asking about suicidality might exacerbate or reinforce such thoughts or behaviours[60]. Approximately 65 per cent of committee members surveyed believed that participation in suicide research might be detrimental to participants and that suicide symptoms may intensify.

Despite this belief, two recent studies[61] [62] found that repeated assessment of suicidal ideation was not associated with increased suicidal thoughts or behaviours, even up to 2-years following the initial assessment. This outcome was interpreted as suggesting that basic, non-treatment research on suicidal ideation was not associated with subsequent suicidal behaviours among depressed adults.

Some have argued[63] [64] [65] that despite the lack of empirical evidence, if a person talks about feeling suicidal, then that person deserves a response. Suicidal thoughts or comments, in their view, should never be dismissed as unimportant and the person should be reassured that their plea for assistance has been heard and that they will be helped. While there is no guarantee that a person who is asked about suicide will not attempt to kill themselves, it has been argued[66] that the potential benefits of penetrating the isolation that usually surrounds a person at risk of suicide, far outweighs the actual risk.

There are some studies that suggest talking and asking about suicide is not inherently harmful:

- Screening for risk of suicide and asking about suicide in a primary care setting among those with signs of depression did not appear to increase the likelihood of a person having thoughts that life is not worth living[67].
- A study examining the impact of suicide risk questions to at-risk youth (e.g., impaired from substance abuse, depressed, or past history of a suicide attempt) as well as a general youth population, found that neither group was distressed or more suicidal following the introduction of the questions[68].
- High school students who were asked about suicidal ideation and behaviours as part of a mental health screening program, did not report higher levels of emotional distress or suicidal ideation than students who were not asked about suicide risk[69]. In fact, students reporting substance abuse problems, major depressive symptoms and suicidal ideation demonstrated decreased emotional distress.
- One study undertaken with US college students investigated recognition and response to suicidal peers[70] . When given the statement "It would be helpful to a friend who was thinking of killing him/herself if I asked them directly '*Are you thinking about killing yourself*"", the majority of students felt it would have a positive or neutral effect on the outcome.

Literature has demonstrated that health professionals themselves face difficulties when discussing suicide and patients vary greatly in their opinions about discussing suicide. It would be reasonable to expect that the general public will experience at least a similar level of challenge and variability.

Research[71] [72] [73] has revealed that mental health nurses and doctors do not actively discuss suicide with their patients due to fears that discussing suicidality may actually increase suicidal intent and behaviour. Talseth et al. suggested that psychiatric inpatient unit nurses often avoided the subject, despite their suicidal patients' expressed need for them to be present and listening[74]. Research undertaken with GPs in Denmark revealed similar outcomes where doctors were reluctant to use the word "suicide" in conversations with their patients[75].

Physicians in five different locations across England revealed that they did not like asking people about suicidal thoughts because they worried that it might make them feel worse[76]. When patients

were asked how they felt about being asked questions on suicidal ideation and behaviour, 39 per cent indicated that they felt 'OK' or neutral, 27 per cent were surprised at being asked such questions, and 27 percent reported feeling either upset, embarrassed, alarmed, or uncomfortable. Patients were also asked about how they felt GPs should ask such questions. Responses showed that there was equal division between those who felt that GPs should use a direct approach and those who felt that language should be chosen carefully and terms such as 'suicide' should be avoided.

Content considerations

Suicidologist, Edwin Shneidman, coined the term "psychache" to describe the unendurable mental pain, intolerable emotion, and unacceptable anguish that are the basic ingredients of suicidality. When it comes to the issue of "*What do I say to someone who might be suicidal*?" Shneidman suggested that the key questions are: "*Where do you hurt*" and "*How may I help you*?"[77]

The most relevant piece of literature pertaining to intervention conversations is the research undertaken by the Mental Health First Aid Training and Research Program at the University of Melbourne[78]. Using Delphi methodology the researchers assembled an expert panel of mental health consumers, carers and clinicians from Australia, New Zealand, the UK, the USA and Canada. After a review of the literature, a list of 114 statements was assembled regarding how to assist someone who is thinking about suicide and included ideas on what to say. Panel members voted on the most acceptable 30 statements and these were used to develop guidelines for members of the public who wanted immediate information about how to assist someone who is at risk of suicide. The guidelines open with a warning prior to proceeding with step wise directions.

Earlier authors have suggested what to say and how to listen to a person at imminent risk of suicide. They assert that if the communication is with someone at perceived imminent risk then the atmosphere will be one of extreme urgency and emotional pressure whereby helpers may require clear guidelines for communication[79] [80].

These authors also assert that two processes often mentioned as almost universally present in the mind of the suicidal person, particularly in the crucial final phase, are that:

1. The suicidal person nearly always feels isolated and cut-off with a desperate sense of absolute aloneness;
2. The suicidal persons' perception of the world is drastically narrowed and a tunnel vision almost impermeable to external influences develops.

As such, a fairly broad base for the grounding of intervention dialogue is provided, suggesting that the helper should portray an attitude that is fully empathic while positioning him or herself at the suicidal person's side if possible in an attempt to allay the person's sense of isolation. The text of the discussion is firmly based on the suicidal persons' "reasons for living and reasons for dying". Further suggestions are made about the role of loss and grief in reasons for considering death and about behavioural considerations when contemplating entering a discussion with a suicidal person at imminent risk[81].

Miraldi provided a technical paper encouraging investigation into communication research to inform intervention conversations relating to suicide and harnessing theories of persuasion.

> "*Typically, responses to suicidal disclosures are not treated seriously. . . Communication research is desperately needed in this area to determine the effectiveness of responses to the suicidal individual. Persuasion is a major part of the preventative response. Communication researchers need to apply their knowledge of persuasive processes to determine how to persuade individuals not to take their own lives. Also, how are individuals persuaded and how*

do they persuade themselves to [die by] suicide? As opposed to the controlled experiments and hypothetical situations normally employed to study persuasion, scholars should analyse how emotions and irrationality operate in … suicide/attempts."[82]

Evidence for gate-keeper training

Most suicide prevention education/training is designed to identify someone at risk, learn how to approach them, have a conversation, evaluate the situation and encourage them to access professional help. However, although some literature attests to the efficacy of training programs, few specifically relate to talking to a suicidal person within the community.

Gatekeeper training programs for community members are offered in many cities and towns across Australia. Such training programs have demonstrated positive changes in knowledge and attitudes about suicide for those trained[83][84][85] [86] [87]. However, there is limited evidence for observed skills or behaviour change in trainees as a result of community level training[88], or of community impact. Behavioural rehearsal has been recommended as an important component of gatekeeper training to improve the likelihood of skills being utilised[89].

Gatekeeper skills generally include the following:

1. Active listening: Shows emotional responsiveness/reflects feelings accurately; concern, care; nonverbal communication;
2. Clarifying/confirming questions: Enquiries and follow ups to "decode" the content or meaning of indirect or even direct suicidal communication;
3. Directly asks about suicide: Asks directly in one of the following ways: Suicide/suicidal? Kill yourself? Ending your life/end it all? Wish you were dead?
4. Persuades: Encourages help-seeking. Uses persuasive phrases: "I think you need help, let's call someone."
5. Refers: Identifies specific person (name) or place for help, and supports the connection (not vague suggestion such as call the hotline)[90].

Sensitive communication and clarifying questions are important in interacting with suicidal individuals, but, most community suicide prevention programs focus specifically on dispelling myths about suicide and providing information about suicide specific skills (i.e. asking about suicide, being persuasive and encouraging help-seeking, and providing an appropriate referral). It has been suggested[91] that identifying students at high risk for suicide in school settings requires open communication about issues of emotional distress, and that most gatekeeper training does not change communication styles. To have an impact on general communication skills, it is likely that more comprehensive training focusing on communication skills (e.g., empathy, active listening) and that identifies participants who are ready to engage others in emotionally charged discussions, would be necessary.

Context for conversations

During a suicidal crisis, significant others are required to make a series of highly complex decisions about what is happening and what, if anything, they should do about it. Their proximity to the suicidal person, their emotional investment in the relationship, and a range of other factors can make it difficult for them to decipher, heed warning signs, and take appropriate action. Interventions to promote public involvement in suicide prevention should highlight the ambiguous nature of warning signs and explicitly tackle the potential emotional blocks to awareness and intervention[92].

Qualitative research by Owens and colleagues investigated the complex context in which an intervention conversation within family and social networks take place[93]. This retrospective study sought to understand how the social network of a suicidal person was influenced about whether to, and how to, intervene; including the social processes and ways in which personal relationships may impact on one's ability to recognise and respond to the possibility of suicide. The authors interviewed 31 friends and family members of 14 people who had died by suicide (aged 18 -34) and who were not in contact with secondary mental health services at the time of their death.

Owens et al. identified three broad categories preventing friends/family from recognising and responding to a suicidal crisis:

1. Difficulties faced by the suicidal person in effectively communicating their distress;
2. Difficulties experienced by significant others in interpreting and heeding distress signals;
3. Difficulties experienced in taking action.

The study found that although family and friends were aware that something was seriously wrong, deciding to say something, to intervene, working out what action to take, and then summoning the courage to take it posed enormous challenges. Just "*saying something*" was a strong regret of many friends and family.

Many public education messages use the "see-do" or "see-say-do" formula, i.e., "If you see this, you should do that" ("see-do") or "If you see this, you should encourage the afflicted person to do that" ("see-say-do"). These models are based on two underlying assumptions:

1. That people can be taught what things to look out for;
2. When they spot them, they can act sensibly and in accordance with received guidelines.

The evidence provided by Owens et al. demonstrated that there are a number of issues that may be complicit in undermining friends and family members from seeing, saying and doing anything.

Similarly, other authors[94] have argued that, despite there being no guarantee that a person who is asked about suicide might not kill themselves, the benefits of asking outweighs the potential risks. The authors discuss what potential barriers might exist for a [young] person to ask about suicide, including: lack of knowledge of possible suicidal behaviour; lack of knowledge that talking about suicide is helpful; fear and emotional discomfort; and uncertainty and lack of confidence. Therefore, they argue that in order to be able to talk about suicide a person would have to have:

- Recognition that their friend is potentially exhibiting suicidal behaviour;
- Knowledge that such a direct conversation is both appropriate and helpful;
- Capability to overcome the fear and anxiety involved in talking directly and openly about suicide;
- A strong sense of self-efficacy.

The study demonstrated that self-efficacy was the main predictor of a young adult's intention to talk to a potentially suicidal friend. They further state that "knowledge gain alone may not lead to helpful action unless the conviction that one can take action based on the knowledge (perceived self-efficacy) is also fostered". For young adults the researchers suggested the inclusion of experiential learning, social modeling, participant modeling and role playing of open and direct approaches and responses of potentially suicidal peers could contribute to increased self-efficacy and therefore action.

Evidence from public health campaigns

An evidence review conducted in Scotland [95] collated all literature published in English from 1990-2007 regarding the impact of suicide awareness-raising campaigns and the effects of encouraging people to talk about suicide. They found some evidence of positive impacts on knowledge and awareness, and found no evidence to suggest any negative impacts or risks to individuals. At the same time, however, of the review did not find any research to support positive behaviour change following suicide awareness campaigns.

Mental health literacy is the knowledge and beliefs about mental disorders that aid in their recognition, management, or prevention; it is also a determinant of help seeking. As such, it is presumed to be important in community suicide prevention programs. In Australia there have been a number of government, professional, and charitable organisations which have been designed to enhance public and professional knowledge about mental disorders, particularly depression. A naturalistic study conducted between 1998 and 2004 in a random, representative population sample examined the changes in mental health literacy and treatment seeking of those with major depression (with and without suicidal ideation), and those who were neither depressed nor suicidal[96].

Results indicated that there was marked improvement in mental health literacy for all three groups, although there was less change for those most in need of intervention (i.e. those with major depression and suicidal ideation). Furthermore, there were fewer changes in appropriate treatment seeking in those with major depression and suicidal ideation. These findings were consistent with literature reporting limited problem solving and decision making in people who are suicidal, and indicates that there are limits to broad based community education programs. The authors conclude that more focused suicide prevention initiatives are required, specifically for those who are depressed and suicidal[97].

Conclusions

The breadth of this current project is extensive; however the research evidence does not stack up with commensurate size. There is remarkably little evidence for how to have a community conversation about suicide despite all the public dialogue requesting that such takes place.

The most concerning is the lack of evidence demonstrating positive effects on outcomes for participants in that conversation. It is fair to say that this may be because such research has simply not been investigated or that it is very difficult to measure effects.

The development of Community Guidelines for discussing suicide would create an opportunity to determine outcomes by the implementation of a comprehensive evaluation strategy alongside the implementation of the guidelines.

Emerging recommendations

The following recommendations have been suggested from the review of literature and should be considered in the development of the community guidelines for discussing suicide. These are based on the full literature review, not just the summary provided above.

Recommendation 1:

The research suggests that norm-based persuasive communications have their best effects when descriptive and injunctive normative messages work in tandem. Descriptive norms relate to 'what people typically do' and injunctive norms relate to 'what people typically approve or disapprove of'. Community Guidelines to discuss suicide would need to be cognizant of social-norms theory and its relevance to inadvertently normalise suicidal behaviour.

Recommendation 2:

Embed Guidelines dissemination within existing community structures already in place e.g. community service organizations providing services for older people and aged care facilities. Ensure that staff members have some training and awareness to be able to support conversations which are precipitated by the dissemination of Community Guidelines.

Recommendation 3:

The Delphi methodology utilised by the Mental Health First Aid Research Team has proven useful in the development of guidelines for members of the public on many mental health topics and across different cultural settings. Such methodology could be utilised by this Project to include broad expert consensus input on community discussions about suicide.

Recommendation 4:

NSW Government should consider expanding these Guidelines to include information relevant to Non Suicidal Self Injury (NSSI).

Recommendation 5:

The development of these Guidelines alone will not necessarily lead to action. The concept of self-efficacy needs to be taken into consideration when developing dissemination strategies with an appreciation of the following: In order to be able to talk about suicide a person would have to have: (1) Recognition that their friend is exhibiting potentially suicidal behaviour; (2) Knowledge that such a direct conversation is both appropriate and helpful; (3) Capability to overcome the fear and anxiety involved in talking directly and openly about suicide (4) A strong sense of self-efficacy.

Recommendation 6:

The belief that talking about suicide makes people feel worse is quite entrenched despite it being unfounded. Even doctors and nurses work under this misapprehension. For the general public to talk about suicide, the Community Guidelines will need to acknowledge how far reaching the negative belief is and take steps to actively address and debunk them.

Recommendation 7:

During an intervention conversation don't use 'no-problem' negative polarity inference questions (e.g. "No thoughts of harming yourself, right?") which implies that denial of suicidal thoughts is the correct answer. Also, try not to respond to denials with words like: "right", "good then", and "okay" which may shut down future conversations when the person is feeling suicidal. Try to frame the intervention conversation within a contextual dialogue to create a safe and non-judgemental environment.

Recommendation 8:

Research evidence reveals that suicidal people do not often openly initiate conversations about suicide, even with their doctor or a suicide helpline that they have called. Community Guidelines need to allow for this and encourage 'concerned others' to be the ones to initiate the conversation.

Recommendation 9:

Gatekeeper training models may be useful in providing a framework for intervention conversations. However communication skills such as empathy and active listening might be required in emotionally charged circumstances.

Recommendation 10:

Intervention conversations should include imminent risk circumstances. Guidelines should take into consideration the almost universal sense of isolation and narrowing of perspective experience by a suicidal person as well as their feelings of loss and ambivalence with conflicted reasons for living and reasons for dying.

Recommendation 11:

Consideration of the emotional blocks that often exist for friends and family of a suicidal person are imperative to appreciate when considering intervention conversations.

Recommendation 12:

Underlying attitudes and beliefs about suicide have a strong influence on intentions and behaviour and cognitive dissonance may hijack many to avoid using these Guidelines. It is important to acknowledge and address these when considering the uptake of such Community Guidelines for Discussion of Suicide. NSW Government needs to investigate and address the social, cultural and interpersonal environment that the Guidelines sit within. Without this, the Guidelines may not be utilised.

Recommendation 13:

There needs to be an evaluation framework developed to determine whether these Guidelines are utilised, by whom, in what ways and whether they lead to any positive outcomes.

Recommendation 14:

Given the lack of evidence in this specific area, it will be important for the Community Guidelines Project to be clear about the intended and expected outcomes of the project and to set up effective planning around dissemination, implementation and evaluation strategies. The evaluation framework will need to be developed to determine whether these Guidelines are utilised, in what ways, by whom, for whom, in what context, under what circumstances and whether they lead to any positive outcomes.

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CONVERSATIONS MATTER

resources for discussing suicide

hunter institute of mental health

NSW GOVERNMENT Health

Mental Health Commission of New South Wales