Development of core principles for 'Conversations Matter' resource content

Outcomes Report: Development of Core Principles for 'Conversations Matter' Resource Content.

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Developed by:
Hunter Institute of Mental Health

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hunter institute of mental health

Mental Health Commission of New South Wales

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This report and other research and evaluation reports for the program are available online at www.himh.org.au or www.conversationsmatter.com.au

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Chapter 1: Executive Summary

1.1 Aim

The Hunter Institute of Mental Health has developed resources to provide practical support for communities and professionals to guide safe and effective conversations about suicide. The final resource, called Conversations Matter, was guided by a set core principles. This report describes the process of review undertaken in the development of these core principles.

1.2 Methods

The initial principles were drafted based on a review of the available evidence and existing resources and programs, in combination with feedback obtained from consultations with key informants across four settings and from representatives from key target groups. Settings consultations included representatives from the following sectors: education, workplace, communities/online and families. Target group consultations were with representatives from the following groups: people bereaved by suicide; older people; young people; men; mixed adults; people in rural communities; people from the lesbian, gay, bi-sexual, trans-sexual, inter-sex population (LGBTI); people from culturally and linguistic diverse backgrounds (CALD); consumer; and carers. These principles were presented to external reviewers who were asked to rate their level of agreement with prevention-focused, intervention-focused and postvention-focused conversation principles by completing an online survey. Three review panels were convened: (1) an expert review panel consisting of academics, clinicians or program leaders known for their significant work in the suicide prevention sector; (2) a target group review panel of people who work with identified priority target groups and (3) a settings review panel of stakeholders who work in various identified settings. The review process was a two- step, mixed methods approach to measure levels of agreement. The reviewers were asked to rate their level of agreement and provide qualitative comments for each principle. Reviewers were invited to complete a second online survey of principles that had been added, or existing principles that had been substantially re-written, based on outcomes of the first round of review.

1.3 Results

Forty five people were invited to review the principles (nine experts, 25 from key target groups and 12 from settings). Thirty five reviewers completed the initial online survey: six expert panel members, 11 setting panel members and 18 target panel members. Of the 95 initial principles, 66 were agreed to by all panel members (34 of these items had a neutral rating selected by an average of one reviewer), 19 had one panel member disagree, and seven had two or more panel members disagree. Principles that had strong levels of disagreement or consensus for change in the comments were re-written. Ten principles were substantially edited and were sent out for second review. Twenty nine reviewers completed the online survey of the revised principles. All panel members agreed or were neutral for seven of the 10 principles, one principle had 18% of reviewers disagree, one principle had 12% of reviewers disagree and one principle had 6% disagree. Nine of the principles presented in the second review were accepted. A total of 93 key principles were accepted: 34 prevention-focused principles, 28 intervention-focused principles and 31 postvention-focused principles (see appendix).

1.4 Conclusion

The two-step, mixed method review process provided information on the level of agreement with core principles in an area where there is very little empirical evidence to guide resource development. Having a mixed method (quantitative and qualitative) of gathering information was beneficial in allowing reviewers to easily indicate level of agreement, but still gave the opportunity for more nuanced feedback. Time constraints prevented a full Delphi method of review, however, this method provided a good balance between expediency and rigorous review.

Chapter 2: Background and Methods

2.1 Background

The Conversations Matter resources were developed under a project originally called "Community Guidelines for Discussing Suicide". The project was originally funded by the NSW Ministry of Health as part of the NSW Suicide Prevention Strategy 2010-2015. The Hunter Institute of Mental Health (HIMH) was contracted by the NSW Ministry of Health (Mental Health and Drug and Alcohol Office) to work in consultation with a state-wide steering committee to develop resources to support community conversations about suicide.[1]

The NSW Suicide Prevention Strategy 2010-2015 identified that a potential mechanism for implementing change in the way suicide is discussed in the community is by strengthening the capacity of individuals, families, schools, workplaces and the local community to identify signals associated with suicide, and to improve their self-efficacy to intervene. The Conversations Matter resources can be used to guide one-on-one conversations, as well as groups and large-scale conversations. They provide information to support people when: they would like to talk about suicide generally (prevention-focused); when they are worried that someone is thinking about suicide (intervention-focused) and when there has been a death by suicide (postvention-focused). As there is very little empirical evidence to support the content of these resources, it was necessary to undertake an external review process to identify a set of core principles to guide the resource content. This report describes the process of review undertaken in the development of these principles.

2.2 Method

Draft principles were developed by HIMH staff after reviewing and analysing the available evidence and existing examples of practice, in combination with the feedback obtained from consultations with key informants across four settings (education, workplace, communities/online and families) and community members from key target groups (people bereaved, older people, young people, men, mixed adults, rural, lesbian, LGTBI, CALD groups, carers and consumers). The 95 draft principles covered advice on prevention (32), intervention (30) and postvention (33) focused conversations.

Three panels were asked to review the principles via an online survey. The expert review panel included individuals known nationally for their extensive work in suicide prevention as either a researcher, clinician and/or program leader. The settings panel was made of professionals working in, or in partnership with, education settings (such as schools, TAFE or Universities), workplaces, communities (including those working in online environments) and family settings. The third panel was made of people representing particular target populations including people bereaved, older people, young people, men, mixed adults, rural, LGBTI, CALD, carers and consumers.

A two-step, mixed methods approach to measure levels of agreement was undertaken. The first step asked each panel member to indicate their level of agreement with each principle via an online survey. For each principle responses were based on a seven point Likert scale, from "strongly agree" to "strongly disagree" with a middle "neutral" rating. Responses were analysed by one member of the evaluation team and then reviewed by the program leader for accuracy. Results on agreement were collated and reviewed by members of the project Steering Committee.

Panel members were also given the option to provide further open-ended comments on each principle. Principles that had no disagreement ratings were retained, although minor amendments were made to some based on the qualitative comments. Those principles that had negative comments and/or substantial disagreement on the Likert scale were re-drafted for a second review. For step two, reviewers were invited to complete a second

[1] From 2014 Conversations Matter is being managed and supported by the Mental Health Commission of New South Wales.

online survey, to review principles that had been added or substantially re-written based on outcomes of the first round of review.

Chapter 3: Results

3.1 Demographics

Forty five people were invited to review the principles (nine experts, 25 from key target groups and 12 from settings). Thirty five reviewers completed the initial online survey: six expert panel members, 11 setting panel members and 18 target panel members. Table 1 summarises the composition of the three review panels and the number of people who responded to each review. Table 2 outlines background information about the reviewers. Table 3 summarises the initial review and second review outcomes.

Of the 95 key principles, 66 were agreed with by all panel members (34 of these items had a neutral rating selected by an average of one reviewer), 19 had one panel member disagree, and seven had two or more panel members disagree.

Table 1. Percentage of responses by review panel

Panel	Composition	Response to initial review n= 45 (% invited)	Response to 2nd review n= 45 (%invited)
Expert Review	Six experts currently working in the suicide prevention sector	6 (67%)	4 (44%)
Settings Review	11 stakeholders who work in various settings: Education (n=3) Workplace (n=2) Communities/ online (n=1) Families (n=3)	11 (92%)	8 (67%)
Target Review	18 people who work with the identified priority target groups: bereaved, older people, young people, men, mixed adults, rural, LGBTI, CALD, carers and consumers	18 (72%)	18 (72%)

Review panel members were asked to nominate their area of expertise, their involvement in particular settings and if their involvement with particular target groups. This information is summarised in Table 2.

Table 2. Demographics of reviewers for initial survey

	Expert	Target Group	Settings
No. of Respondents	6	18	11
Prevention	67%	89%	91%
Intervention	67%	67%	55%
Postvention	67%	33%	27%
Work settings			
Educational	83%	56%	55%
Workplace	50%	44%	45%
Communities	67%	67%	45%
Online	33%	11%	18%
General	50%	28%	27%
Individuals bereaved by suicide	83%	56%	55%
Older people (65+)	33%	67%	27%
Young people (18-25)	50%	67%	73%
Men	67%	67%	82%
LGBTI	50%	33%	55%
Aboriginal or Torres Strait Islander	67%	17%	64%
Culturally and linguistically diverse	50%	44%	45%
People living with a mental illness	50%	61%	36%
Carers	50%	67%	55%
Adults	67%	67%	91%
Rural populations	67%	39%	55%

3.2 Results: Initial review

Prevention principles:

There were 32 prevention principles presented to reviewers. Based on the first review:

- Two principles had comments and ratings that resulted in the principles being substantially rewritten and requiring a second review.
- Two new principles were added due to qualitative comments and required a second review.
- Nineteen principles had minor edits and were retained without further review.
- Eleven principles were accepted without change.

Intervention principles:

There were 30 intervention principles presented to reviewers. Based on first round reviews:

- One principle was split into two and both required second round review.
- One principle received a large number of comments resulting in a substantial rewrite, requiring a second review.
- One principle was merged into another.
- Two principles were removed due to qualitative comments.
- Nineteen principles had minor edits and were retained without further review.
- Six principles were accepted without change.

Postvention principles:

There were 33 postvention principles presented to reviewers. Based on first round reviews:

- One principle was split into two and both required a second review.
- Two principles were rewritten and required a second review.
- Two principles were merged into two other principles and retained without further review.
- One principle was deleted due to qualitative comments.
- Twenty five principles had minor edits and retained without further review.
- Two principles were accepted without change.

Principles that had strong levels of disagreement or consensus for change in the comments were re-written. As summarised below, 10 principles were substantially edited and sent out for a second review. Twenty nine reviewers completed the online survey of the revised principles. All panel members agreed or were neutral for 7 of the 10 principles, one principle had 7% of reviewers disagree and one principle had 3% of reviewers disagree.

3.3 Results: Second round review

Second round review: There were 10 principles presented to reviewers as part of the second review:

- Seven principles accepted (no disagreement ratings) without change.
- One principle had low levels of disagreement (6-12%). This principle accepted given the very low level of disagreement.
- One principle had low levels of disagreement and qualitative comments that supported splitting into two principles.
- One principle had 12% strongly disagree rating and 6 % neutral rating. This principle was removed due to ratings and qualitative comments.

Table 3: Summary of review process

	Total presented for review	Accepted without change	Minor edits only	Major edits[#]	New[#]	Total Retained	Removed
Initial review	**95**	**19**	**63**	**7**	**4**	**93**	**6**
Prevention	32	11	19	2	2	**34**	0
Intervention	30	6	19	2*	1	**28**	3
Postvention	33	2	25	3	1	**31**	3
Second review	**10**	**8**	**0**	**0**	**1**	**9**	**1**
Prevention		2	0	-	1	3	-
Intervention		2		-	-	2	1
Postvention		4		-	-	4	-
Total principles Retained						**92**	

Required second review; *note 1 deleted at 2nd review

Chapter 4: Conclusions

4.1 Discussion

This study uses a two-step, mixed method process to review core principles that informed the full content of a resource that provides practical support for communities and professionals to guide conversations about suicide. The aim of the target group and setting panels was to ensure that the content and format of the guidelines was appropriate and accessible for the target groups and settings. The expert review panel provided knowledge and expertise from academics and program leaders in the suicide prevention, intervention and postvention sectors in development of the final core principles. Given that the evidence underpinning the resources is limited at best, the views of experts in the field (and their level of agreement) was important to the integrity of the core principles. The principles endorsed in this review have been used to guide the development of the content for online resources for the community and for professionals. These resources are hosted on the Conversation Matters website (www.conversationsmatter.com.au).

4.2 Conclusion

The two-step, mixed method review process provided information on the level of agreement with core principles in an area where there is very little empirical evidence to guide resource development. Having a mixed method (quantitative and qualitative) of gathering information was beneficial in allowing reviewers to easily indicate level of agreement but still gave the opportunity for more nuanced feedback. Time constraints prevented a full Delphi method of review however this method provided a good balance between expediency and rigorous review.

Appendix: Final core prevention, intervention and postvention principles and review panel results

Prevention Principles	Edit required at 1st reviews	Accepted at 1st review	Edit required at 2nd review	Accepted at 2nd review
1. Members of the community are interested in the issue of suicide and want opportunities to talk about it, however the fear, stigma and ignorance that still exists can make it difficult for people in the community to talk openly about the issue.	Major	x	Minor	✓
2. There is only limited evidence specifically investigating whether broader discussions about suicide will be helpful or harmful to audiences so definitive conclusions across settings cannot be made.	Major	x	Minor (split in two)	✓
3. Presentations or conversations about the issue of suicide should therefore be planned, monitored and ideally evaluated.	Added	x	Nil	✓
4. There should be an identified purpose for holding a discussion about suicide with clear intended outcomes that can be evaluated.	Added	x	Nil	✓
5. The way the issue of suicide is discussed is important. While conversations can inform and educate the audience, if not handled well they may also upset, alienate or increase risk of some individuals in the audiences.	Minor	✓		
6. Where possible and suitable to the audience, have discussions about the broader issues of suicide and suicide prevention face-to-face so that people's reactions and understanding can be monitored and support provided to individuals if necessary.	Minor	✓		
7. Online methods are favoured by some people (e.g. young people) and can give a sense of community and connection. Where conversations occur online, it is best if they are moderated and participant guidelines are developed and agreed to before commencing the discussion.	Minor	✓		
8. If possible, discuss suicide prevention awareness strategies as part of a broader health or wellbeing program and explore options to reinforce the messages over time.	Minor	✓		
9. For conversations to have an impact on behavior change they should focus on development of knowledge and skills rather than just discussing the extent of the problem.	Minor	✓		
10. Prepare prevention-focussed conversations/presentations about suicide in advance so that they are relevant and appropriate to the intended target audience.	Minor	✓		
11. For a planned discussion, give people notice that the issue will be raised (in class, at work, in an online forum) and what might be covered so they can make an informed decision about participation.	Minor	✓		
12. Set ground rules and expectations before the discussion starts, especially for group discussions and ensure support options are available for those who may be distressed.	Nil	✓		
13. Some group discussions may not be the best place for personal disclosure, depending on the participants, the setting and focus of the discussion. Set and discuss ground rules for personal disclosure up front.	Nil	✓		
14. Understand cultural barriers which hinder the discussion of suicide in some communities and prepare for them before the discussion.	Nil	✓		
15. Ensure that whoever is facilitating the discussion has credibility with the target group, is appropriately trained, adequately prepared, and can manage difficult comments or emotional responses.	Nil	✓		
16. If a person with lived experience is facilitating, or co-facilitating, the discussion, make sure they are trained and have access to support before, during and after the presentation.	Minor	✓		
17. If the conversation is occurring in an Aboriginal community, ensure the presenter has gained approval to proceed from a suitable Aboriginal authority.	Nil	✓		
18. Where practical, choose an appropriate physical and emotional location for the discussion – e.g. where the person or audience is going to feel comfortable and safe talking.	Minor	✓		

	Edit required at 1st review	Accepted at 1st review	Edit required at 2nd review	Accepted at 2nd review
19. Ensure enough time has been allocated for the discussion to ensure questions can be answered and people followed up if they need additional support.	Nil	✓		
20. When leading the discussion, don't place any moral or value judgements on the act of suicide and do not push people to talk or participate when they would prefer not to. Presenters should be knowledgeable enough to provide context and facts that address any myths or misconceptions raised.	Minor	✓		
21. Avoid offering simplistic explanations for why suicide occurs. Any conversation about suicide should outline the complexity of the issue and be framed in relation to known risk factors and protective factors.	Minor	✓		
22. Use a strengths-based tone in the conversation, emphasising that suicide is mostly preventable, address myths and misconceptions and outline information that assist people to respond appropriately.	Minor	✓		
23. Check the accuracy of your information and use only reputable sources. Communicating unsubstantiated, sensational or inaccurate information is unhelpful to the community.	Nil	✓		
24. Personal stories are best used in prevention conversations if they are appropriate to the audience and focus on how a person overcame suicidal thinking and the things that assisted them to recover.	Nil	✓		
25. Avoid judgemental phrases or language which glamorises or sensationalises suicide. e.g. consider using 'non-fatal' not 'unsuccessful'; or 'died by suicide' or 'took their own life' rather than 'committed suicide' or 'successful suicide'.	Nil	✓		
26. Avoid language which sensationalises suicide or exaggerates suicide rates or trends. For example, use 'increasing rates' or 'high rates' if it is accurate rather than 'suicide epidemic'.	Minor	✓		
27. Sometimes language can be misinterpreted especially across different cultural groups. The presenter should understand the cultural aspects of language before attempting to discuss suicide in a particular setting.	Minor	✓		
28. Avoid discussing the methods or locations of suicide deaths in any detail, even in general conversations. Talking in specific detail about the methods of suicide or locations where suicides occur can create images that are upsetting for people and can increase the risk of imitative behavior by people vulnerable to suicide.	Minor	✓		
29. Respectfully challenge and clarify any inappropriate comments to ensure the safety of all participants.	Minor	✓		
30. Monitor participant responses and have systems in place to support anyone who becomes distressed.	Minor	✓		
31. For education sessions, it is best to use two people - one to present material and the other to monitor and respond to participant needs.	Minor	✓		
32. For education sessions, consider using case studies and hypotheticals rather than real-life examples to ensure safety and minimise individual identification with the problem.	Minor	✓		
33. Let your audience know that it is ok to reach out for help and encourage discussion with people they trust, such as family, friends, teachers, colleagues, or professional services.	Nil	✓		
34. Provide clear and relevant options for seeking help for suicidal ideation– including at a minimum details for 24/7 crisis counselling services.	Nil	✓		
Intervention Principles				
1. There is only limited evidence, outside of clinical settings, specifically investigating whether asking someone about their suicide risk will increase or decrease their risk. Expert opinion and current program approaches suggest that talking to someone about whether they are contemplating suicide will generally not increase their risk.	Added	x	Nil	✓
2. If initiating a conversation with someone about whether they are having suicidal thoughts, do it in private rather than in a	Minor	✓		

group setting.				
	Edit required at 1st review	**Accepted at 1st review**	**Edit required at 2nd review**	**Accepted at 2nd review**
3. When asking someone whether they are feeling suicidal it is preferable to do it face-to-face. If a face-to-face format is not an option (or not the preferred option), use a mode of communication that both parties are comfortable with and which allows for privacy (e.g. private chat online or telephone.)	Major	x	Nil	✓
4. If someone indicates potential suicidal ideation online (e.g. a Facebook post), it is preferable to respond by asking the question of whether they're feeling suicidal in a private forum (e.g. over the telephone or by private online message).	Minor	✓		
5. When asking whether someone is suicidal, it is <u>preferred</u> that the person asking the questions is someone the person might feel comfortable with and confide in.	Minor	✓		
6.Before initiating the conversation, the person asking should consider their own state of mind and whether they would be able to calmly respond to the answers given.	Minor	✓		
7. Where practical, conduct the conversation in an appropriate and safe environment. For example – a place that allows for privacy and/or a place that is culturally acceptable.	Minor	✓		
8. Allocate necessary time for the conversation, if it is planned in advance. A suicidal person may need a substantial amount of time to talk through what is going on for them.	Minor	✓		
9. Consider any cultural factors which might impact on the conversation. People from different cultures interpret suicidal experiences though a range of cultural, spiritual and religious understandings. Be aware of different values and the way people express themselves.	Nil	✓		
10. When communicating with someone from a culturally diverse population, where it is appropriate and practical try to have someone from the same culture there with them, to help to translate language and other cultural differences that may exist.	Minor	✓		
11. Build rapport with the person by listening without judgment or criticism, offering support, compassion and comfort.	Minor	✓		
12.Take the person seriously and accept their reasons for wanting to die. Don't offer the person advice or minimise their reasons for wanting to die (e.g. '*Try not to worry about it.'*).	Minor	✓		
13. Use open ended questioning techniques to develop a deeper understanding of their situation. For example, instead of saying 'Has this been going on for a long time?', ask 'How long has this been going on?'.	Nil	✓		
14. Give the person who is suicidal the opportunity to do most of the talking, if they are able to. They need the opportunity to talk about their feelings and may feel relieved for being able to do so.	Minor	✓		
15. To find out whether the person is suicidal, it is usually best to ask directly if rapport has already been built. For example, "Are you having thoughts of suicide?" or "Are you thinking about killing yourself?".	Minor	✓		
16. Ask the question/s without judgment – e.g. "Are you thinking about killing yourself?" rather than "do you really want to kill yourself?" or "you don't want to kill yourself do you?".	Minor	✓		
17. Tell the person that while many people think about suicide, there are alternatives to acting on the thoughts.	Minor	✓		
18. If it is appropriate, explore past experiences or behavior that can indicate risk, including: any previous suicide attempts, whether they know anyone who has died by suicide, whether they have has a recent crisis or loss.	Minor	✓		
19. To try to ascertain level of intent, ask whether the person has a current suicide plan – including how they will do it, when they will do it and any steps already taken. For example: *Have you decided how you would kill yourself? Have you decided when you would do it? Have you taken any steps to secure the things you would need to carry out your plan?*	Minor	✓		
20. Take the appropriate steps to keep the person safe. If the person has access to means, talk to them about having them	Minor	✓		

removed or try to remove them, only if it is safe to do so.				
21. The person initiating the conversations should focus on conducting the conversation in a respectful and caring way, using simple language that the person at risk of suicide can understand. The person initiating the conversation should not avoid the discussion because they don't know the most appropriate terms to use.	Minor	✓		
	Edit required at 1st review	**Accepted at 1st review**	**Edit required at 2nd review**	**Accepted at 2nd review**
22. Where possible people should try to use simple non-colloquial descriptions of suicidal behavior, rather than stigmatizing or outdated language. For example, say "Are you thinking about suicide?" rather than "Are you thinking about committing suicide?" or "Are you thinking about topping yourself?".	Minor	✓		
23. The use of body language can build rapport and validate people's thoughts. Aim to use open gestures and allow appropriate amounts of physical space.	Nil	✓		
24. Never promise to keep suicide a secret. The number one priority is to keep the person at risk safe, this may mean breaking confidentiality.	Nil	✓		
25. Contact emergency services immediately if you decide that the person is at imminent risk.	Nil	✓		
26. Involve the person at risk in identifying persons to invite into the resolving the problem. This may be a professional, a service such as a helpline or people who have supported them in the past (family, friends, elders or clergy).	Minor	✓		
27. Encourage the person at risk to seek professional help.	Nil	✓		
Postvention Principles				
1. The way a suicide death is discussed is important. While most people will not be adversely affected by discussion of a suicide death, people who are vulnerable (including those bereaved and those contemplating suicide) may be adversely impacted if the conversation is not handled sensitively.	Minor	✓		
2. When having conversations about a suicide death, find a balance between ensuring that suicide is not being made secret or something that is shameful and ensuring suicide is not glamorised or presented as a way of dealing with problems.	Minor	✓		
3. Before discussing a suicide death, consider the individual circumstances of people who are part of (or listening to) the conversation – e.g. their age, cognitive ability, their connection to the person, their connection to the community, whether they are currently contemplating suicide etc.	Minor	✓		
4. If you are afraid of talking to someone bereaved by suicide for fear of saying the wrong thing, show concern and explain that you don't know what to say rather than avoiding the person/s.	Minor	✓		
5. When having conversations following a suicide death, where possible conduct the conversations either one-on-one or in a small group so that people's responses to, or interpretation of, the information can be monitored and questions answered.	Minor	✓		
6. Before discussing a suicide death in a public forum (e.g. online), ensure that those directly affected by the death have already been notified.	Major	x	Nil	✓
7. If discussing a suicide death in a public forum (e.g. online), consider the details given and the way the conversation is moderated given that members of the public who may be vulnerable can be impacted by the details given and the way the death is discussed.	Major	x	Nil	✓
8. Public memorials for someone who has died by suicide (whether online or in the community) should be carefully planned and monitored to ensure the messaging does not inadvertently glamorise suicide.	Major	x	Nil	✓
9. Choose an appropriate physical and emotional location for talking to the person/s affected by suicide – e.g. where you and the person/s are going to feel comfortable and safe talking.	Minor	✓		
10. Allow people affected by suicide to choose the person/s they would like to talk to, provided the person is equipped to deal	Minor	✓		

with the discussion – e.g. children may prefer to talk to grandparent rather than parent, a student may prefer to talk to a counselor rather than the teacher.				
11. If the purpose of the conversation is to notify people of a suicide death, have the discussions as soon as possible after the death is confirmed to allow for management of rumors or misinformation and to identify people who may need additional support.	Minor	✓		
	Edit required at 1st review	**Accepted at 1st review**	**Edit required at 2nd review**	**Accepted at 2nd review**
12. Sometimes there will be uncertainty about whether the death was a suicide or not, so avoid making assumptions before a suspected suicide has been discussed by someone close to the person or reliable source.	Minor	✓		
13. If needing to tell a group of people (e.g. in a school, in a workplace) give staff some key talking point they can use to explain what has happened, to ensure a consistent message is given.	Minor	✓		
14. Ensure information about a suicide death and the community/school/workplace response is provided by consistent spokesperson/s with a connection to the community/ school/ workplace.	Minor	✓		
15. Obtain the cooperation of friends and colleagues in not spreading unconfirmed information about the person who has died or explicit details of the death. This includes spreading information through social media.	Minor	✓		
16. People bereaved by suicide will grieve differently and are likely to have intense feelings that may include anger, sadness, fear and guilt. Allow the person to talk freely and openly and listen without judging, offering advice or trying to gloss over their feelings with clichés (e.g. "time heals all wounds").	Minor	✓		
17. If talking to someone bereaved by suicide, be open to talking freely about the person who died.	Minor	✓		
18. The way people are brought up, their gender, age or culture may influence the way they grieve and communicate. The person may be experiencing shock, numbness and disbelief that may make it hard to communicate with them or for them to communicate with you.	Minor	✓		
19. While there is no 'right' or 'wrong' when it comes to talking about suicide, try to avoid judgemental phrases or language which glamorises or sensationalises suicide, particularly in group or public conversations.	Minor	✓		
20. Use language that reduces rather than increases panic in the community/ school/ workplace when talking about a suicide death or deaths.	Minor	✓		
21. Ensure that the information you provide and the language you use is culturally appropriate.	Nil	✓		
22. Use simple language when talking about suicide with a child and avoid ways of explaining the death which can confuse the child or be taken literally (e.g. *'he's gone to sleep.')*	Minor	✓		
23. When talking to children, ensure you do not glorify the act of suicide as a way of dealing with problems, but also be careful not to talk in a negative way about the person who has died.	Minor	✓		
24. Avoid offering simplistic explanations for why a suicide death occurred. Conversations about suicide should try to outline the complexity of the issue and be framed in relation to the things that may increase someone's vulnerability (risk factors) and the things that may reduce someone's vulnerability (protective factors).	Minor	✓		
25. Talking in graphic detail about the method of suicide can create images that are upsetting and can increase the risk of imitative behavior by people who are at risk of suicide. Conversations that include details about the method or location of a suicide death should be carefully planned (especially in a group or as part of public conversations).	Minor	✓		
26. Ensure any cultural considerations regarding talking about death or a person who has died by suicide are understood and applied	Nil	✓		
27. If a community forum is deemed appropriate, organise it in collaboration with relevant services, community leaders and stakeholders and in consultation with services that have specific expertise in postvention responses.	Minor	✓		

28. Ensure community forums avoid focussing on the specific suicide event. They should be planned to focus on understanding bereavement, promoting support and care for those affected and encouraging help-seeking.	Minor	✓		
29. Community forums occurring soon after a suicide death should consider the audience and their needs to ensure that any prevention messages presented (e.g. we can prevent suicide if we know the warning signs) do not increase feelings of guilt and distress in those directly affected.	Major	x	Nil	✓
30. Encourage those affected by suicide to seek support from people close to them, bereavement support services or health professionals. In group discussions, the presenter should clearly address avenues for obtaining support.	Minor	✓		
31. Refer people affected by suicide to accurate and helpful information and resources.	Minor	✓		

CONVERSATIONS MATTER

resources for discussing suicide

hunter institute of mental health

NSW GOVERNMENT Health

Mental Health Commission of New South Wales