Support for Families, Whānau and Significant Others after a Suicide Attempt

A literature review and synthesis of evidence

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Such a dangerous thing to love what death can touch.

Spalding Gray, 1941-2004

CONTENTS

OVERVIEW

This report has been commissioned by the Ministry of Youth Development to review current evidence-based knowledge about support and services for families, whānau and significant others following the non-fatal suicide attempt of a family member, relative or friend. It is a parallel report to a review and synthesis of research and evidence regarding the provision of support to family, whānau and significant others following a suicide death [1]. The information in the present report is intended to provide background and context for the furtherment and development of support services for people who are affected after a suicide attempt. This report contributes to work being undertaken to develop a comprehensive national suicide prevention strategy for people of all ages.

This paper has been commissioned to address "mainstream" generic issues for the general population including all ethnic groups. Companion reports focus upon:

i) Cultural perspectives (including those of Māori, and other ethnic populations) which are relevant to the provision of support for families, whānau and significant others after a suicide attempt [2].

ii) Resource materials produced in New Zealand, and internationally, which provide information and support for families and individuals after the suicide attempt of someone that they know [3].

iii) Existing support and related services, and the needs that stakeholders perceive for such services and resources to be available for those affected after a suicide attempt [4].

This review focuses upon health-related research associated with the provision of family and related support after a suicide attempt. While there are other perspectives and approaches to the provision of support, a health-based perspective is adopted for this report for the following reasons: a. many of those who make suicide attempts have a mental illness at the time of the attempt, may be in mental health care, may suffer physical health consequences after a suicide attempt, and may require hospitalisation after an attempt; b. those who present to an Emergency Department after a suicide attempt should, as a matter of best practice, be assessed by mental health professionals, given a care plan, and followed up, as deemed appropriate, by mental health services and/or General Practitioners [5]; c. the consequences of lack of support, or the burden of care, upon family members and others, may be manifested as physical and emotional stress, and/or physical and mental illnesses; d. the health professionals who provide care to those who attempt suicide, and to their families, may be those who are best able to provide the information and support that alleviates caregiver burden.

Review of the literature and synthesis of evidence

This report provides an overview of the literature about support and services after a suicide attempt focussing on the following key points:

- The epidemiology of suicide attempt behaviour;
- Common characteristics of suicide attempt patients;
- Characteristics of the family environment of people who make suicide attempts;
- The emotional responses of family members to a suicide attempt;
- The needs for support of family, whānau and significant others after a suicide attempt;
- Assessment, treatment and management of people who make suicide attempts;
- Approaches by which support might be offered to family, whānau and significant others after a suicide attempt.

The report attempts to synthesise findings from the review of evidence to develop a tentative model of best practice recommendations about the provision of support to families, whānau and significant others after a suicide attempt.

Themes

The following themes emerged from review of the literature:

- There is little published literature addressing the impact of suicide attempts on families, whānau and significant others, or exploring the needs that families and significant others have for support after suicide attempts. There are no substantive findings about the types of services which might best support such families, and no evidence of efficacy, effectiveness and cost-effectiveness for any programmes designed to support families, whānau and significant others after a suicide attempt. However, there are parallel literatures in two related areas: the needs for support, and services to address these needs, of the families of people with mental illness, and of families who are bereaved by suicide. This report draws upon those literatures.
- Most people who make serious suicide attempts have a mental illness. Professional treatment of this illness is the first line of support for families.

- Within the last two decades there have been significant changes in the delivery of mental health care, and in the treatment of those who make suicide attempts. Care has moved from being institutionally-based to having a community and primary care focus. This trend has placed an increasing demand upon families and significant others for care and support of people who make suicide attempts. A further consequence of this trend is the need for careful consideration of the types of support structures needed to ensure that family, whānau and significant others are able to meet these demands.

- Suicide attempts range in intent and medical severity from the mildly self-injurious to the determinedly lethal. Not all suicide attempts come to medical or family attention. However, most people who make medically serious suicide attempts will present to Emergency Departments. Since the group who present to Emergency Departments provides the most readily identifiable population of those who have made suicide attempts and their families, this report will address, primarily, this population. However, recommendations for this population are generalisable to the wider population of families, whānau and significant others of all those who make suicide attempts, regardless of the medical severity of the attempt.

- There are a series of guidelines for the assessment, treatment and management of those who make suicide attempts and present to Emergency Departments. These guidelines recommend that all who present in this way should receive a suicide risk assessment and a psychiatric assessment, and that a treatment and care plan, and a crisis plan, should be developed for each person before discharge. Guidelines recommend that family and significant others be consulted for information in assessment of the patient, and in developing treatment, care and crisis plans.

- It has been established that a suicide attempt engenders stress and distress in significant others. Having a family member with mental illness also causes stress. The majority of those who make suicide attempts will have a mental illness and/or stressful life circumstances.

- Those who make suicide attempts may have estranged or difficult relationships with family members. They may also have difficult behaviours. While most family members and significant others feel sympathetic towards the person who has attempted suicide, some may feel angry and guilty, and it may be helpful for professionals to acknowledge that such feelings are understandable.

- The families of those who make suicide attempts need information, access to clinical guidance and advice, access to help in crises, access to respite care, and emotional support. For some, counselling, and learning problem-solving or stress management techniques may also be useful.

- Many families report difficulties in communicating with health care professionals. A particular issue relates to information-sharing, privacy and confidentiality, with many families believing that they do not have access to the information they need to provide care and safety for their family member.

- In the present social environment, traditional sources of family and social support are declining. Families of those who attempt suicide may derive some support from sharing their experiences in support groups with others with similar experiences. There is a need to explore other sources of acceptable support for such families, including various forms of support groups, educational programmes, telephone support, online internet support, and emergency access cards for use in crises.

- The needs of families and significant others are multiple and diverse, and will depend, to some extent, on individual strengths. This implies that such families may be supported in a range of different ways and there is need for a range of different types of support services.

- There is strong consensus that all families and significant others are likely to benefit from enhanced knowledge about mental illness, and suicidal behaviour, treatment approaches, management and the health and related services available to families.

- There is need to explore the extent to which individually tailored support programmes may be required for family members, rather than a reliance upon more generic forms of support.

- There is also a need to explore whether there is a need for gender-specific types of support. (Women tend to seek solutions and support from others for problems. Men tend to enact direct, targeted solutions to problems).

- There is a need to explore the extent to which culturally appropriate forms of support are effective and the extent to which more generic forms of support are appropriate, acceptable and effective.

- There is a strong need for research to identify needs for support, to identify culturally appropriate forms of support, and to develop and evaluate, by way of randomized controlled trials or similar designs, the efficacy, effectiveness, and cost-effectiveness of a range of programmes and support services which might potentially meet the needs of families and significant others after a suicide attempt.

- Given the current dearth of research evidence regarding provision of support to families and significant others after a suicide attempt, policy development and service development need to maintain a flexible approach to this issue, incorporating and adjusting recommendations with changing evidence.

Recommendations

Major recommendations suggested by the review include:

1. **Policies which encourage greater linkages between families and existing services**
   There is a need to encourage lines of communication between families and existing services. In particular, there is a need for the development of clear guidelines and policies about the principles of communication relating to privacy, confidentiality and information-sharing between mental health professionals and families of 'at risk' individuals. *It is recommended that, to expedite this process, consideration is given to involving the Royal Australian and New Zealand College of Psychiatrists, the Ministry of Health and the Privacy Commissioner in developing guidelines for the effective communication of mental health information from clinicians to families. These guidelines could include, but should not be limited to, issues related to suicidal behaviours. Such guidelines should be adequately implemented with regular training provided after initial implementation.*

2. **Provision of information**
   There is a need to develop clear and systematic policies regarding the provision of information to families about suicidal behaviour, and how to support and seek help for suicidal people. *It is recommended that the Ministry consider developing information sheets and guidelines for families after suicide attempts with these guidelines paralleling the extensive material on support to families after suicide.*

3. **Support services designed to assist families**
   Recent guidelines recommend that family, whānau and significant others be invited to provide information as part of the suicide risk and psychiatric assessment of the individual who has made a suicide attempt, and, where appropriate, be included in decision-making about treatment and care plans, and crisis plans. There is need to develop policy and practice guidelines to ensure that these recommendations are implemented and embedded as 'best practice' in the field.

   In addition, there is a need to consider ways of developing more formal approaches to providing support from the health care system to families of people who make suicide attempts, including, perhaps, peer support groups, respite care, counselling and family education programmes. *It is recommended that the Ministry undertake a review of existing health and mental health support services to examine which of these could be adapted or extended to provide support to families after a suicide attempt.*

4. **Provision of culturally appropriate support services**
   There is a lack of research evidence about the needs for culturally appropriate support services and the effectiveness of such services. *It is recommended that the Ministry explore the extent to which culturally appropriate support services are needed in order to ensure that various cultural groups and ethnic populations are provided with effective support.*

5. Ongoing evaluation and assessment of needs and policies

There is a lack of research evidence about support services for families, whānau and significant others after a suicide attempt, and no substantive findings in this field. This conclusion implies that there is a need for ongoing assessment of needs in this area, and the development, trial and evaluation of a range of approaches by which support might be offered. In turn, there is a need for policy and service development in this area to include a strong component dedicated to research and evaluation, and to be flexible in incorporating and adjusting recommendations with changing evidence. *It is recommended that, in implementing policy changes, the Ministry, wherever possible, sets up randomised trials or similar designs to evaluate the outcomes of service change on family functioning, family wellbeing and related outcome measures.*

1. BACKGROUND AND CONTEXT

1.1 Background

In the last decade there has been growing concern about the issue of suicide and suicidal behaviour amongst New Zealanders. These concerns have been motivated by evidence suggesting that New Zealand has one of the highest youth suicide rates in the developed world and by parallel evidence suggesting relatively high suicide rates in adult and older adult populations [6]. However, while public concern tends to focus on completed suicide, suicide attempts are far more common.

Suicide attempts vary in the extent of intent to die, and in medical severity, ranging from those which result in no more than minor physical harm to those that are medically serious and require intensive care and treatment. Many suicide attempts do not require hospitalisation, presentation to the Emergency Department, or visits to the General Practitioner, and may never come to attention. For these reasons the extent of suicide attempt behaviour is difficult to assess. However, one measure is provided by the number of attempts that require hospital admission. In New Zealand, in the year 2000, there were 458 suicide deaths, but 12 times as many suicide attempts (N=5060) which required hospital admission during the period 2000/2001. (Suicide attempt data are collected from mid-year to mid-year, while suicide data are recorded for a complete year, from January to December). The direct cost of such attempts, in terms of medical services, is in excess of $5.5 million per annum.

Two lines of evidence suggest that a focus on those who make suicide attempts constitutes a substantial component of a comprehensive approach to reducing and preventing suicidal behaviour. Firstly, many of those who die by suicide have made a previous suicide attempt [7]. Secondly, many of those who make a non-fatal suicide attempt will make subsequent attempts, with a significant fraction of these further attempts resulting in death [8-10]. For example, in a five year study of a series of 302 individuals who made medically serious suicide attempts in the Canterbury region, Beautrais found that 37% made at least one further suicide attempt within five years with 7% (1 in 12) dying within five years of the index admission [10]. In addition, this population was also subject to high rates of subsequent mental disorders, psychiatric hospitalisation and psychosocial problems (including, criminality, imprisonment, unemployment, relationship breakdowns, beneficiary status, and financial problems) [11]. In recognition of this burden of risk, the New Zealand Youth Suicide Prevention Strategy has a mission statement which includes the reduction of *'suicide and suicidal behaviour'* [12]. It is expected that the forthcoming New Zealand All Age Suicide Prevention Strategy will also address both suicide and suicide attempt behaviour.

Suicide attempts that come to the attention of family, whānau and significant others can be a source of considerable fear, anxiety and concern. Families are often especially concerned about the risk of further suicidal behaviour, and their responsibilities in trying to prevent further attempts. For example, in a Swedish study of 84 significant others of suicide attempters, one year after the attempt, a majority of significant others were concerned that the patient would harm themselves again [13].

Within the last two decades, there has been an increasing emphasis on the role of primary and community care for the management of psychiatric illness, including suicidal behaviour [14]. In turn, this trend has placed an increasing demand for care and support upon family, whānau and significant others of those making suicide attempts. A further consequence of this trend is the need for careful consideration of the kind of support structures needed to ensure that family, whānau and significant others are able to address these increasing demands. The primary focus of this report is upon that issue.

The specific issues reviewed in this report are described as follows:
Chapter 1 provides background and context for this report, describes terminology and definitions, discusses the epidemiology of suicide attempt behaviour in New Zealand, and provides estimates of the number of people closely affected by a suicide attempt and likely to benefit from support. These estimates are generated in order to provide a realistic basis for service planning and resource allocation

Chapter 2 describes common characteristics of those who make suicide attempts, focussing on the features of suicidal individuals that are particularly relevant to family history and family functioning, and likely to affect a family's capacity to support someone who has made a suicide attempt. Particular consideration is given to the characteristics of adolescents and young people who make suicide attempts, since this population constitutes the majority of suicide attempters.

Chapter 3 describes typical approaches to assessment, treatment and management of individuals who have made suicide attempts. This information provides a background and context in which to examine the responses of family members to suicide attempts, their needs for support and the ways in which support might best be provided.

Chapter 4 outlines the spectrum of reactions to suicide attempts that may be displayed by family members. These may include guilt, anger, fear, shame, and related emotions. The chapter also examines evidence on the process of adaptation following the suicide attempts. This chapter also reviews the literature regarding the needs that family, whānau and significant others have for support after a suicide attempt.

Chapter 5 describes the range of support services that may be offered to the families of those making suicide attempts. The chapter also highlights some of the specific issues to be considered in developing programmes that support such families. In particular, issues relating to privacy and confidentiality are explored.

Based on the evidence, findings and conclusions reviewed in the previous chapters, Chapter 6 outlines a series of recommendations for "best practice" for providing support to families, whānau and significant others after a suicide attempt.

1.2 Terminology and definitions

Until recently there has been a lack of conceptual clarity about the terms *'attempted suicide'* and *'suicide attempt'*, although they have been widely used. They have tended to be used as omnibus terms to describe a range of suicidal, self-harm and self-injurious behaviours, and behaviours described as *'parasuicidal'*. The common features of the behaviours subsumed under these terms are that people try to harm themselves by self-poisoning, or self-injury, but do not die. However, in a series of other measures these behaviours display considerable diversity. For example, the degree of intent to die amongst those making suicide attempts varies from none to extensive. Moreover, the relationship between intent to die and the medical severity of a suicide attempt is controversial, with some studies suggesting no association between measures of intent and seriousness of the attempt [15 16]. Some suicide attempts are undertaken to get help in times of emotional crisis, while some attempts have elements of both help-seeking and intent to die, and some are undertaken with the sole aim of death. The outcomes of suicide attempts are often difficult for those making such attempts to predict or control, and depend upon intent to die (or not), the degree of planfulness (or impulsivity), the lethality of the method used, whether help was sought or given, and related issues. All of these features conspire to make the notion of *'suicide attempt'* a *'fuzzy'* concept that subsumes a spectrum of behaviours ranging from the mildly self-injurious to the determinedly lethal. This fuzzy concept has variously been described by such labels as *'deliberate self harm'* [17], *'attempted suicide'* [18 19], and *'parasuicide'* [20 21] with each of these descriptions having it's supporters and detractors [17 18]. For the large World Health Organisation/European Study of Parasuicide *'parasuicide'* and *'attempted suicide'* were regarded as equivalent definitions [22]. Further ambiguity in definition arises from the use of the term *'non-fatal deliberate self-harm'* when death was not intended, where the behaviour is designed to be not fatal and any death outcome is accidental [23], and from the terms *'(indirect) life-threatening behaviour'* and *'high risk taking behaviours'*.

Recently, the American Psychiatric Association (APA) published best practice guidelines for the assessment and treatment of suicidal patients [24]. For these guidelines the APA adopted the following definition of suicide attempt: *"self-injurious behaviour with a non-fatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die",* provided by O'Carroll and colleagues [18]. For the purposes of the present report, the definition above, used by the APA, will be adopted, and the terms *'attempted suicide'* and *'suicide attempt'* will be used equivalently.

Parallel to the difficulties in classifying suicide attempts, there are difficulties in describing those individuals closely affected by a suicide attempt. These may be parents, partners, children, siblings, grandparents, whānau and others. For the purpose of this report this group of individuals will be described as *'family, whānau and significant others'*. In addition, we have determined that the population of those closely affected by a suicide attempt comprises all those who define themselves in this way.

1.3 The epidemiology of suicide attempt behaviour

As noted previously, suicide attempts are far more common than completed suicides, and there are at least two ways of estimating the prevalence of suicidal behaviours. First, official hospital statistics provide an estimate of the fraction of the population that is admitted to hospital following suicide attempts. These figures give a lower limit estimate of the overall prevalence of suicide attempts in a community since they omit the substantial fraction of suicide attempts that do not require hospital admission. The alternative approach is through population surveys that seek to ascertain, through questioning, the fraction of people who admit to having ever made suicide attempts. This fraction gives a closer estimate to the true population prevalence but is also likely to be a lower limit estimate owing to the under-reporting of suicidal behaviours. International findings from community surveys are broadly consistent in suggesting that between 1-4% of participants report that they have attempted suicide at some point in their lives [25-27].

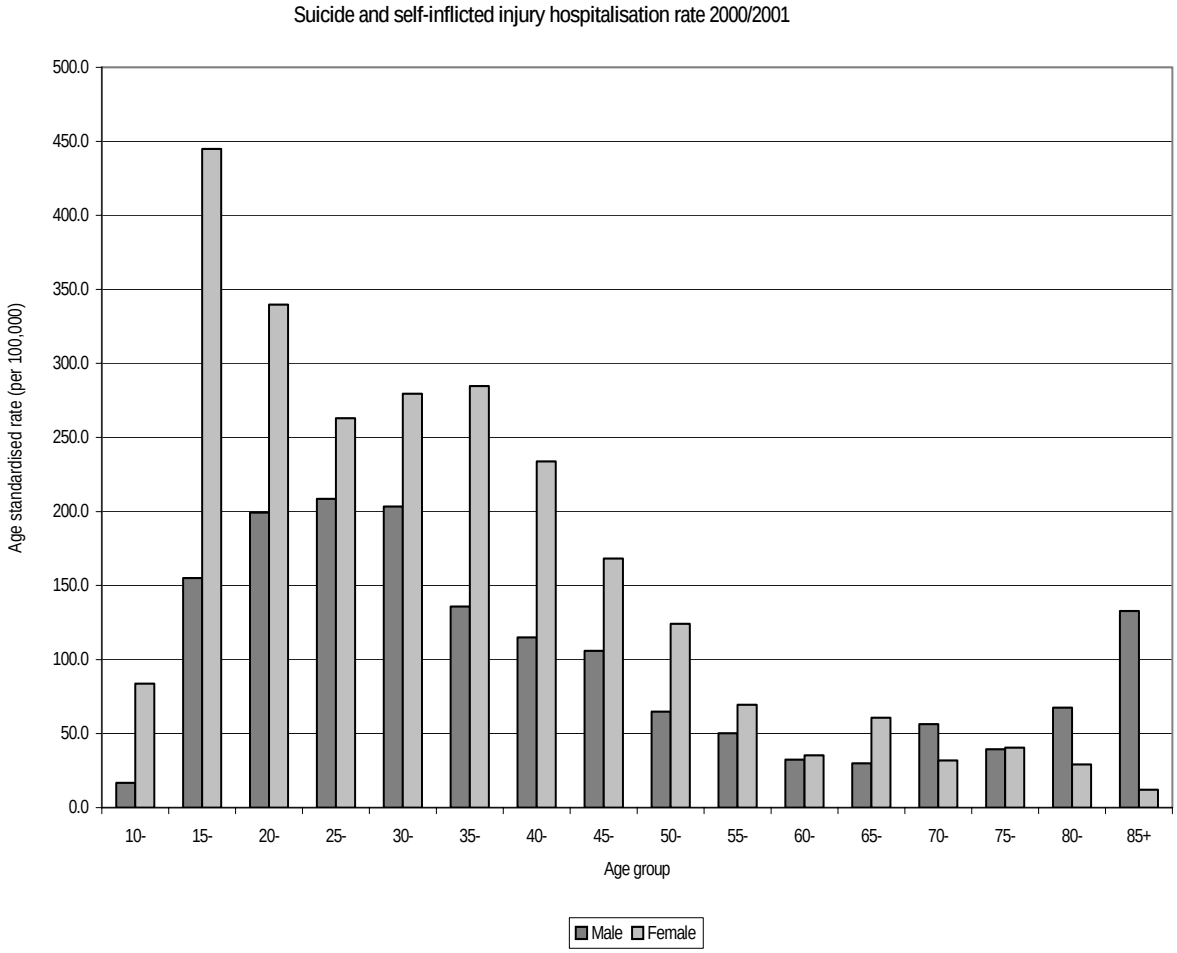
There are only limited New Zealand data on the fraction of New Zealanders making suicide attempts. However, data from the Christchurch and Dunedin cohort studies suggest that by the age of 25 in the region of 8% of young people report ever having made a suicide attempt [28]; Fergusson, unreported data. Furthermore, in a random sample of a study of 1028 adults Beautrais found that 1% reported making a suicide attempt [26]. Collectively these figures suggest that up to 8% of New Zealanders may make a suicide attempt at some time in their lives. Hopefully this issue will be addressed in greater detail in the forthcoming New Zealand Mental Health survey that proposes to examine suicidal behaviours on a population-wide basis (www.moh.govt.nz).

One indication of serious suicide attempt prevalence is provided by hospitalisation data. New Zealand is one of the few countries that routinely collects national admission data for attempted suicide. However, there are a number of caveats that need to be applied to these data. Traditionally, official data for suicide attempt admissions included those cases in which individuals were admitted to hospital as day patients or inpatients. Recently, some district health boards (DBHs) have begun to include, as suicide attempt admissions, those presentations to the Emergency Departments that do not require inpatient or day patient admission. This change precludes time series analysis of national suicide attempt admission data.

Another reason for a cautious approach to time series analysis is that changes in treatment practices over time have led to changes in admission policies and practices. For example, gastric lavage is no longer used as a common approach to suicide attempts by overdose, decreasing the number of overdose attempts requiring admission [29]. In addition, recent changes in the international system used to classify self-harm and suicide attempt behaviour may also contribute to inconsistencies in suicide attempt admission data from year to year. Suicide attempt admission data may include cases of deliberate self-harm in which, however, there was no intent to die. Hospital admission data also include the relatively small fraction of cases in which people are admitted after suicide attempts and subsequently die in hospital. It is also important to note that suicide attempt admission data include all admissions. However, a significant fraction of admissions in any one year are accounted for by people who make repeated suicide attempts. For example, 22% of all admissions for attempted suicide to Christchurch Hospital in 2001 were repeat admissions, and, over a 10-year period, 27% of those who were admitted for an index suicide attempt were re-admitted, at least once, for a further attempt [30]. These caveats notwithstanding, DHB and national suicide attempt admission data provide a useful measure of suicide attempt behaviour, and a potentially useful way of identifying individuals who are at risk of further suicidal behaviour and families who need support after a suicide attempt.

Bearing these caveats in mind, Figure 1 shows rates of admission to hospitals in New Zealand during the 2000/2001 year (mid-year to mid-year) for suicide attempts and episodes of deliberate self-harm, by age group and gender (www.moh.govt.nz). In total, there were 5060 admissions. For the total population, the rate of admission was 129.2 per 100 000. (By comparison the rate of suicide in 2000 was 11.2 per 100 000). Numbers and rates of admission were almost twice as high in females (N=3260 admissions; rate: 167.4 per 100 000) compared to males (1800 admissions; 91.7 per 100 000). Rates of admission were similar for Māori (284 admissions; rate: 93.5 per 100 000) and non-Māori males (1516 admissions; rate: 90.6 per 100 000), but higher for non-Māori females (2801 admissions; rate: 172.9 per 100 000) compared to Māori females (459 admissions; rate: 144 per 100 000). Rates of admission were highest amongst young people aged 15-24 (1496 admissions; rate: 282.4 per 100 000).

Amongst young people aged 15-24, admission rates were higher amongst non-Māori (292.1 per 100 000) than Māori (244.8 per 100 000), and amongst females (1018 admissions; rate: 393.5 per 100 000) than males (478 admissions; rate: 176.3 per 100 000). Non-Māori females had the highest suicide rate of any group (416 per 100 000).



(New Zealand Health Information Service)

1.4 Estimation of the number of people affected by a suicide attempt

Estimates of the number of family, whānau and significant others affected by a suicide attempt appear to be lacking. It has been estimated that, conservatively, approximately six individuals are closely affected by each suicide *death* [31]. If this estimate is applied to the population of suicide attempters, then, again conservatively, there may be a population of up to 30,000 family members, whānau and significant others who, each year, are affected by the suicide attempt of a relative or friend which has required admission to hospital. If the population of concern is extended to include those people who make a suicide attempt and who present to Emergency Departments, and are assessed but not admitted, then there may be a population of up to 60 000 individuals each year closely affected by a suicide attempt of sufficient severity to require either presentation to the Emergency Department or hospital admission [32].

2. CHARACTERISTICS OF SUICIDE ATTEMPTS

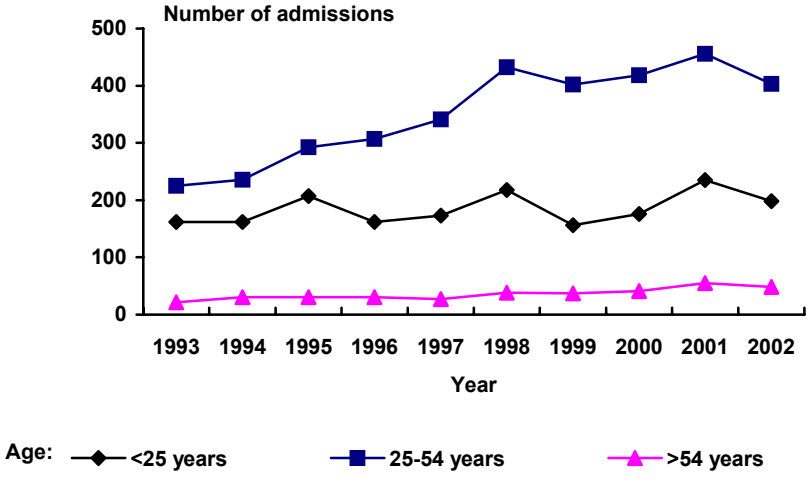
This chapter describes some common features of suicide attempts including methods, age and gender differences. In addition, the chapter provides an overview of the risk and protective factors associated with suicide attempts in young people, adults and older adults. The chapter focuses particularly on those features of suicide attempts that are related to family and whānau functioning. The overall aim of the chapter is to build up a statistical profile of suicide attempters, and of suicide attempts.

2.1 Age and gender features of suicide attempts

In most Western countries rates of attempted suicide are highest amongst young females aged 15-24. Amongst males, rates are also highest in 15-24 year olds but male rates are substantially less than female rates [24 27]. A New Zealand study found that female rates of attempted suicide were consistently almost twice as high as male rates throughout the 15-24 age period, with 1.7% of males and 3.7% of females reporting that they had attempted suicide by age 16; 3.2% of males and 7.1% of females reporting having made an attempt by age 18; 5.5% of males and 9.5% of females by age 21 [33]. Recent New Zealand research suggest that rates of attempted suicide appear to be increasing in adults and older adults (but not in youth) [30].

These trends are illustrated in a recent study of admissions to Christchurch Hospital for 1993 to 2002 for attempted suicide. Figure 2 shows age differences and trends for the population divided into three age groups: youth (<25 years); adult (25-54 years); and older adults (≥55 years). The number of adult admissions for attempted suicide increased significantly during the last decade, with 1.7 times more adult admissions in 2002 than in 1993. The number of older adult admissions also increased significantly, with 2.3 times more admissions in 2002 than in 1993. There was a significant trend for the number of female (but not male) youth admissions to increase over time.

Figure 2. Number of attempted suicide admissions to Christchurch Hospital, by age, 1993-2002



2.2 Methods of suicide attempts

A number of New Zealand studies have examined the range of methods used in non-fatal suicide attempts which present to Emergency Departments or require hospital admission [34-37]. These studies have been conducted in both North Island and South Island centres. Further information is provided by annual surveillance conducted by the New Zealand Health Information Service (NZHIS) (www.nzhis.govt.nz). All data lead to a clear consensus about the mix of methods used for suicide attempts with these methods being dominated by overdose/self-poisoning which accounts for approximately 80% of all suicide attempts requiring hospital admission, with cutting/stabbing being the next most common method. These differences are illustrated in Table 1, which shows data from a ten-year study of all hospital admissions for suicide attempts in the Canterbury region [35]. This study shows that the majority of all attempts (between 87-93% each year) involved overdose/self-poisoning.

A small number of studies, using community surveys, has examined the methods used in all suicide attempts, irrespective of whether these attempts require medical attention or not. These studies suggest that, in contrast to hospital admission data, drug overdoes is less common. For example, in a study of a series of suicide attempts reported by members of the Christchurch Health and Development Study at age 21, 24% involved wrist cutting, 6% involved attempted hanging, with 63% involving drug overdose [38].

Table 1. Proportion of attempted suicide admissions to Christchurch Hospital involving various methods, 1993-2002

	Year									
Method	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Overdose	0.91	0.92	0.93	0.87	0.88	0.90	0.87	0.87	0.89	0.87
Cutting	0.02	0.02	0.03	0.05	0.04	0.04	0.05	0.06	0.04	0.05
Carbon monoxide	0.06	0.04	0.02	0.04	0.04	0.02	0.04	0.03	0.03	0.04
Other	0.01	0.02	0.03	0.04	0.04	0.04	0.04	0.04	0.04	0.04

2.3 Risk and protective factors for suicide attempts

A large and growing international literature has examined risk and protective factors associated with suicide attempts in adolescents and young people aged less than 25 years, and in adults and older adults. These studies have employed both case control and longitudinal research methods to identify factors that may contribute to risk of suicide attempt. In general, there has been good agreement between studies about the risk factors for attempted suicide. These factors include:

Social and demographic factors. Several New Zealand studies have examined linkages between suicide attempts and measures of socioeconomic and educational disadvantage. Rates of suicide attempt behaviour are elevated amongst young people with poor educational qualifications and from families with low socioeconomic status [33 39 40]. Simi1ar trends have been found for adults and older adults [26 41].

Childhood adversity. Numerous studies suggest clear linkages between exposure to childhood adversity and rates of later suicide attempt behaviour in young people [33 42-44] Risk factors span parental separation or divorce, child abuse and neglect, parental psychopathology, familial violence, and impaired parent child relationships. In adults, these early childhood factors appear to be less influential in determining suicide attempt risk [45]. Nevertheless, in older adults with serious suicidal behaviour, factors such as childhood sexual abuse and poor paternal care remained associated with increased risks of suicide attempt [41].

Personality characteristics. Risks of suicide attempt behaviour in young people have been found to be associated with a range of personality characteristics including high levels of neuroticism, hopelessness, risk taking, low self esteem, impulsiveness and aggressivity [38 46-48]. Similar personality traits have been found to be associated with suicide attempt behaviour in adults and older adults [49-51].

Mental health factors. Although social factors, childhood adversity and personality characteristics may act to determine individual susceptibility to suicide attempt behaviour, the major risk factors for suicidal behaviours are mental disorders. Four disorders have consistently been identified as making major contributions to suicide attempt behaviour: mood disorders, substance use disorders, conduct and antisocial disorders, and anxiety disorders. In addition, other disorders, including eating disorders and personality disorders, may also contribute to suicidal behaviours. Many of those making suicide attempts have multiple mental disorders. This strong association between mental disorder and suicide attempt has been found for youth, adult and older adult populations [24 52-54].

Psychosocial stressors. Various forms of psychosocial stress or discrimination may act to precipitate suicide attempt behaviours. These factors may include exposure to adverse life events, losses, conflicts and crises, unemployment, and discrimination due to sexual orientation. In older adults health impairments, declining physical capacity, widowhood, social isolation and feelings of loneliness may also play an influential role in provoking suicide attempts [41 55-60].

Genetic and biologic factors. There has been increasing research interest concerning the role of genetic and biologic factors in the aetiology of suicidal behaviours. This research has been underwritten by the observation that a family history of suicidal behaviour is a strong risk factor for suicide and suicide attempts [61-63]. In addition, twin studies have suggested substantial heritability (up to 45%) of suicidal behaviour [64 65]. More recently, research has focussed upon examining possible genes that may convey vulnerability to suicide attempts [66].

Protective factors. There is growing interest in the exploration of a range of protective factors that may mitigate risks of suicidal behaviours. Despite this interest far less is known about protective factors than is known about risk factors. (The principal reason for this is that identification of protective factors requires a pre-existing understanding of risk factors). Factors that have been suggested as conveying resilience to suicidal behaviours, especially amongst young people, include good self esteem, problem solving skills, social support and social network, a good relationship with at least one individual, positive school experiences and a spiritual faith. [38 67 68].

Amongst adults and older adults, research findings suggest a range of potential protective factors, including a confiding, supportive relationship; social support, social connectedness and interaction including participation in organisations, and having a hobby; good coping and adaptive skills; good physical and mental health; adequate pain relief; good palliative care and treatment of depression for those with terminal illnesses; early, adequate and sustained treatment and management of depression; strong religious and/or spiritual values; adequate support following bereavement; recognition of, and respite from, family discord and conflict, and restricted access to means of suicide, especially guns, for older adult males [58 59 69-73].

2.4 Circumstances of suicide attempts

Most suicide attempts are made when people with some of the life course risk factors described above encounter acutely stressful situations, which engender emotional turmoil or distress. Suicide attempts are made as a way of ending the emotional distress, either permanently, by death, or for respite. Suicide attempts may have a cathartic effect for some, and an individual's mood may improve. However, after a suicide attempt, patients may also feel ashamed and helpless, and fear parental and family rejection. They may also feel isolated, unloved and worthless within their family and whānau. A suicide attempt that requires admission to hospital will almost invariably gain attention for the attempter from family, significant others and professionals. However, while the initial reaction of family members may be sympathetic, they may also be angry and fearful of further such behaviour, and view the attempt as manipulative.

2.5 Repetition of suicide attempts

As noted earlier, suicide attempts are frequently repetitive. The implication of this is that many making such attempts will have both a history of previous suicide attempts, and/or health contacts for episodes of mental disorder [58 74]. For example, in a study of 302 individuals making medically serious suicide attempts, Beautrais found that 24% had made previous suicide attempts, and 71% had a history of previous contact with outpatient psychiatric services [26]. Females are more likely than males to make further suicide attempts, and young people (<25 years) and adults (25-54 years) are more likely to make further

attempts than older adults (>54 years) [35]. These observations suggest that families of those who make suicide attempts may commonly have to address and manage issues relating to repeated suicidal behaviour.

2.6 The longer term consequences of suicide attempts

An issue that is of particular relevance for families and whānau of suicide attempters concerns the extent to which the suicide attempt will be associated with further attempts or related risk issues. Studies of suicide attempt populations suggest that the psychosocial prognosis of these individuals is often poor and is characterised by: death by suicide or accident; further non-fatal suicide attempt behaviour; recurrent psychiatric disorder; recurrent psychosocial adversity and stressors including marital conflict, domestic violence, and criminality [9-11 30 75]. These observations imply that a particular focus of family concerns after a suicide attempt relates to the risk of further such behaviour, and of other adverse, psychosocial outcomes. The high rates of contact that suicide attempters have with health care staff suggest these professionals may be best positioned to offer support, advice and clinical guidance to families.

These individual characteristics of suicidal and suicide attempt patients have implications for the type and provision of family support, family therapy and services which are provided after a suicide attempt. These issues will be discussed in the next chapter.

3. ASSESSMENT, TREATMENT AND MANAGEMENT OF SUICIDE ATTEMPT PATIENTS

This chapter provides a brief outline of the typical approaches to assessment, treatment and management of individuals who have made suicide attempts. This information will provide a background and context in which the responses of family members to suicide attempts, their needs for support and the ways in which support might best be provided can be examined. For the purposes of this report, this discussion will focus on suicide attempts that result in presentations and/or admissions to hospital Emergency Departments, or to General Practitioners. For the sake of brevity and readability, the report will refer to presentations to Emergency Departments, although the principles discussed are generalisable to all types of suicide attempt behaviour, regardless of medical severity.

3.1 Assessment of suicide attempts

Recently, a series of best practice guidelines has been developed, in New Zealand, and overseas, which outline key recommendations for the assessment and management of individuals who have made suicide attempts or who are at risk of suicide [5 24 76 77]. All the guidelines are consistent in making the following key points:

i) Presentation to Emergency Departments

Everyone who makes a suicide attempt or is suicidal and who presents to an Emergency Department should receive a psychiatric evaluation and/or suicide risk assessment. Such assessments should follow recommended, structured outlines and should augment case notes. Relevant staff should receive appropriate training in conducting such assessments. Most people who make suicide attempts or who are at risk of suicide will be accompanied to the Emergency Department by family, whānau or significant others, and the concerns of family and whānau should be considered. Family and whānau can also often provide useful information and input into the assessment. The New Zealand guidelines also note that family and relatives need to be supported by Emergency Department staff.

ii) Psychiatric evaluation

The strongest conclusion that may be drawn from assessment of suicide attempters and those who die by suicide is the association between mental illness and suicidality. Psychological autopsy studies of those who have died by suicide, and of medically serious suicide attempters, find that in excess of 90% have at least one psychiatric disorder at the time of their attempt. Most commonly these disorders are mood disorders and substance use disorders. These findings have been reported for adolescents, young people, adults, and

older adults, and imply that the assessment of those who have attempted suicide or who are suicidal should include efforts to identify and treat any psychiatric illness, including substance use disorder. Accordingly, a psychiatric evaluation conducted after a suicide attempt will include: a current mental state examination; an account of the patient's mental health history including past suicide attempts and the intent associated with each; mental health treatment history; physical illness; present life circumstances, stresses, life events and precipitating factors for the current attempt; questioning about current suicidal ideation, plans and intent; family history of suicidal behaviour and mental illness; and an assessment of the patient's current level of functioning and possible vulnerabilities, strengths and protective factors. While individual risk factors (such as depression, for example) may confer suicide risk, suicide risk increases, almost exponentially, with an increasing number of co-existing risk factors [52]. Detailed descriptions of appropriate psychiatric assessments of patients at risk of suicide are provided by the New Zealand guidelines [5], the APA practice guidelines [24] and, for children and adolescents, by the guidelines of the American Association of Child and Adolescent Psychiatrists (AACAP) [76]

The New Zealand guidelines include the specific recommendation that clinicians should *"adequately consult with whānau, family and friends where possible"* [5, page 19]. Those who make suicide attempts may not always divulge all relevant aspects of their mental health history and treatment, or current circumstances, to Emergency Department or mental health staff, and involved family members can provide information to achieve a more comprehensive assessment.

iii) Suicide risk assessment

In addition to determining psychiatric status, the risk of further suicidal behaviour has to be established, and a treatment and management plan developed which minimises risk of suicide and suicide attempt. Based on evidence from psychological autopsy and clinical studies, the suicide risk assessment takes into account risk and protective factors including: sociodemographic factors (age, gender, marital, ethnic, employment and occupational status, sexual orientation); current mental health status and mental health history (including mood disorders; substance use disorders; anxiety disorders; eating disorders; psychotic disorders including schizophrenia; personality disorders; comorbidity; previous psychiatric illnesses, their course and severity; prior suicide attempts, their intent and lethality); psychological symptoms associated with increased suicide risk (including hopelessness, anxiety and agitation, impulsivity and aggressivity, and command hallucinations); physical illness or disability; current or past psychosocial adversity (including childhood history of sexual or physical abuse); domestic violence; psychosocial factors (including religious or spiritual beliefs; social connectedness, social support; reasons for living; dependent children; personal coping or problem solving skills); extent of current suicidality, including intent, suicide plans, and access to potentially lethal means of suicide [5 24 76 77]. In all of these areas, family members can contribute pertinent information to help clinicians reach a decision regarding suicide risk.

3.2 Treatment and management after suicide attempts

Based on assessment of suicide risk, a range of treatment and management options is available. The aims of treatment are to ensure patient safety, to treat mental illness, and to establish a therapeutic alliance. The New Zealand guidelines for assessment and management of people at risk of suicide recommend that *"by the end of the assessment, there must be a clearly documented survival plan that specifically includes a safety strategy "* [5, page 25]. Treatment options include discharge from the Emergency Department with follow-up as an outpatient, discharge to respite care, or hospitalisation as an inpatient in a psychiatric ward or unit (transferred after medical clearance). These options are discussed in the guidelines, but some specific issues of particular relevance to families, whānau and significant others include:

i) Mental Health Act (1992)

For some individuals, detention under the Mental Health (Compulsory Assessment and Treatment) Act, 1992 may be required. Under Sections 110C, 111 and 119 of this Act police, registered nurses and clinicians in charge of a hospital are able to detain patients until a medical practitioner has assessed them if there are reasonable grounds for believing that the person may be mentally disordered. Suicidality may be considered such grounds, and people who have made suicide attempts may be detained, under the Act, in Emergency Departments, as a last resort to prevent them leaving the hospital before assessment if there is serious concern that the person is mentally disordered and/or at risk of suicide [5].

ii) Hospitalisation

Individuals who are assessed as being at serious risk of harming themselves or others are likely to be hospitalised. Other factors indicating hospitalisation include violent behaviour, severity of psychiatric illness and the treatment required for such illness, and lack of appropriate psychosocial supports to allow someone to be cared for at home. Hospitalisation *per se* is not a treatment, but does provide an opportunity for further assessment, observation, and treatment of someone who is suicidal. There is no evidence that hospitalisation reduces long term suicide risk [78-80] although it is often a family's perception that hospitalisation should provide a guarantee that patients will not be able to make further suicide attempts.

iii) Discharge from the Emergency Department

Individuals for whom hospitalisation is not indicated will be discharged home with a treatment or management plan. Depending on the assessed level of suicide risk, this plan may include: prescription of medication for psychiatric illnesses; increasing the frequency of outpatient appointments and between-visit telephone contacts; assessing suicide risk at each further contact and modifying the treatment plan as necessary; provision of access to 24-hour crisis or emergency support; consultation with colleagues and other practitioners, and

with family and whānau, as necessary; the provision of information to the patient and the family about relevant mental illnesses and treatments, as necessary; the provision of information to the patient and family about issues relating to confidentiality, privacy and information-sharing. [5 24].

3.3 Specific treatments to reduce suicide and suicide attempts

There is relatively little empirical evidence for specific treatments or interventions after a suicide attempt to reduce the risk of further suicidal behaviour. In general, research in this area has been limited by single studies, and by studies with small numbers of highly selected participants. There is a need for randomised controlled studies of therapies and interventions that have shown promising findings, and for replication of single studies which have shown effectiveness [79]. The following interventions have shown some effectiveness or promise of effectiveness:

- Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy (IPT) have both been shown to reduce the likelihood of suicide attempt and of symptoms of depression in patients who had attended Emergency Departments for suicide attempts [79].

- Dialectical Behavioural Therapy (DBT) has been shown to reduce suicidal behaviour among patients with borderline personality disorder while they are in therapy [81].

- Provision of an emergency 'ready access' card suggests a trend to reduced suicidal behaviour amongst patients who have attended an Emergency Department for attempted suicide [82-85].

- Being referred for active follow-up after a suicide attempt has been associated with reduced risk of repeated suicide attempt [86].

In addition, there is some evidence that seeing the same therapist after discharge is associated with higher rates of attendance at outpatient appointments and with higher rates of taking medications [79].

A limited number of psychopharmacological treatments for specific mental illnesses have been shown to reduce suicidality in patients with these illnesses. Specifically:

- Long term maintenance therapy with lithium has been shown to reduce suicide and suicide attempts in patients with recurrent bipolar disorder and major depressive disorder [87-92].

- The antipsychotics clozapine, and perhaps olanzapine, have been shown to reduce suicide and suicide attempts in patients with schizophrenia [93 94].

- Electroconvulsive Therapy (ECT) has been used with selected patients who are acutely suicidal and has been shown to decrease short-term suicidal ideation [95-97]. However, ECT has not been shown to decrease longer term suicide attempt or suicide risk.

Notably, there is no evidence from randomised controlled trials (RCTs) that antidepressant therapy is associated with reductions in suicide or suicide attempts [91 98-100]. Similarly, there is no evidence from RCTs that treatment with mood-stabilising anticonvulsant drugs reduces suicidality in patients with mood disorders [24], and no evidence from RCTs that treatment with antianxiety agents reduces suicide or suicide attempts in patients with depression and anxiety [101].

However, the failure of randomised controlled trials to show significant reductions in suicidal behaviour for antidepressant therapy may reflect the methodological difficulties of research in this area. In particular, the low base rate of suicide imposes severe limitations on research designs, since only extremely large studies might be able to show an effect. While suicidal ideation and suicide attempt are more common and might be used as alternative outcome measures, their relationship to completed suicide is still unclear. Further, many studies have excluded, for ethical, liability and safety reasons, those who are suicidal, or who have made a suicide attempt, thus limiting the extent to which findings may be generalised to the clinical population.

However, controlled trials of antidepressant therapy versus placebo have shown significant reductions in suicidal ideation [102-105]. There is also growing evidence from population based studies to suggest that the recent widespread introduction and use of the class of antidepressants known as selective serotonin re-uptake inhibitors (SSRIs) has resulted in a decrease in suicide rates [106-109]. For example, Olfson and colleagues recently showed that a 1% increase in the use of antidepressants by adolescents was associated with a reduction of 0.23 suicides per 100,000 per year.

In summary, there are now well-established guidelines for assessing individuals who present to Emergency Departments after a suicide attempt or at risk of suicide. Similarly, there are guidelines for developing treatment, care and safety plans for these patients. These guidelines recommend that families, whānau and significant others be included in assessment and in developing treatment, care and crisis plans. There is relatively little evidence for specific treatment or interventions after a suicide attempt to reduce the risk of further suicidal behaviour. Further research is needed for interventions that show promise of effectiveness. The first line of treatment for suicidal behaviour is treatment of specific underlying mental disorders.

4. FAMILY RESPONSES AND NEEDS AFTER A SUICIDE ATTEMPT

This chapter outlines some features of the family environment of those who make suicide attempts, describes some family responses to suicide attempts, and lists the needs that family members may have for support after a suicide attempt.

4.1 Characteristics of the family environment of suicide attempters

As noted above (Chapter 2), extensive research evidence suggests that those who make suicide attempts often come from family backgrounds which are characterised by a range of disadvantageous and dysfunctional characteristics including: parental separation and divorce; parental psychopathology; exposure to family violence; childhood sexual, physical, and emotional abuse and neglect; family socioeconomic disadvantage; receipt of institutional care and welfare services in childhood; poor parent child communication, and related factors.

These features suggest that the families of suicide attempt patients may have tendencies: to be disorganized, unstable, concrete thinking, inflexible and rigid; to have poor problem solving skills; to avoid conflict; to have family secrets; to have poor family communication styles; to have poorly specified, perhaps unclear, roles for family members; to lack defined generational boundaries, and to project inappropriate parental feelings on to children or adolescents [110 111].

It is important to note that the families of suicide attempt patients are not invariably characterised by these features. Nevertheless, it is the case, that, often, such families have some of the elements described above.

4.2 Family responses to suicide attempts

After a suicide attempt, there may be a series of changes in family routines and functioning. These may include: changes in family routines because of the suicide attempter's compromised level of functioning; feelings of anger, frustration and irritability in family members because of the disruption caused to the family; feelings of guilt and blame; feelings of resentment and shame because of the suicide attempt and of the impact for the family; heightened feelings of anxiety and fear about further suicidal behaviour, and perhaps, such behaviour in other family members; and, generally, feeling the need to be extremely cautious and careful in dealing with the person who has made the suicide attempt.

Individuals who have made suicide attempts may also have difficult or estranged relationships with family members. Such difficulties may be of longer-term duration and may have preceded the suicide attempt, may be associated with longstanding mental illness, or may have been associated with recent problems that precipitated the suicide attempt.

It is common for family members to try to help the suicidal person by advocating common sense solutions. However, people who are depressed and suicidal do not find such advice helpful, and this may increase frustration for family members. In addition, the families of, particularly adult and/or repeat suicide attempters, may feel hostile and fearful towards the attempter, and may request the removal of the attempter from the family environment to a place of respite or clinical care.

While there are relatively few studies of families after suicide attempts, the families of those who have died by suicide have more often been studied. The findings from these studies suggest that relatives of people who have died by suicide have a high risk of medical problems, and of health care treatment in the year after a suicide [112], and are, themselves, at increased risk of suicide (for a review see, [1]).

4.3 Family needs after a suicide attempt

A relatively small number of studies has examined the specific needs of families and significant others for support after the suicide attempt of a family member. These studies suggest that a suicide attempt engenders stress within the families and significant others of the attempters [113 114]. Further, it is well recognised that having a family member with a mental illness causes stress [115-117]. The majority of those who make serious suicide attempts will have a mental illness and/or stressful and difficult life circumstances. These factors underline the importance of contact with, and providing support for, significant others after a suicide attempt. Despite the apparent obviousness of these needs, the issue of providing support for family members and significant others after a suicide attempts appears to be almost always obscured by the immediacy and urgency of addressing the treatment needs and further suicide risk of the attempter.

Several specific themes emerge from the limited number of research studies of family needs after a suicide attempt. These needs include:

i) Support and information about coping with suicidal behaviour

Several studies report that families of suicide attempters have strong needs for information and support [118-120]. For example, Wasserman [120] explored the suicidal communication of individuals who had made suicide attempts and their significant others. She found that despite their need for psychological support, most significant others received no support. Further, most significant others had understood the messages and threats of the attempter but had responded with 'near-total silence', suggesting that they felt ill-equipped and/or powerless to react to suicide threats. These findings were echoed by those of a small

qualitative study of the experiences of 15 Norwegian relatives of adult family members who had seriously thought about, or attempted, suicide. The relatives reported feelings consistent with being helpless and powerless about the situation [121]. Kiev [114] explored the attitudes held by the significant others of suicide attempters and concluded that significant others should be helped to be supportive without being controlling.

ii) Involvement in care and management plans

Several studies found that families wanted to be involved in assessment and treatment plans. In a Swedish study significant others interviewed immediately after a patient's suicide attempt were found to add important information to the assessment of the patient [13]. In an extension of this study, telephone interviews were conducted with 84 significant others one year after the suicide attempt. The significant others were parents (44%), partners (27%) and those in other relationships with the attempted (29%). The significant others reported that, one year after the suicide attempt, 63% of the patients had mental health problems and 80% had psychosocial problems (including relationship difficulties, financial problems, unemployment). A majority of significant others feared further suicidal behaviour from the patient. Two thirds of the significant others of those who had been hospitalised after the index suicide attempt, and 90% of the significant others of those who had been treated as outpatients, had not been involved in the care and treatment of the patient after the suicide attempt, although most had wanted this involvement. Many significant others had questions about the suicidal behaviour to which they had not received answers, and almost half reported that they had not talked to the patients about the suicide attempt. One year after the suicide attempt, most significant others were functioning well and reported good wellbeing. However, a small subgroup (< 20%) was performing poorly. This small group tended to be characterized by poor social support, mental health problems of their own, worries related to the attempter, and other problems (for example, financial problems). They wanted better support from health care staff in relation to the suicide attempter.

A Canadian study of 100 families of patients at risk of suicide reported that they received less help than they wanted in terms of how to improve their relationships with the patient, and follow-up for care and treatment plans. However, they reported that they were given more information than they had originally sought regarding diagnosis and managing their own feelings [119].

iii) Counselling for family members

Families have also reported that they want joint counselling with the person who has made the suicide attempt. For example, in a Swedish study, more than half of significant others wanted counselling together with the patient, and one third wanted individual professional support after the suicide attempt [13].

iv) Improved liaison and support from health care providers

A series of studies has examined the perceptions and experiences of the relatives of people who have died by suicide about the contact and care received from the health care system prior to the suicide. Although these reports are made with hindsight and are coloured by the suicide death, they provide pertinent information, given the limited number of studies of relatives of suicide attempters. For example, a Swedish study of 13 relatives of people who died by suicide reported that the relatives felt that their concerns about suicidal behaviour had not been taken seriously by staff, that they were not invited to participate in the care of their relative, that they had received limited information about the patient's medical care and doubted staff competence [122]. Similarly, an Australian study of relatives of people who had died by suicide reported that they did not know how to give help to family members who were suicidal, nor how to secure help for them [123]. Further, they believed that their needs were ignored by healthcare staff at a time when they and the suicidal person were desperate for advice and support. They felt that, in part, their needs for help were ignored and patients at risk of suicide were marginalised by health care staff because those at risk of suicide displayed negative and self-destructive behaviours. The families believed that the lack of information provided by healthcare staff reflected a lack of commitment and concern for suicide attempt patients and their families. These findings are consistent with those of Birtchell [124] who found that the negative attitudes of healthcare staff towards those who made suicide attempts prevented them from establishing a therapeutic alliance with the attempter (and, by implication, with family members and significant others).

v) Support in managing repeated suicide attempt behaviour

A significant proportion of those who make an initial suicide attempt will make further attempts. This repetitive aspect of suicidal behaviour has implications for family members in terms of their needs for support and assistance to manage this behaviour. These needs include: assistance in encouraging the attempters to adopt more constructive ways of expressing distress or solving problems than making suicide attempts or threatening suicide; strategies to enable families to cope with repeated attempts, since families tend to become emotionally exhausted and, sometimes, inured to repeated attempts; approaches to managing long-term family stress engendered by family members with chronic suicidality; ways for families to address the emotional exhaustion, cynicism and dismissal of the suicidal behaviour, and of suicide risk, which may occur when a family member makes repeated suicide attempts or has chronic suicidality.

Taken together, the findings of these studies suggest that the needs of significant others and families of those at risk of suicide and those who have made suicide attempts include:

- information and professional support after a suicide attempt;
- specific information about how to protect and care for their family member, and how to access the health care system for help when necessary, especially in crises;
- joint counseling with suicide attempters, where possible;

- involvement in treatment planning, where possible;
- assistance to address the family impact of repetitive suicidal behaviours, and chronic suicidality.

It is also noted that while most significant others will feel sympathetic towards the person who has made a suicide attempt, in some circumstances, significant others may have strong feelings of guilt and anger. In these cases, significant others may find it easier to offer support to the patient if clinicians first encourage expression of feelings of anger and guilt, and explain that such feelings are understandable.

There are a series of issues that are relevant in considering family capacity to care for members who have made suicide attempts. These issues include:

- Recognition of the fact that the needs of family members and significant others for support will depend upon their personal strengths and resources.
- Within families, responses and interpretations of illnesses and suicide attempts may vary, and this may be a source of stress.
- Most people who make suicide attempts are discharged home to their family's care directly from the Emergency Department, or after a short period of respite care or hospitalisation. Relying upon significant others and families to care for patients without taking into account their ability to provide care and support to the patient can create a potentially unsafe environment for both the suicide attempter and for family members.
- In addition to deinstitutionalisation placing an increased responsibility for patient care on families, families may have fewer sources of support available to them than previously, as traditional forms of social and family support decline.

Given the relatively limited number of studies of significant others and families of those who have died by suicide or made suicide attempts, it is useful to seek collateral information about the needs of families for support from the larger body of studies of the families of patients with chronic or severe mental illness. Such information is relevant given that, as noted above, many of those who make suicide attempts have mental disorders. Recent reviews of caregiving in families with a (severe) mental illness suggest the following conclusions [116 118 125-187]:

- The effects of caregiving on families of those who are mentally ill are commonly described as 'caregiver/family burden'.
- The most significant predictors of caregiver burden are the severity of symptoms (especially, difficult behaviour) and disability.

- Different mental disorders generate similar perceptions of caregiver burden.
- 'Caregiver burden' includes demands on caregiver's personal freedom and impacts on their emotional relationships and physical and emotional health.
- Caregivers report that they encounter many problems in communicating with health care professionals.
- Caregivers initial responses to learning that a family member has a (severe) mental illness include fear, confusion, shock, sadness and guilt. In time, they also often experience anger, frustration, and feelings of helplessness and powerlessness.
- Caregivers feel that they do not receive sufficient practical support from health care professionals when they are trying to care for someone with disturbed and difficult behaviours, often in a crisis situation.
- Caregivers feel that their knowledge about their family member and the contribution they make to caring for them are undervalued by health care professionals.
- Caregivers feel that they would be helped by the availability of adequate respite care facilities, including those appropriate for use in crises.
- Caregivers feel socially isolated and lacking in social support.

These responses suggest that the needs of caregivers of the mentally ill include:

- information about the specific mental illness, it's treatment and management;
- involvement in decision-making, and development of treatment and care plans;
- acknowledgement of their caregiving contribution;
- social support;
- destigmatisation of mental illness;
- community and public understanding of mental illness, and support for their role as caregivers;
- adequate respite care and facilities;
- access to help, including respite care, in times of crisis;
- access to information about their relative;
- clarification of privacy, confidentiality and information-sharing guidelines.

Comparisons may also be drawn with the literature on the needs of families with relatives in intensive care units (ICUs), and specialized treatment units such as burns units. A small fraction of suicide attempt patients require such specialized care after a suicide attempt. A series of studies confirms that the families of patients in these facilities have strong concerns about the patients, and needs for extensive information, and for support. Major sources of support are family and friends, and ward staff [119] [188-190]. These findings underscore the importance of ensuring good communication between staff and family members, and of staff providing reassurance to families.

5. PROVISION OF SUPPORT TO FAMILY, WHĀNAU AND SIGNIFICANT OTHERS AFTER A SUICIDE ATTEMPT

In contrast to the large literature on support for families bereaved by suicide, very little has been published about the needs of families of those making suicide attempts, and there are no substantive findings upon which to base recommendations for family support. For this reason the material presented in this chapter will be based on the extensive literature on providing support to families of people who are mentally ill. There are two reasons for taking this approach. First, research evidence suggests that the majority of those making suicide attempts will have a mental illness. Second, follow-up studies of those who make suicide attempts reveal that mental illness is an ongoing problem for many [11].

5.1 Types of support for families, whānau and significant others after a suicide attempt

There are a series of mechanisms by which support to families and significant others might be provided. These mechanisms include:

5.1.1. Family education and provision of information

Family education programmes

Family education programmes are designed to reduce the stress and burden of families with a relative with mental illness, to improve their coping skills and to enhance family wellbeing. The primary aim of family education programmes is to be educational and supportive for the family [141 147]. (Family education programmes differ from family *psychoeducational* programmes which combine educational and therapeutic strategies aimed at enhancing the family's communication and coping skills with the primary goal of reducing the patient's rate of relapse). Conceptually, the basis of family education programmes lies in health education, rather than family therapy [191].

Family education programmes tend to use a group format, may be led by professionals and may be provided from mental health care settings. Some programmes may be organised by family members themselves. Programmes are usually of short duration, extending over 2-3 months or 10-12 sessions. There have been only limited evaluations of family education programmes for families of those with mental illnesses. However, these findings suggest that families report greater satisfaction with mental health treatment, reduced anxiety, stress and burden, and improved coping skills, with these effects lasting for at least six months [152 161]. There is a need to trial and evaluate this type of educative and supportive programme with the families of those who have made suicide attempts.

Provision of written information, guidelines and resources

Families' and significant others' needs for information extend to written information and resources. Such information may supplement information provided in meetings or support groups, and may be provided: on internet websites (for example, http://www.thesupportnetwork.com/CASP/brochures.html); as resources or handbooks given out after a suicide attempt from health care settings [192]; or as health information handouts available from general practitioner surgeries, citizens advice bureaux, mental health information clearing houses and similar sites. A wide array of such materials has been developed and their review is the subject of a parallel report [3].

Public education programmes to reduce the stigma of mental illnesses

Public education campaigns to reduce the stigma of mental illness may provide support to families of individuals with mental illness, and of those who attempt suicide, by changing public and health care providers' perceptions of, and attitudes towards, mental illnesses and their treatment and management [123 193-196]. This is an area in which further research and evaluation is required to determine the most safe and effective approaches to public awareness about suicide prevention, to improve mental health literacy about mental illnesses and to develop public health messages about suicide prevention and mental illness [197].

5.1.2. Approaches to improve liaison between family, and health care providers

Involving the family in patient assessment procedures

Research evidence suggests that families and significant others can contribute valuable collateral information after a suicide attempt, want to do so, and feel 'heard' and 'acknowledged' by health care professionals when given the opportunity to contribute in this way [13 121 123]. Best practice guidelines acknowledge and support these findings, and recommend that it is important, in assessing suicide attempt patients, to obtain information from involved family members and significant others [5 24 76].

Including the family in developing treatment and care plans

Families of suicide attempters also report that they want to be included in developing treatment and care plans, especially since, in the current primary and community care environment, most of those who make suicide attempts are discharged home soon after the attempt. Families become their *de facto* caregivers and assume responsibility for their care and safety, despite reporting that they feel they lack adequate knowledge, skills and support for this task [13 198]. Although no consistent outcomes have been reported for the families of suicide attempters, there is promising evidence that involving the family in developing care and treatment plans for patients with mental illness reduces family stress and burden [161]. Best practice guidelines for treating people with suicidal behaviour support this approach, and recommend involving family and significant others in developing care and treatment plans, where appropriate [5 24 76].

Providing the family with information about accessing help in crises

Families of those who have made suicide attempts have particular fears about further suicidal behaviour, and want to know how to access help in times of crisis [123 198]. If families are provided with information about how to give help to someone who is suicidal and how to secure professional help, they may feel less helpless and powerless. The general literature about managing suicidal patients supports this view, and best practice guidelines recommend that families and significant others be involved in developing crisis plans [5 24 76].

5.1.3 Support and assistance to the family

Individual consultation with a health care professional

A Swedish study suggests that a significant proportion of families of those who make suicide attempts would like to have professional counselling, preferably shortly after the attempt, in order to understand and better cope with the attempt [13]. However, the effectiveness of providing professional counselling to families after suicide attempts has not been evaluated. This is an issue that needs further investigation, along with the feasibility of providing such counselling within a mental health care delivery system which, in New Zealand, is currently under-staffed and under-resourced [199].

Support groups

Many families of suicide attempters report that they would like to meet with other families that share similar experiences. Support groups provide opportunities for learning from others' experiences and for drawing support and understanding. Such groups may be established by professionals in the field or by families with personal experiences who are interested in meeting others with similar experiences. A professional may lead a group, permanently or initially, to ensure that correct information is made available. Such groups may also be established and offered through treatment facilities such as community mental health centres [200]. An extensive literature about support groups for families of people with mental illness suggests that support groups improve families' knowledge and understanding of illnesses, increase their knowledge of available services and their ability to access these services, improve their coping and problem solving capacities related to their relative's illness and promote personal wellbeing and social support [130 147 152 200-206]. Support groups would appear to offer some promise for meeting some of the needs for knowledge, guidance and support that the families of suicide attempters express. However, the establishment, experiences and potential benefits of support groups with families of suicide attempters remain issues to be investigated.

Online self help support groups

In communities which do not have live support groups (because of geographical isolation or lack of resources) online support groups may be an acceptable substitute for providing support to the families of people who make suicide attempts. These online groups (also known as listserves, forums, bulletin boards, mailgroups and egroups) also allow anonymity, participation at any time, and can provide written information about how to provide support and help to those at risk of suicide. Research evidence suggests that online groups can provide support and information for people with a range of health related problems [207-209]. However, there appears to be little research about online groups that addresses major mental illnesses [210] [211] and further research is required to establish the contribution that online groups might potentially make to supporting, specifically, families of those who have made suicide attempts.

Traditional family therapies

There are a range of therapies which aim to involve families in treatment after a suicide attempt, particularly when children and adolescents have made suicide attempts [212-214]. Furthermore, families of suicide attempters report that they would like counselling with the attempter [13]. The primary objective of various forms of family therapy is therapeutic benefit for the person who has attempted suicide (rather than the support and wellbeing of family members and significant others). However, since individual suicidal behaviour and family functioning are often co-determined, involvement in family therapy may have therapeutic gains both for the person who has attempted suicide, and for their family (see, for example, [214]).

Treatment approaches vary in the extent to which they: involve families in treatment; conduct interviews with family members separately; attempt to address family stresses and problems, and, especially for children and adolescents, attempt to address parental psychopathology, parental conflict, and offer guidance in parenting; use inpatient and/or outpatient treatment; involve families in discussions of risk; and the extent to which professionals treating suicidal patients involve families in therapeutic alliances. These aspects of particular forms of family therapy are beyond the brief of this report. However, it is noted that the extent to which families feel supported after a suicide attempt may reflect the extent to which they are included or involved in these aspects of treatment.

Family psychoeducational programmes

Of particular relevance to providing support to families of suicide attempters is the body of evidence regarding interventions for families of people with mental illnesses. Typically, such interventions offer information to families about the specific illness and treatment, and teach problem solving, communication and management skills to families [152] with the aim of improving patient relapse and compliance. Evaluations of these interventions suggest that they result in improvements in the family's burden of distress and stress, in the family's relationship with the patient, and in family functioning [129]. There is a need to evaluate the contribution that similar types of interventions might make to reducing family stress and distress after a suicide attempt.

Respite Care

One form of direct support often requested by families is respite care. The families of individuals with chronic or severe mental illness make this request [125] as do the families of those who make suicide attempts (Beautrais, unreported data). Families report that they would like respite care to be made available to give them regular breaks from caregiving responsibilities, and also in times of crisis. In particular, families of suicide attempters often feel that respite care immediately after a suicide attempt would provide an opportunity for the family to recover from the stress and distress caused by the attempt, without having to immediately assume responsibility for the care and safety of the person who has just made an attempt.

5.2 Considerations in providing support to families, whānau and significant others after a suicide attempt

There are a number of factors that may influence family involvement or compliance in support programmes. These factors include:

- chronic suicidality and consequent treatment choices facing families (i.e. "least restrictive" or "most safe" environments);
- repeated suicide attempts;
- chronic mental illness;
- patient compliance with medications and/or treatment;
- family fatigue, hostility and guilt following a suicide attempt.

These considerations suggest the need for such factors to be addressed clinically as part of a treatment and care plan that includes family support, consultation and involvement.

5.3 Privacy and confidentiality issues

A major concern of families and significant others of those who make suicide attempts relates to sharing information about the patient, and privacy and confidentiality issues. This issue is a source of significant frustration and stress for families (Beautrais, unreported data). This observation suggests that one way of alleviating family stress would be to clarify professionals' responsibilities in sharing and releasing information to families of adults with mental illness and those who make suicide attempts, and to ensure that families and professionals clearly understand the requirements of confidentiality policies, the types of information that are confidential and the circumstances under which confidentiality can be

waived. A United States study which examined how health care providers and families interpreted and implemented polices relating to the release of patient information suggested that few families understood confidentiality policies, and that neither families nor providers were clear about the types of information that were confidential. Further, providers tended to interpret such confidentiality policies conservatively [215]. The authors suggested that this conservative interpretation may occur because providers find it convenient to use the policy as a barrier to avoid dealing with families, and/or because institutional efforts to simplify the requirements of confidentiality issues may result in a message to staff that is interpreted as a "bottom line message" to "protect patient information". These concerns suggest that a practical way to support families of suicide attempters may be to provide clear, written information to them about confidentiality and privacy policies, and to ensure that institutional staff clearly understand, and consistently implement, such policies.

In summary, in comparison with more straightforward clinical problems, working with suicidal patients and their families often involves complex issues of family dynamics, family psychopathology and risk management. Despite these potential difficulties, the relatively limited literature on working with families of suicide attempt patients suggests that it is beneficial to involve the family in the treatment and management process following a suicide attempt. The family can provide useful information about the patient, and the clinician or therapist can guide the family to respond in appropriate ways, hopefully allaying or reducing the fears and concerns that family members have about further suicidal behaviour. There is a need for further research to examine family needs after a suicide attempt, and to develop and evaluate programmes designed to meet these needs.

6. BEST PRACTICE RECOMMENDATIONS FOR PROVISION OF SUPPORT TO FAMILIES, WHĀNAU AND SIGNIFICANT OTHERS AFTER A SUICIDE ATTEMPT

As noted earlier, the principal difficulty in arriving at a model for best practice in the area of family support after a suicide attempt is the lack of relevant literature in the field. Because of this, all recommendations are based largely on argument by analogy with parallel areas of support for families of people with mental illness and support for families bereaved by suicide. For these reasons any best practice recommendations must be seen as highly tentative and in need of empirical evaluation before widespread implementation. Notwithstanding these caveats the present review suggests that the following lines of policy and service development may be helpful in providing support to families and significant others of those who make suicide attempts:

Policies which encourage greater linkages between families and existing services

Some of the ongoing concerns in the general area of mental health relate to issues of communication between families and health care staff in cases of mental illness and suicidal behaviour. These issues have been further exacerbated by concerns about privacy, confidentiality and information sharing. There is a need for the development of clear guidelines and policies about the principles of communication between mental health professionals and families of 'at risk' individuals, including those making suicide attempts. ***It is recommended that, to expedite this process, consideration is given to involving the Royal Australian and New Zealand College of Psychiatrists, the Ministry of Health and the Privacy Commissioner in developing guidelines for the effective communication of mental health information from clinicians to families. These guidelines could include, but should not be limited to, issues related to suicidal behaviours. Adequate provision should be made to ensure guidelines are well implemented.***

Provision of information

Families of people with mental illness, and of those who make suicide attempts, need information about their relative's illness, treatment and management in order to be able to offer support, ensure safety, and access help in times of crisis. This information can be provided in person by health care staff meeting with families and significant others. Information can also take the form of written material about suicide attempt behaviour, warning signs of suicide, typical family responses after a suicide attempt, and information about how to support and seek help for someone who is suicidal. Given the strong linkages between depression and suicidal behaviour, it is also appropriate to make available similar information about depression.

Finally, families need to be provided with clear information about sources of help and assistance in times of crisis. Potential sites for making such information available include hospital emergency and acute psychiatry departments, community mental health centres, general practitioner surgeries, citizen's advice bureaux, public libraries, and Internet websites. There is a need to develop clear and systematic policies regarding the provision of information to families, including identification of sites and service providers best able to provide such information. ***It is recommended that the Ministry consider developing information sheets and guidelines for families after suicide attempts with these guidelines paralleling the extensive material for families after suicide.***

Support services designed to assist families

The changes in treatment and management of suicidal behaviour and mental health in the last two decades, which have placed an increasing emphasis on community and primary care, have imposed an increased burden of care on families and significant others. Families are now more often acknowledged as partners in providing care, and recent guidelines recommend that family and significant others be invited to provide information as part of the suicide risk and psychiatric assessment of the individual who has made a suicide attempt, and, where appropriate, be included in decision-making about treatment and care plans, and crisis plans. There is need to develop policy and practice guidelines to ensure that these recommendations are implemented, and embedded, as 'best practice' in the field.

In addition to being included in developing care plans, families have additional needs for support which may be met, in part, by providing: personal or on-line peer support groups; respite care facilities; education programmes which include teaching problem solving, communication, help-seeking and related skills; and opportunities to discuss concerns with, and seek advice from, health care professionals. There is a need to consider ways of developing more formal approaches to providing these types of support from the health care system to families of people who make suicide attempts. ***It is recommended that the Ministry undertake a review of existing health and mental health support services to examine which of these could be adapted, or extended, to provide support to families after a suicide attempt.***

Ongoing evaluation and assessment of needs and policies

As noted above, there is a lack of research evidence about support services for families and significant others after a suicide attempt, and no substantive findings in this field. This implies that there is a need for ongoing assessment of needs in this area, and the development, trial and evaluation of a range of approaches by which support might be offered. In particular, the needs of various subgroups require exploration. It is likely, for example, that parents, peers, siblings and partners may have different needs for support. In turn, there is a need for policy and service development in this area to include a strong

component dedicated to research and evaluation, and to be flexible in incorporating and adjusting recommendations with changing evidence. ***It is recommended that, in implementing policy changes, the Ministry, wherever possible, sets up randomised trials or similar designs to evaluate the outcomes of service change on family functioning, well-being and related outcome measures.***

In conclusion, the circumstances and consequences of a suicide attempt closely affect family, whānau and significant others. Treating and managing those who have made suicide attempts should include, as a matter of policy, the provision of support, information and guidance for family members, not only to improve the prognosis and outcome for the person who has made the suicide attempt, but also to alleviate family stress and distress in its own right.

APPENDIX I. SEARCH STRATEGY

The materials used in this review were obtained from a number of sources. These sources included:

i) Searches of computerised databases including:

Clinahl
Clinpsych
Current contents
Embase
Medline
Psychinfo
The Cochrane Library

Search terms included:
"adolescents "
"attempted suicide "
"bereaved by suicide support (group)"
"burden"
"carers"
"caregiver"
"caregiver burden"
"chronic mental illness"
"counselling"
"crisis support"
"critical incident debriefing"
"critical incident response"
"debriefing"
"family burden"
"family education "
"family psychoeducation "
"family support"
"first responder"
"intervention"
"mental illness"
"parasuicide"
"post traumatic stress disorder"
"postvention"
"psychiatric illness"
"psychoeducation"
"teenage (d) (ers)"
"severe mental illness"
"significant others"
"suicide attempt"
"suicidal ideation"
"suicidal behaviour "

"support network"
"support"
"survivors"
"well-being"
"volunteer counselling"

ii) Searches of websites and specific journals including those of:

American Association of Suicidology.
American Foundation for Suicide Prevention.
Befrienders.
CDC (Centres for Disease Control).
CRISIS journal.
CRUSE.
International Association for Suicide Prevention.
National Injury Surveillance Unit.
OMEGA (Journal of Death and Dying).
SIEC (Suicide Information and Education Centre).
The Samaritans.
World Health Organisation.

iii) The author's personal collection of books, reviews, journal articles, collections of conference abstracts and related materials.

iv) Searches of reference lists of publications described in (ii) and (iii) above.

The review attempted to apply broad inclusion criteria for the large number of publications and materials identified during the search procedure. In the case of New Zealand literature, these broad inclusion criteria were relaxed further to allow a comprehensive discussion of New Zealand studies. Regrettably, however, the literature search revealed no studies.

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