Developing a community plan for preventing and responding to suicide clusters

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A ‘suicide cluster’ is ‘... a group of suicides or acts of deliberate self-harm (or both) that occur closer together in time and space than would normally be expected in a given community’ (Centers for Disease Control and Prevention, 1988; O’Carroll, 1988)
Sources of evidence

• Descriptive studies which describe members of cluster and attempt to map relationships between them
• Studies employing statistical techniques to detect clustering (e.g., Scan statistic, Knox statistic)
• Community perceptions also important
e.g., Johansson et al (2006)

**CLUSTER 1: Three teenagers who suicided within an 11 month period**

1. 17 year old boy
   - Hanging
   - T1
   - Lived and worked close to 1
   - Parents attended same church as 1

2. 17 year old girl
   - Hanging
   - T1 + 8 months

3. 14 year old girl
   - Hanging
   - T1 + 11 months

**CLUSTER 2: Three teenagers who suicided within a 17 month period**

1. 17 year old boy
   - Jumping from tower
   - T1
   - Lived on same block as 1 and knew him

2. 17 year old boy
   - Jumping from tower
   - T1 + 14 months
   - Lived on same block as 2, knew him and identified him by name in suicide note

3. 16 year old girl
   - Hanging
   - T1 + 17 months
• Examined 10,176 suicides which occurred across Australia between 2004 and 2008
• Used scan statistics to detect spatio-temporal suicide clusters
• At a national level, identified:
  • 4 clusters using a temporal window of 1 month
  • 12 clusters using a temporal window of 2 months
  • 9 clusters using a temporal window of 3 months
• Key clusters were concentrated in the Northern Territory, northern Western Australia and northern Queensland
Settings and groups at high risk

• Settings at relatively higher risk of suicide clusters include schools, prisons, mental health facilities, Indigenous communities and communities with previous experience of suicide or suicide clusters

• Internationally, it has been estimated that clusters account for 1-5% of all suicides by young people, 6% of suicides in prisons and 10% of suicides by people with mental illness

Sources: Hazell, 1993; McKenzie and Keane, 2007; Haw, 1994; Hanssens and Hanssens, 2007; Gould et al, 1987; McKenzie et al, 2005
Developing a practical resource

• Team comprised Jane Pirkis, Anne Lockley, Shelby Williamson, Jo Robinson, Georgina Cox, Derek Cheung, Laurencia Grant and Richie O’Gorman

• Funded by the Australian Government Department of Health and Ageing to develop a practical resource to assist communities which may be experiencing a cluster

• Resource was to take the form of a practical toolkit and checklist designed to assist communities in dealing with suicide clusters
CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters

OUTLINE

I. A community should review these recommendations and develop its own response before the onset of a suicide cluster.

II. The response to the crisis should involve all concerned sectors of the community and should be coordinated by:
   A. Coordinating Committee, which manages the day-to-day response to the crisis, and
   B. Host Agency, whose responsibilities would include "housing" the plan, monitoring the incidence of suicide, and calling meetings of the Coordinating Committee when necessary.

I. The relevant community resources should be identified.

II. The response plan should be implemented under either of the following two conditions:
   A. When a suicide cluster occurs in the community, or
Stage 1: Conducting reviews of current literature and existing data

Stage 2: Conducting stakeholder consultations

Stage 3: Developing draft resource

Stage 4: Seeking feedback on draft resource

Stage 5: Finalising resource
Stage 1: Literature and data reviews

• Review of academic papers, ‘grey’ literature and media reports to identify existing knowledge re. clusters and their prevention, including examples of clusters and examples of interventions

• Review of existing data to identify previous occurrences of suicide clusters, so that these areas and communities can be followed up in the consultation and feedback stages (Stage 2 and Stage 4)
Stage 2: Stakeholder consultations

- Designed to seek input from suicide prevention experts and organisations/communities which have experienced suicide clusters
- Individuals and organisations/communities identified through reviews of literature and data, our own networks of suicide prevention experts, and additional ‘snowballing’
- Consultation framework developed which focused on both content and application of the resource
- Particular consideration given to organisations/communities at heightened risk of clusters (e.g., Indigenous communities, schools)
Stage 3: Developing draft resource

- Draft developed on basis of information gathered via the reviews and the stakeholder consultations
- Contained complete sections and was formatted, but it was anticipated that content, structure and design might change somewhat, based on the feedback elicited in Stage 4
Stage 4: Seeking feedback on draft

- Written and oral feedback sought to test and ultimately confirm the content, structure and format of the resource
- Particular efforts made to seek input from those who participated in Stage 2 and people from organisations/communities which had experienced clusters
- Designed to test usefulness of resource in assisting relevant groups to develop a community plan
Stage 5: Finalising the resource

• Feedback collated and resource modified accordingly
• Final resource underwent a process of professional editing, design and formatting
3 phases, 8 steps

**Phase 1: Preparedness**
- Step 1: Identify a lead agency to develop and host the Plan
- Step 2: Identify relevant, available contacts and resources
- Step 3: Establish the facts

**Phase 2: Intervention/Postvention**
- Step 4: Provide ongoing accurate information
- Step 5: Identify individuals, groups, and areas of greater risk
- Step 6: Respond to immediate risks and support needs

**Phase 3: Follow-up**
- Step 7: Link to longer term suicide prevention work
- Step 8: Revise & update the Community Plan
Phase 1: Preparedness

Step 1: Identify a lead agency or steering committee to develop and host the plan

This decision should be made on the basis of:

• Organisational mandates and existing responsibilities;
• Existing networks and relationships;
• Cultural considerations and community access; and
• Availability of resources, particularly skilled and knowledgeable staff, and time
Step 2: Identify relevant available contacts and resources

A community plan should include the names and contact details of individuals and organisations that can come together as a cluster response team. Roles in this team might include:

- Co-ordinating the response;
- Collecting and monitoring suicide data and information;
- Providing information;
- Identifying and supporting those at risk; and
- Follow-up, including longer-term risk reduction programs
Phase 2: Intervention/post-vention

Step 3: Establish the facts

A suicide and the possible onset of a cluster may be accompanied by significant rumour and suspicion, including that spread quickly through social media. A member of the cluster response team may need to check with a range of information sources to establish what is happening. Information sources might include, for example, police, hospital emergency departments and community health workers.

It is important for details to be confirmed as soon as possible to enable tailoring of the response, and to ensure any public statements are accurate.
Phase 2: Intervention/post-vention

Step 4: Provide ongoing and accurate information

The community plan should include identification of a designated media contact person to coordinate provision of a single, factual account of the situation and the response. Proactive engagement with the media may help to ensure sensitive media reporting that encourages help-seeking and doesn’t increase the risk of further suicidal acts.
Step 5: Identify individuals, groups and areas of greater risk

Assessing the risk of a cluster forming requires exploration of community, social and environmental domains, as well as individual circumstances.

Mapping and screening processes can be used to identify individuals, groups and areas of potentially elevated suicide risk. Informal processes of observation, and the use of safe spaces for debriefing and providing information should also be considered.
Step 6: Responding to risks and immediate support needs

The community plan will need to identify what services and support can be made available to those affected by the suicidal act(s). The community should identify how to:

- Provide immediate support to the bereaved, both for day-to-day practical needs and to assist them to cope with their grief;
- Provide information, including about suicide risk, how to talk about suicide, and available services;
- Increase access to debriefing and counselling for those affected by, or involved in responding to, the crisis;
- Establish support networks and ensure that people at risk are not left alone at critical times;
- Organise group events to encourage a sense of identity and hope and reduce individuals’ isolation; and
- Reduce access to means of suicide.
Phase 3: Follow-up

Step 7: Link to longer-term suicide prevention work

There is considerable value in linking the crisis response to a longer-term program of suicide risk reduction and community recovery. The anniversaries of suicide deaths can bring to the surface a range of difficult emotions for family and friends. The community plan should consider promoting help-seeking and making additional services available at this time.
Phase 3: Follow-up

Step 8: Revise and update the community plan

The experience of responding to a cluster will provide an opportunity to update and expand the contents of the community plan. Updating the plan may also allow the cluster response team to reflect on and debrief about the experience.

The lead agency or steering committee can also consider establishing and maintaining systems for the ongoing monitoring of suicidal acts, and documenting and sharing the experience of responding to the cluster with others.
Issues

• Strength of the evidence base; diversity of stakeholder views; balancing existing evidence and stakeholder views
• Usefulness and applicability of the resource to different organisations/communities
• Dissemination of the resource
• Ongoing evaluation of the resource
For copies of the resource

Go to ... http://www.livingisforeveryone.com.au/Library-item.html?id=1448

Or go to ... http://www.livingisforeveryone.com.au ... and search for ‘suicide clusters’

Or email me at ... j.pirkis@unimelb.edu.au