Guidelines for best practice psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts

The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

THE UNIVERSITY OF WESTERN AUSTRALIA | Poche Centre for Indigenous Health

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Contents

Foreword

Suicide is a critical issue for Aboriginal and Torres Strait Islander peoples and communities. The Australian government and Indigenous leaders are now accepting that the legacy of colonisation, across different levels, is responsible for Aboriginal communities' disproportionate experiences of suicide and other disadvantages. Colonisation impacts all levels of society, from structural barriers to family support networks, and is made up of complex and interrelated factors. Any proposed solutions or measurements attempting to address the issues of suicide and self-harm for Aboriginal peoples must consider these historical and contemporary complexities.

Therefore, I am pleased to support these important guidelines, which, when implemented in health care settings, have the capacity to create meaningful and empowering change. The ongoing history of colonisation in Australia has undermined relationships between Aboriginal and Torres Strait Islander people and communities and public services, including hospitals. It is crucial that this trust be strengthened in order to establish effective intervention and postvention strategies regarding suicide and self-harm within Aboriginal communities. The following guidelines support non-Indigenous practitioners to increase their cultural responsiveness and to meet their responsibility to build genuine and respectful relationships with Aboriginal people and communities.

These guidelines are important for all practitioners, and particularly non-Indigenous practitioners, to better understand their capacity to engage more responsibly with Aboriginal people. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) found that several critical changes were necessary to shift into a more empowering and effective space within Aboriginal suicide prevention. Ensuring that all relevant mental health staff achieve key performance indicators in cultural competence and delivery of trauma informed care was one of these recommendations.[1]

Increased cultural responsiveness is a timely and necessary step towards ensuring that mainstream services are not harmful, but instead, are relevant and helpful for Aboriginal peoples and communities. As mainstream services become more culturally responsive and safe, they are better able to engage meaningfully with Aboriginal people and work alongside Aboriginal communities to strengthen social and emotional wellbeing and reduce the impacts and instances of suicide and self-harm.

Professor Pat Dudgeon

Project Director, Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

[1] Pat Dudgeon et al., 'SOLUTIONS THAT WORK: WHAT THE EVIDENCE AND OUR PEOPLE TELL US' (Perth: University of Western Australia, 2016).

Background

These guidelines contain recommendations for the effective and appropriate psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts. Development of the guidelines has been informed by a combination of the available practice-based evidence for improving patient outcomes and the expertise of professionals and those with lived experience of self-harm and suicidal thoughts amongst Aboriginal and Torres Strait Islander people.

Hospitals are one of the most common points of contact for professional help following self-harm. However, many people have negative experiences of the hospital care they receive after a suicide attempt.[2] Patient dissatisfaction with the quality of care in hospitals relates to a lack of communication, unsympathetic attitudes of hospital staff, and feeling as though needs were not being attended to. Ultimately, poor experiences of hospital care following self-harm are associated with lower levels of help-seeking behaviour and engagement in recommended treatments.

This may be even more likely for Aboriginal and Torres Strait Islander people for whom clinical mental health care is often experienced as inappropriate and unhelpful because it neglects important considerations essential for social and emotional wellbeing (SEWB).[3] Addressing the specific needs of Aboriginal and Torres Strait Islander people is vital to improving the quality of care provided during hospital visits involving self-harm and suicidal thoughts.

Maintenance of high-quality clinical assessment is central to addressing adverse experiences of hospital care following self-harm.[4] In particular, comprehensive psychosocial assessments are recommended for all people presenting to hospital following self-harm and suicidal thoughts. These assessments are used by mental health professionals to gather information about the risks, needs, and strengths of an individual to determine the most effective and appropriate care and treatment for underlying mental health concerns. When conducted properly, these assessments can promote hope[5] and improve outcomes for people presenting with self-harm and suicidal thoughts.[6]

Whilst evidence-based clinical guidelines exist for managing self-harm in hospital settings and other guidelines have been developed for engaging Aboriginal and Torres Strait Islander people in mental health services in general, there remains a gap in evidence concerning how the two might best be combined. These guidelines aim to meet the need for quality guidance for assessing self-harm and suicidal thoughts by Aboriginal and Torres Strait Islander people in hospital settings.

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[2] Fiona L. Shand et al., 'Experience of Health Care Services After a Suicide Attempt: Results from an Online Survey', *Suicide and Life-Threatening Behavior* 48, no. 6 (1 December 2018): 779–87, https://doi.org/10/gcskqn.

[3] Pat Dudgeon, Helen Milroy, and Roz Walker, eds., *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, 2nd ed. (Canberra: Telethon Institute of Child Health/Kulunga Research Network, 2014).

[4] Cheryl Hunter et al., 'Service User Perspectives on Psychosocial Assessment Following Self-Harm and Its Impact on Further Help-Seeking: A Qualitative Study', *Journal of Affective Disorders* 145, no. 3 (5 March 2013): 315–23, https://doi.org/10.1016/j.jad.2012.08.009; Tatiana L. Taylor et al., 'Attitudes towards Clinical Services among People Who Self-Harm: Systematic Review', *The British Journal of Psychiatry* 194, no. 2 (February 2009): 104–10, https://doi.org/10/c7rgxw.

[5] Taylor et al., 'Attitudes towards Clinical Services among People Who Self-Harm'.

[6] Robert Carroll et al., 'Psychosocial Assessment of Self-Harm Patients and Risk of Repeat Presentation: An Instrumental Variable Analysis Using Time of Hospital Presentation.', *Plos One* 11, no. 2 (26 February 2016): e0149713–e0149713, https://doi.org/10.1371/journal.pone.0149713.

Developing the guidelines

The guidelines were developed using an approach called the 'Delphi expert consensus' method, a technique widely used in mental health research[7] to systematically establish recommendations for practice based on expert opinion. The Delphi process involves administering a series of questionnaires to a panel of experts who must rank items in terms of their importance to the stated aims of the research. Items that reach a high level of endorsement within the expert panel are retained as recommendations. Remaining items may either be re-rated if endorsement within the panel is close to consensus or rejected if only low levels of endorsement are reached. This process of seeking consensus occurs multiple times until all items have been endorsed or rejected, or after a fixed number of iterations.

Items for the initial questionnaire were obtained by systematically reviewing the scientific literature, other research reports, and existing guidelines for statements identifying best practice clinical assessment of Aboriginal and Torres Strait Islander people. With respect to guidelines, the search was limited to those containing recommendations on managing self-harm in a hospital or similar clinical setting. With the exception of the high-quality guidelines produced by the National Institute for Health and Care Excellence (NICE) in the United Kingdom (UK), the international literature and guidelines reviewed were limited to countries with similar postcolonial histories as Australia, such as New Zealand, Canada, and the United States of America (USA). After reviewing the literature, it was determined that the guidelines would focus on comprehensive psychosocial assessment. Not only does this align with existing clinical best-practice for the hospital management of self-harm, but the content of psychosocial assessments provides enough scope and basis for more adequately considering the SEWB of Aboriginal and Torres Strait Islander peoples. A SEWB perspective requires a more holistic view of self-harm and suicidal thoughts as the interplay of distinct individual, social, cultural, and historical influences. Only best-practice statements considered relevant against the requirements of both comprehensive psychosocial assessment and the SEWB of Aboriginal and Torres Strait Islander peoples were retained. Just under 300 best-practice statements were identified through this process as items for the initial questionnaire presented to the expert panel. Several items were also included in subsequent questionnaires based on statements suggested by expert panellists after considering the initial questionnaire.

The expert panel comprised 28 individuals from across Australia with considerable professional and/or personal experience with the mental health and/or prevention of suicide amongst Aboriginal and Torres Strait Islander peoples. Just under half (48%) of the expert panel identified as being of Aboriginal and/or Torres Strait Islander origin. Participants had extensive experience in hospital settings, primary health care services, Aboriginal medical services, community mental health, and community-based suicide prevention programs. Most participants worked as mental health professionals, including Aboriginal mental health/SEWB workers and suicide prevention workers. Other roles occupied by panellists included medical doctors and researchers.

[7] Anthony F Jorm, 'Using the Delphi Expert Consensus Method in Mental Health Research', *Australian & New Zealand Journal of Psychiatry* 49, no. 10 (1 October 2015): 887–97, https://doi.org/10.1177/0004867415600891.

Guidelines for best practice psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts

1 Introduction to the guidelines

1.1 Background

Very little clinical guidance exists for managing self-harm and suicidal thoughts by Aboriginal and Torres Strait Islander peoples in hospital settings. Effective and appropriate clinical assessment is needed to improve the quality of care provided to Aboriginal and Torres Strait Islander peoples.

Comprehensive psychosocial assessments are not only considered an essential component of hospital management of self-harm but can help to ensure that a detailed understanding of the social and emotional wellbeing (SEWB) needs, risks, and strengths of Aboriginal and Torres Strait Islander peoples can become a routine part of clinical decision-making.

Therefore, these guidelines have been developed to recommend what should comprise appropriate, best-practice psychosocial assessment with Aboriginal and Torres Strait Islander peoples presenting to hospital following self-harm and suicidal thoughts and how to ensure that these assessments are both effective and appropriate.

1.2 What are the aims of these guidelines?

The principles and recommendations for clinical best practice contained in these guidelines have the following preventive aims:

- **Develop the cultural competency of hospital staff as a foundation for providing more culturally responsive hospital mental health services.**
- **Recommend practices and strategies that encourage patient and cultural safety**
- **Improve the quality of assessments that informs clinical decision-making.**
- **Promote a person-centred approach to clinical decision-making that is focused on supporting recovery in the community.**
- **Increase patient satisfaction with hospital services.**
- **Encourage future help-seeking behaviours.**

1.3 Who are these guidelines for?

These guidelines are for all clinical staff in hospitals responsible for providing mental health assessments, especially mental health nurses, clinical psychologists, psychiatrists, and Aboriginal mental health workers, where available. Clinicians should apply the recommendations in these guidelines, as needed, to the assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and/or suicidal thoughts. The recommendations provided here may also be applicable to mental health professionals following-up with individuals in outpatient settings after hospitalisation following self-harm and/or suicidal thoughts.

1.4 How should these guidelines be used?

These best practice guidelines are intended to enhance existing practices. They have been designed within existing frameworks for standards of practice and should be used in conjunction with existing clinical practice guidelines and jurisdictional protocols and policies for managing self-harm and suicidal thoughts in hospital settings. To make more effective use of the recommendations within these guidelines, clinicians should be familiar with the following frameworks:

- **National Practice Standards for the Mental Health Workforce, 2013, especially Standard 4: Working with Aboriginal and Torres Strait Islander people, families and communities**
- **Guidelines for the Provision of Psychological Services for, and the Conduct of, Psychological Research with Australian and Torres Strait Islander People of Australia, 2015**
- **Gayaa Dhuwi (Proud Spirit) Declaration, 2015**
- **Dudgeon, Pat, Helen Milroy, and Roz Walker, eds. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. 2nd ed. Canberra: Telethon Institute of Child Health/Kulunga Research Network, 2014, especially Chapter 15 'Principles of Practice in Mental Health Assessment with Aboriginal Australians'.**

The recommendations contained in these guidelines are designed to establish a standard for best practice. They do not represent prescriptive instructions or a single correct approach for all clinical situations. They are designed to increase the sensitivity of clinicians to important social, historical, and cultural influences of the SEWB of Aboriginal and Torres Strait Islander people that are relevant to conducting appropriate and effective psychosocial assessments that can lead to improved quality of care and patient outcomes. These guidelines can, therefore, be used as part of training and professional development with hospital staff responsible for the assessment and care of Aboriginal and Torres Strait Islander people. Wide dissemination of these guidelines will also support their implementation. Further research and review of the guidelines are recommended to ensure they are improving the quality of care and outcomes for Aboriginal and Torres Strait Islander people.

1.5 A word on terminology

A wide variety of terms have been used to describe behaviours and thoughts associated with suicide or self-injury. Whilst the terminology that has been developed is important to classifying clinically important features of these behaviours and thoughts, these guidelines have adopted a simple nomenclature that aims to be easy to read and understand but may not capture many of these important nuances.

Suicide: Self-inflicted death with evidence (explicit or implicit) that the act was intentional.

Self-harm: Wilful self-inflicting of, at times, painful, destructive, or injurious acts in which the person may or may not have intended to take their own life.

Suicide attempt: Self-harm with a non-fatal outcome accompanied by evidence (explicit or implicit) that the person intended to take their own life.

Suicidal thoughts: Thinking about or planning suicide.

Suicide-related behaviours: A label that will be used in this document to refer collectively to self-harm and suicidal thoughts.

2 Principles supporting increased cultural responsiveness

Disparities in health and wellbeing exist between non-Indigenous Australians and Aboriginal and Torres Strait Islander people. One pertinent example is that Aboriginal and Torres Strait Islander people are much more likely than non-Indigenous people to die by suicide. These disturbingly elevated rates of suicide by Aboriginal and Torres Strait Islander people point to historical influences, especially the intergenerational impact of colonisation on present day experiences of grief, loss, trauma, and social and emotional wellbeing. Ongoing cultural blindness, ethnocentrism, and racism perpetuate this gap in mortality and social and emotional well-being outcomes for Aboriginal and Torres Strait Islander people.

Furthermore, some mainstream concepts of mental health do not directly translate into Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing and vice versa. Therefore, principles enabling more culturally responsive psychosocial assessment are needed to ensure that clinicians are more sensitive to the SEWB of Aboriginal and Torres Strait Islander people who are experiencing self-harm and/or suicidal thoughts and behaviours.

2.1 Understanding the importance of SEWB

Aboriginal and Torres Strait Islander people have a relational concept of self, encompassing the individual, together with their family, the wider cultural group, and the land. Furthermore, family and community relationships are central to an individual's social and emotional wellbeing. Therefore, the term social and emotional wellbeing (SEWB) is used here to reflect how Aboriginal and Torres Strait Islander people view and experience their physical and mental health and emotional wellbeing through the lens of social, spiritual and cultural contexts and important relationships, primarily to kin, family and country situated within distinct communities.

Psychosocial assessments should therefore consider how individuals are affected by loss or disintegration of connections to family, culture, and/or land that underpin social and emotional wellbeing and should focus on how recovery is best supported by recognising social and cultural needs of each individual in the context of family, community, and other relationships.

Clinicians need to demonstrate an understanding of a holistic view of suicide and self-harm, that recognises the contributions of life experience (including historical or intergenerational trauma), and self-harm in family and community.

2.2 Respect for the diversity of Aboriginal and Torres Strait Islander people

Expressions of compromised social and emotional wellbeing vary across different groups of Aboriginal and Torres Strait Islander people. Styles of communication and expressions of need are most likely to vary across cultural and/or language communities, regions (such as urban, town, and remote settings), exposure to stolen generations experiences, as well as different kin relationships, age, and gender.

For clinicians to be able to conduct more culturally responsive and effective assessments, it is important that they are familiar with the communities, cultures, and languages of Aboriginal and Torres Strait Islander people in the area/region within which they are working. This is to ensure clinicians consider regional and local variations in behavioural customs when interacting with the person they are treating and culturally distinct beliefs and motivations about self-harm and suicide across groups of Aboriginal and Torres Strait Islander people.

Therefore, clinicians should be informed of the following aspects of the local communities and cultures within which they are working:

- **Local cultural protocols and kinship structures**
- **Culturally sanctioned behaviours and social explanations of mental illness and wellbeing** (e.g. illness can be perceived as a normal reaction to spiritual forces or a curse)
- **Any culturally sanctioned self-harming behaviours** (e.g. sorry cuts)
- **Cultural resources to promote healing and resolution of cultural issues.**

2.3 Sensitivity to shame

The concept of shame is important to many Aboriginal and Torres Strait Islander communities. The experience of shame can be overwhelming, embarrassing, disempowering, and a barrier to further engagement.

Many Aboriginal and Torres Strait Islander people find it difficult to talk about personal information and feelings with a stranger, especially in a one-on-one situation. This is in part due to a sense of shame associated with presentation to hospital and returning to family when discharged. Furthermore, amongst Aboriginal and Torres Strait Islander people there is widespread suspicion and mistrust of public services, such as the hospital. Clinicians should be mindful that Aboriginal and Torres Strait Islander people may sometimes respond in a way to attempt to please the treating clinician (e.g. answering "yes" to close-ended questions). Clinicians should also demonstrate sensitivity to expressions of Aboriginal and Torres Strait Islander-specific diversity in gender and sexual identity, such as Sistergirls and Brotherboys, and any associated needs and concerns about stigma or discrimination.

Clinicians should take care when discussing locally sensitive topics that could trigger shame, such as:

- **Traditional ceremonial practices** (e.g. "sorry business" or initiation in traditionally oriented regions)
- **Discussing the loss of someone close, especially a family member or someone to suicide**
- **The intersection of cultural taboos, stigma, and challenges experienced by LGBTQI+ Aboriginal and Torres Strait Islander peoples and suicidality**
- **Local taboos and conventions for naming dead persons**
- **Sensitivities to gender and age balance between the patient and clinician**
- **Asking about relevant but sensitive issues within wider the social context and networks, such as exposure to self-harm, substance misuse, domestic violence, social exclusion** (e.g. "wrong skin" relationships or not living in home community/country).

2.4 Approaches to care for Aboriginal and Torres Strait Islander people

Clinicians should be following the broad principles of person-centred, recovery focused practice, and trauma informed care appropriate to Aboriginal and Torres Strait Islander people. Core skills of person-centred care such as: empathy, warmth, friendliness; openness and understanding without judgement; a willingness and desire to listen to and help the person; and, sensitivity, acceptance, and respect for everyone's culture in hospital assessment are vital. Clinicians should, always, demonstrate respect for the autonomy of individuals by providing culturally appropriate information about options for care and treatment. Engagement can be facilitated in some instances by demonstrating interest in, or knowledge of, the person's home community/country.

2.5 The role of reflective practice

It is important that all clinicians involved in assessment be aware of their own beliefs, attitudes, and assumptions in relation to self-harm, suicide, and Aboriginal and Torres Strait Islander people. To improve the quality of care for Aboriginal and Torres Strait Islander people, clinicians must be willing to implement changes to their own practice resulting from critical self-reflection about the impact of their own cultural beliefs, attitudes, and values.

3 Effective and appropriate engagement

It is important to build a trusting relationship and establish rapport at the beginning of the interview. The recommendations below highlight important considerations for engaging Aboriginal and Torres Strait Islander people in psychosocial assessment and maintaining this level of trust and care throughout the assessment process.

3.1 Recommendations for initial engagement and involving others in the process of assessment

Upon first meeting the person, clinicians should greet each family and community member present as a sign of respect. Clinicians should, always, demonstrate respect for the autonomy of patients by including patients in decision-making about their care, and ensuring consent has been obtained prior to providing a service. Rights and limits to confidentiality should be explained to the individual. The clinician should also provide the person with an introduction that explains the clinician's role, the process of assessment, and purpose of the interview.

A corroborative history relevant to assessing the person's current SEWB should be sought wherever possible (e.g. from family, kin/community, medical records). It should not be assumed that all Aboriginal and Torres Strait Islander people will want their family involved, and people who can make decisions for themselves should be allowed to. Prior to commencing formal assessment, the person should be asked whether they want their family or others involved. Clinicians should specifically ask the person about any concerns they may have with confidentiality when involving others, such as Aboriginal and Torres Strait Islander clinicians and support staff. Finally, clinicians should seek cultural and further psychiatric advice during the assessment if a patient does not appear to have the capacity to make decisions for themselves in order to identify if further support or assessment is necessary.

The inclusion of Aboriginal and Torres Strait Islander clinicians or support staff (e.g. liaison officers) in the assessment process is ideal, but not necessary, as they are not always available in many contexts. When Aboriginal and Torres Strait Islander clinicians and support staff are available, they should first be consulted to determine if it is appropriate for them to be involved and if any confidentiality issues exist that need to be avoided.

It is also important for the clinician to ask, "what language do you normally speak at home?" in order to learn more about the person's background and to determine if an interpreter is required. Interpreters should be used throughout the assessment if the person does not speak English at home or has a preference to speak in their first language. Any trouble with hearing or history of ear disease that may act as a communication barrier should also be identified.

If possible, the person should be given the choice to have the assessment conducted in a physical location that is more informal but still safe and private, especially if that space reflects Aboriginal and Torres Strait Islander cultures.

3.2 Recommendations for communicating and interacting with Aboriginal and Torres Strait Islander people during the assessment

Assessment across cultures can be challenging for both the person presenting with self-harm and suicidal thoughts and the clinician. The following recommendations are designed to reduce barriers to patient-clinician communication and interaction and enable a more culturally appropriate and effective assessment interview.

Attitude and disposition	Communication strategies
• **Anticipate and respect silences.** This includes observing non-verbal and social cues, tuning in to speech patterns and local idioms, and taking time before responding. • **Show empathy with the person's distress.** Validate the person's thoughts and feelings and acknowledge that these may be hard to talk about. • **Monitor their own body language** to ensure they are not communicating negative or unhelpful attitudes towards the person. • **Avoid assumptions about gender and sexuality to ensure LGBTQI+ patients feel safe and secure** (e.g. by using open-ended questions and inclusive language).	• **Ask the person to describe or "tell the story" of events that led to their self-harm and/or suicidal thoughts.** • **Conduct interviews at a relaxed pace.** • **Engage in conversation including topics that are not directly relevant to the assessment but may help in building rapport.** • **Minimise use of jargon and give explanations using concrete language/examples.** • **Reassure the person that they are trying to help if they seem fearful or distressed** (e.g. "I'm sorry to ask you all these questions, but they will help to sort out what is happening. They are questions we always need to ask."). • **Listen carefully to the person and acknowledge they have been understood.** • **Listen for, and be prepared to hear, thoughts and responses of significant others present at the assessment.**

If the person is clearly uncomfortable, ask if they would prefer to talk to someone else. This can be done by letting them know there may be clinicians available who are closer in age or of the same gender.

To ensure Aboriginal and Torres Strait Islander people remain engaged in the assessment process, there are several things clinicians should avoid. Clinicians should not do the following:

- **Dismiss the person's emotions.** Allow the person to express their feelings (e.g. allow them to cry, express anger, or scream).
- **Express negative or judgemental opinions when discussing self-harm and/or suicidal thoughts** (e.g. "You're not thinking of doing anything stupid, are you?").
- **Dismiss self-harm and suicidal thoughts as 'attention seeking'.**
- **Offer glib, superficial reassurances to the patient or minimise their reasons for wanting to die** (e.g. "Try not to worry about it", "Cheer up!", "You have everything going for you", or "Everything will be alright").

3.3 Recommendations for assessment refusal and self-discharge prior to completion of assessment

Standard protocols should be followed for responding to people presenting with self-harm and suicidal thoughts who may refuse assessment or attempt to prematurely self-discharge. If an Aboriginal and Torres Strait Islander person with diminished capacity and mental health concerns wishes to self-discharge, however, then they should be urgently referred for more formal assessment and measures should be taken to prevent them leaving. It is also recommended that all Aboriginal and Torres Strait Islander people who wish to leave prior to psychosocial assessment, should at least have an assessment of the presence of mental health issues and whether they have somewhere safe to go in the community.

4 Elements of a comprehensive psychosocial assessment

What is presented below is a list of all risks, needs, and strengths that should be considered when assessing Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts. Many of these areas can be assessed using standardised and validated structured assessment tools. Caution should be used, however, when choosing, administering, and interpreting results obtained from such tools. Many structured assessment tools have not been appropriately validated for use with Aboriginal and Torres Strait Islander peoples. The Best Practice SEWB Screening and Assessment Tools resource produced by the Centre for Best Practice Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) should be consulted for its review of important clinical and cultural considerations when choosing assessment tools for use with Aboriginal and Torres Strait Islander people and its list of appropriate existing tools to choose from.

Overall, use of a clinical interview and subsequent judgement of the clinician is recommended as the most appropriate source of assessment of an individual's risks, needs, and strengths. The assessment interview should be conducted in a way that is consistent with recommendations from the previous section. Moreover, it should also cover the Aboriginal and Torres Strait Islander-specific considerations outlined below for evaluating current and longer-term suicidality, relevant medical, psychiatric, and psychosocial history, life stressors, and the ability to recover in the community.

4.1 Recommendations for assessing current and longer-term suicidality

Suicide risk can be influenced by dynamic factors that are episodic or enduring factors that persist over time. It is important that assessments of current and longer-term suicidality distinguish between these influences and how they might be affected by cultural contexts by evaluating the following:

More dynamic influences	More enduring influences
• **The methods and frequency of past self-harm and suicidal thoughts.** • **Impulsiveness and associated risk-taking behaviours related to current episode of self-harm and suicidal thoughts** (e.g. exposure to unnecessary physical risks, preoccupation with risky activities, drug misuse, or engaging in harmful or hazardous drinking). • **Any rage or angry preoccupation with retaliation against others** that may be associated with behaviour leading to self-harm. • **Current levels of intoxication.** • **The presence of suicidal thoughts and their persistence.**	• **The presence of physical injury, its severity, and the potential lethality of the method used.** • **The possibility of intentional self-harm in any unusual 'accident'.** • **The person's subjective awareness of the lethality of their attempt.** • **Signs the person's self-harming behaviour involved an intent to die.** • **Any evidence of warning signs.** This could include covert suicidal ideation, preparatory behaviours, and planned precautions to prevent discovery or interference of the attempt (e.g. making a will, paying debts, hinting – "you will not have to worry about me anymore"). • **The extent to which the patient perceives themselves as a burden on others.** • **Access to any means of self-harm in the home or community.**
Cultural dimensions	
• **Any cultural explanations of perceptual disturbances**. This might commonly include hearing voices or seeing things (e.g. when the voices are of deceased kin who recently suicided). Perceptual disturbances may be considered normal under certain circumstances, but indicative of suicide risk in others. • **Any potential cultural meanings behind and contexts of current self-harming behaviour** (e.g. sorry cuts, mourning/grieving, and loss of status in culture/ community).	

The following are examples of appropriate and direct questions recommended for safely assessing current and long-term suicidality:

- **Have you ever tried to hurt yourself?**
- **Have things been so bad lately that you have thought you would rather not be here?**
- **Have you had thoughts of hurting yourself?**
- **Have you thought about hurting other people?**
- **Are you thinking about killing yourself?**
- **Do you have a plan of what you might do?**

Please note that clinicians should not automatically assume that people are under the influence of drugs or alcohol when presenting with elevated behaviours (e.g. crying, expressing anger, or screaming). It is important to take self-harm and suicidal thoughts seriously even when individuals are under the influence of drugs or alcohol.

If at any time there are any concerns about current suicidality, it is important the patient is not left on their own during the assessment process.

4.2 Recommendations for obtaining a relevant medical and psychiatric history

To obtain a medical and psychiatric history relevant to assessing Aboriginal and Torres Strait Islander people experiencing suicidal behaviours, clinicians should assess the following symptoms and behaviours:

- **Depression,** including the presence of negative feelings like hopelessness, helplessness, loneliness, and feeling trapped
- **Anxiousness,** including feelings of nervousness or worry
- **Psychosis**
- **Recent angry or violent behaviour**
- **Mania**
- **Cognitive functioning**
- **Sleeplessness**
- **Somatic symptoms,** which may often be present, but not be identified by the person or their carer as symptoms of underlying psychological distress
- **Issues of chronic substance abuse and dependence**
- **Medication history and compliance**
- **The presence of any chronic diseases.**

The following are examples of questions for assessing psychiatric history:

Symptom	Examples of what to ask
Depression	• **"Are you feeling sad?"** • **"Do you feel sad inside?"** • **"Do you have no interest in doing things?"**
Anxiety	**"Are you ever worried for no reason?"**
Psychosis	**"Are you..."** • **"hearing voices?"** • **"seeing things?"** • **"having mixed up thoughts?"** • **"worried people have it in for you or are out to get you?"** • **"having silly thoughts?"**
Mania	**"Do you feel like you…"** • **"have too much energy?"** • **"can't slow down?"** • **"are thinking too fast?"**
Cognitive functioning	**"Have you had problems remembering things or finding your way around lately?"**

4.3 Recommendations for obtaining a psychosocial history and assessing life stress

To obtain a psychosocial history of the patient, clinicians should assess the following family-related and other life stressors that may be relevant to current suicidality and future risk of self-harming behaviour:

<table>
<tr><th colspan="2">Family-related stress</th></tr>
<tr><td colspan="2">

Repeated conflict with family members
Worries about family (e.g. those who are sick or in trouble)
Actual or threatened removal of patient's children from his or her care
Removal or separation from family (e.g. Stolen Generations or other history of out-of-home care)
Family break-up (e.g. separation from spouse)
Stress and worry from inability to fulfil family responsibilities
Stress and worry from inability to care for dependent children

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<tr><th>Exposure to destructive behaviours</th><th>Unresolved trauma and grief</th></tr>
<tr><td>

Exposure to self-harming thoughts, threats, and behaviours within family and social networks
Community fights or violence that have affected the person
Experience of violent assault, sexual assault, or rape

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Remembered experiences of childhood neglect or abuse
Anniversary of death or loss of someone close
Recent death or loss among family and social networks
Pre-occupation with suicide death of another person.

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<tr><th>Interpersonal and identity issues</th><th>Stressful life events</th></tr>
<tr><td>

Social withdrawal and/or loneliness (e.g. disengaged from peer involvements and discontinued activities such as sport, work, hunting, fishing, or other social and cultural activities)
Separation from country/community
Conflict and/or perceived threat about sexual identity

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Involvement with police and criminal justice system. Those on probation and parole may be at greater risk
Recent adversity (e.g. loss of employment, cessation of study, eviction from home)
Gambling issues or money worries
Financial stress
Without a permanent fixed address and/or living rough

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In most circumstances, the preferred approach to discussing psychosocial history and life stress is to start with open-ended questions that avoid any judgemental language and do not make any presumptions about the presence of these issues in the life of the person. In instances where psychosocial history and life stress needs to be evaluated more explicitly, the following examples of more direct questions can be used:

Domain of psychosocial risk	Examples of what to ask
History of violence	**"Have you ever..."** • **"hit someone so hard they had to see a doctor or go to hospital?"** • **"used a weapon in a fight?"**
Exposure to destructive behaviours	**"Is there a lot of…"** • **"fighting"** • **"gambling"** • **"drinking"** **"…where you are living?"**
Unresolved trauma and grief	• **"Has someone close to you passed away (recently)?"** • **"Have any bad things happened when you were a child/recently where you had to spend time away from your family?"**
Stressful life events	• **"Have you/your family got enough money each week to buy food?"** • **"Have you been in trouble with the police lately?"**

4.4 Recommendations for strengths-based assessment of ability to recover in the community

To determine the person's ability to recover in the community, clinicians should identify the person's sense of belonging to, and support from, the community and family or kin. Clinicians should identify the presence and importance of the following people in the life of the person:

- **A partner**
- **Family**
- **Children**
- **Peers**
- **Other role models or mentors,** such as elders and leaders who have a strong respected presence in the community
- **At least one person in their life they can turn to when they need help.**

Clinicians should also assess the person's engagement in, and knowledge, of positive health-related behaviours, such as:

- **Meaningful activities that may be related to culture** (e.g. fishing, hunting, art, music, sport)
- **Healthy behaviours** (e.g. good diet, exercise, seeking medical treatment)
- **Positive coping and problem-solving skills.**

Recovery requires the person to have beliefs that they can make positive changes in their life. This is indicated by the person's ability and willingness to:

- **Seek and access help and identify any barriers to accessing services.** Ensure the person has adequate access to continuing care/outreach following assessment and discharge
- **Enter into a therapeutic alliance/partnership, including the person's engagement with other social and health services**
- **Interact socially with others**
- **Look after oneself and engage in daily living skills** (e.g. cooking, shopping, caring for children/elderly, etc).

5 Post-assessment process

5.1 Recommended actions following a psychosocial assessment

Following the psychosocial assessment, clinicians should develop care and/or safety plans within a multidisciplinary team involving Aboriginal Health Workers and/or Cultural Consultants, where available. Care and/or safety plans should be undertaken collaboratively with the person, appropriate significant others. For regional and remote persons and their support groups, clinicians should ensure risk management plans are developed to facilitate healing in community, or on country where there is limited access to services, as well as identify warning signs for early intervention.

Clinicians should also seek the person's consent to inform available carers, family, or friends about the person's condition, treatment options, and needs for follow-up support. This should involve providing the person with full information about the treatment options and make all efforts necessary to ensure there is the opportunity to give meaningful and informed consent before any and each procedure or treatment is initiated.

It is important to ensure that discharge summaries include a comprehensive formulation of the psychosocial assessment, interventions provided, and plans for recovery following discharge, including any referrals for traditional or cultural healing and any social/cultural problem-solving strategies the person is agreeable to.

Clinicians should provide referrals to culturally appropriate mainstream services based on the individual's need for psychological intervention, social care and support, occupational rehabilitation, and treatment for any associated conditions. Ensure that there is a specific point of referral or contact to receive the summary in health services accessed by the patient. Referrals to Aboriginal and Torres Strait Islander-run or culturally appropriate services should be prioritised where available. Relevant traditional or cultural healing should be offered, as needed, in conjunction with mainstream services for treatment and support.

Finally, clinicians should undertake post-assessment reflection with relevant colleagues or supervisors regarding the extent to which they provided a culturally responsive service.

5.2 Recommended formulation of psychosocial assessment

The formulation of psychosocial assessment should include important elements of risk, needs, and strengths to inform further treatment and/or after-care (see table below).

Risks	Needs	Strengths
• **Significant loss or causes of grief** • **Relationship conflicts** • **Perceived threats and adverse experiences** • **Antisocial and other risky behaviours** • **Details of any suicide plan,** such as the means, preparations, lethality, and likelihood of intervention or rescue, planning versus impulsiveness, determination versus ambivalence.	• **Identification of goals** • **Mental health service needs** • **Social support needs** • **Cultural support/inclusion needs**	• **Social/cultural problem-solving strategies the person is agreeable to** • **Individual problem-solving strategies the person is agreeable to** • **Sources of informal help the person has acknowledged as supportive** (e.g. family, friends, kin, Elders, etc) • **Individual coping skills and resources.**

6 Recommendations specific to young Aboriginal and Torres Strait Islander people

Young people (i.e. Aboriginal and Torres Strait Islander children and adolescents up to 24 years of age), presenting to hospital with self-harm and suicidal thoughts, have distinct developmental needs. The recommendations presented in the previous sections are assumed to apply to young people. However, the following section presents additional unique recommendations that should be applied during the conduct of an assessment with young people.

6.1 Recommended strategies for conducting a psychosocial assessment with young people

Young people should be assessed by a person with appropriate expertise in child and adolescent mental health. Clinicians should first determine if the young person has the capacity to give informed consent and can make independent decisions. If possible, it is important to involve the young patient in decision making and provide them with choices about who should be involved in their assessment.

Involvement of non-parent caregivers, such as aunts/uncles and grandparents, is recommended when appropriate and available. It is important, however, to be attentive to how the young person responds to the presence or absence of parents/other caregivers. In cases where a parent's or caregiver's behaviour is hostile or disruptive, it may be helpful for staff to acknowledge that a parent/caregiver is worried about their child, but that their behaviour is interfering with the assessment and treatment of their child. If acceptable to the young person, the examination should be attempted without the parents/caregivers present or with an alternative friend, relative, or peer of appropriate age.

If any young person wishes to be discharged against medical advice, the case should be first discussed with a parent or primary caregiver when appropriate.

6.2 Recommendations for communicating and interacting with young people during the assessment

In addition to recommendations for communicating and interacting with Aboriginal and Torres Strait Islander patients (see 2.2), to enable a more developmentally appropriate assessment interview, clinicians should also do the following:

- **Be friendly, cheerful, easy going, and good humoured when appropriate.**
- **Tell the young person they have done the right thing by talking to someone and seeking help.**
- **Adapt language to suit the age and maturity of the young person.**

If the young person is clearly uncomfortable interacting with the clinician or persistently silent or uncooperative, seek cultural and clinical advice to determine the need to change approach.

To ensure young people remain engaged in the assessment process, there are several things clinicians should avoid in addition to those outlined in 2.2. Clinicians should not do the following:

- **Ask too many questions as it can provoke anxiety and discomfort in the young person.**
- **Use scare tactics or threats when talking to the young person.**
- **Make any promises they cannot keep.**
- **Lecture, criticise, or judge the young person's motivations and circumstances around self-harming actions.**

6.3 Recommendations for assessing risk factors specific to young patients

The following risk factors specific to young people are important to assess when evaluating current and longer-term suicidality (see 3.1), psychiatric and medical factors (see 3.2), psychosocial history, and life stressors (see 3.3).

Family-related stress	Interpersonal issues	Psychiatric issues
• **Parental mental illness and substance abuse** • **Family history of self-harm and suicidal thoughts, and suicide** • **Removal or separation from family** (e.g. current or historical involvement with child protection services, especially out-of-homecare) • **Difficulties in parent–child relationships,** including those related to early attachment problems, perceived low levels of parental caring and communication • **Fighting with family or parents** • **Stressful family life** (e.g. exposure to violence, conflict, or drunkenness at home) • **Parental breakup and separation** • **History of neglect or abuse.**	• **Social withdrawal, combativeness, declining school performance and attendance** • **Lack of engagement in activities with peers** • **Rejection or conflict following the break-up of a romantic relationship** • **Bullying, teasing, jealousy, and other problematic interactions with peers, especially on social media** • **Involvement with police and the juvenile justice system,** especially those recently released on probation or parole who may be at greater risk.	• **Somatic complaints,** as young people more frequently report these as symptoms of emotional distress • **Early psychosis or prodromal symptoms,** especially decline in functioning, irritability, odd behaviour • **Symptoms of depression that may be associated with irritability and not just depressed mood.**

6.4 Recommendations for assessing ability to recover in the community specific to young people

In addition to the considerations outlined in 3.4, to determine the young person's ability to recover in the community, clinicians should also assess the following strengths and supports:

- **The presence and importance of parents**
- **The availability of relevant social, cultural, or educational resources or programs in the young person's community**
- **The young person's need and capacity for inclusion in specific cultural activities** (e.g. funeral ceremonies, rituals, etc).