Suicide First Aid guidelines for immigrants and refugees

**PRE-POOFREADING VERSION (NOT FINAL)**

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**Abstract**

**Objective**: Suicide rates vary across different cultural groups and some immigrant or refugee populations display higher risk for suicide. This study aimed to produce guidelines to help members of the public provide assistance to a person from an immigrant or refugee background who is having suicidal thoughts or displaying suicidal behaviour.

**Method**: The Delphi expert consensus method was used to identify warning signs and first aid actions to include in guidelines. Forty-four professionals and/or advocates with lived experience were asked to rate whether each statement contained in an online questionnaire should be included in the guidelines and to suggest additional statements considered by the respondent to be particularly relevant to a person from an immigrant or refugee background. The Delphi process started with 473 statements and 80 new items were written based on suggestions from panel members.

**Results**: Out of the total 553 statements, 345 were endorsed as appropriate warning signs or helping actions. These statements were used to develop the guidelines.

**Discussion:** The guidelines specific to people from immigrant or refugee backgrounds contain additional items to those included in similar guidelines for English-speaking countries. The guidelines may be used for gatekeeper training for suicide prevention in culturally diverse societies.

## Introduction

Suicide is a serious but preventable public health issue (WHO, 2012). Every year, nearly one million people die by suicide around the world (WHO, 2014). Suicide rates vary between countries and across different cultural groups (Colucci, 2006; Colucci & Lester, 2013; WHO, 2014). As noted in a recently published suicide research agenda (Colucci, Too, & Minas, 2017), suicide research on ethnic minorities is scarce, however existing evidence indicates that, in general, suicide rates in people from immigrant and refugee backgrounds tend to reflect the rates of their home countries (Pavlovic & Marusic, 2001). This has been shown, for example, in studies conducted in Australia (Ide, Kolves, Cassaniti, & De Leo, 2012), Canada (Malenfant, 2004) and Austria (Voracek et al., 2009). Similarities of rates with those of the country of origin were found also among second-generation immigrants (Pavlovic & Marusic, 2001; Voracek et al., 2009). However, research has indicated a greater risk of suicide among second-generation compared to first-generation immigrants (Hjern & Allebeck, 2002; Law, Kõlves, & De Leo, 2014). A recent Europe-specific systematic literature review highlighted that, although there are variations, certain groups of immigrants face consistently higher suicide risks relative to comparable local populations (Spallek et al., 2015).

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Relatively few studies have investigated suicidal behaviours in people from refugee backgrounds, but refugees and asylum-seekers often have several of the risk factors for suicide (De Leo & Ratkowska, 2013). For example, the suicide rate of Bhutanese refugees in the United States was found to be higher than the rate for the American general population, but was similar to the pre-arrival rate of suicide in Bhutanese refugee camps in Nepal (Cochran et al., 2013). Also, in the Netherlands, male asylum seekers have higher suicide risk compared with the Dutch population (Goosen et al., 2011).

This study aimed to develop guidelines for members of the public to recognise suicide warning signs and assist a person from an immigrant or refugee background who is experiencing suicidal thoughts or engaging in suicidal behaviour until appropriate professional help is received or the crisis resolves. This study aligns with previous works by the authors to produce guidelines for English-speaking countries (Ross, Kelly, & Jorm, 2014), Aboriginal and Torres Strait Islander populations (Hart, Jorm, Kanowski, Kelly, & Langlands, 2009) and some Asian countries (Colucci, Kelly, Minas, Jorm, & Chatterjee, 2010; Colucci, Kelly, Minas, Jorm, & Nadera, 2010; Colucci, Kelly, Minas, Jorm, & Suzuki, 2011; De Silva et al., 2016; Hart et al., 2009). These guidelines could be used to develop training of gatekeepers to identify and respond to cross-cultural differences.

**Methods**

This study was based on expert consensus using the Delphi process, a method widely used to develop guidelines (Jorm, 2015; Minas & Jorm, 2010). Ethics approval for the study was obtained from the University of Melbourne Human Research Ethics Committee (Ethics ID number: 1341047.1).

*Participants*

*Forming the expert panel*

Professionals and lived-experience advocates from Australia and other countries were invited to form the expert panel and participate in the study (Figure 1). The responses of both these groups were given equal weight in developing the final guidelines. Professionals who participated in the study were considered to be suicide prevention experts through their clinical and/or research experience. They were recruited by contacting the corresponding authors of relevant international academic publications and through organisations specializing in suicide prevention or in mental health of people from immigrant or refugee backgrounds. Lived-experience advocates were people from an immigrant or refugee background who had thought about suicide or attempted suicide in the past, or people who had someone close to them (e.g. a family member) from an immigrant or refugee background who had attempted suicide or taken their own life. They were invited to participate as a result of their involvement as advocates with the organizations that assisted the investigators to recruit professional members of the panel and their involvement in lived experience/users'/survivors' networks and organizations. Both professional and lived-experience experts were also recruited through mental health conferences and symposia and the networks of Mental Health in Multicultural Australia (MHiMA).

When the invitation letters and Plain Language Statement were sent to professionals and advocates asking them to be involved, they were also invited to nominate other potential panel members.

INSERT HERE FIGURE 1

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*Panel members*

The composition of the panel was not constructed so as to be representative of any particular group. The Delphi method does not require representative sampling; it requires panel members who are information and experience-rich (Jorm, 2015; Jorm, Minas, Langlands, & Kelly, 2008). Panel members were selected on the basis of their individual knowledge, expertise and experience. Nevertheless, in order to increase the cultural appropriateness of the guidelines, when forming the expert panel, we were careful to include professionals and advocate members from diverse cultural groups and geographic regions.

The number of panel members in previous Delphi studies has varied considerably from 15 to 60 (Hasson, Keeney, & McKenna, 2000). The presence of heterogeneous or homogeneous samples influences the decision concerning the required number of participants. For a homogeneous group, 10 to 15 people can be sufficient, whereas a heterogeneous group needs several hundred participants (Skulmoski, Hartman, & Krahn, 2007). De Villiers, De Villiers and Kent (2005) argued that the number of participants can vary according to the purpose of the study, its complexity and resources, but a panel usually consists of 15 to 30 participants from the same discipline, or five to 10 per category from different groupings. De Villiers and colleagues also observed that increasing the group size beyond 30 has seldom been found to improve the results. The participants in this study were professionals with expertise in suicide prevention and lived-experience advocates, and we aimed to have at least 30 members in the panel, with an approximately equal number of professional and advocate experts.

In this study, 52 panel members self-selected to be involved in Round 1 (58% of the experts who were invited to participate). Of these, 44 fully completed the Round 1 survey, 36 the Round 2 and 29 the Round 3. Incomplete surveys were discarded. Among

the 44 panel members, 27 were professionals, 10 were advocates with lived-experience and 7 had both professional and lived-experience (thus their answers were considered as part of the responses of both the professional and advocate groups). The majority of those who had professional experience were psychologists/counsellors (N = 14) and psychiatrists (N = 6). The others were a psychiatric nurse, social worker, mental health advocate, researcher, suicidologist, or trainer. Characteristics of panel members are shown in Table 1.

<div align="center">INSERT HERE TABLE 1</div>

*Materials*

The first round questionnaire was formed using the first aid statements included in the questionnaire that was previously used to develop the guidelines for English-speaking countries (Ross et al., 2014) and the questionnaires used for the guidelines for Asian countries (Colucci, Kelly, Minas, Jorm, & Chatterjee, 2010; Colucci, Kelly, Minas, Jorm, & Nadera, 2010; Colucci et al., 2011). The questionnaire consisted of statements that suggested a potential first aid action (i.e. what the first aider should do or not do) or relevant awareness statements (i.e. what the first aider should know) and were grouped into common themes. The questionnaire also contained a number of warning signs generated from existing literature and items from the questionnaires previously used for the guidelines developed for Asian countries.

This initial questionnaire had 473 items, each describing a warning sign or a potential action that a first aider could do, which could be put to the members of the panel for rating. These items covered the following domains: warning signs, identification of suicide risk, assessing seriousness of suicide risk, initial assistance, talking with a suicidal person, safety plan, ensuring safety, confidentiality, passing time during the

crisis, and what the first aider should know. Actions specific to adolescents or a specific gender were also included. In addition, the questionnaire contained 7 questions on participants' socio-demographics, experience/training, and 23 open-ended questions to generate additional items specific for people from immigrant and refugee backgrounds.

### *Procedure*

The Delphi process consisted of three rounds as per previous suicide guidelines Delphi studies (e.g. Colucci et al., 2010). In Round 1 panel members were asked to complete the first questionnaire through an online survey website (SurveyMonkey.). They were given the option to complete it by email or paper mail, if the former was not possible.

Panel members were informed that the role that can be played by a member of the public providing mental health first aid is different from the role of a clinician. When a person is thought to be suicidal the first aider responds to ensure the safety of the person until the crisis has passed or until the suicidal person receives professional treatment and care. Mental health first aid guidelines need to focus on the immediate prevention of suicide and not on solving the problems that led to the crisis (Meerwijk et al., 2016).

Panel members were asked to rate each statement according to how important they believed it was as a potential first aid action for helping a suicidal person. The response scale was: 1. Essential; 2. Important; 3. Don't know/Depends; 4. Unimportant; 5. Should not be included. The scale was purposefully asymmetric because only items with positive ratings – essential or important - were of interest for the guidelines. This scale has worked well in development of previous guidelines (Kelly, Jorm, Kitchener, & Langlands, 2008).

At the end of each block of items the participants were invited to comment and suggest any additional action that was not included in the questionnaire but, in their opinion, was relevant for people from immigrant and refugee backgrounds (including

cultural, gender, social and religious/spiritual issues). The purpose of inviting such comments and suggestions was to generate culturally-specific material that could be included in the next round questionnaire. The suggestions made by the panel members were reviewed by the research team and, if they represented a new and unambiguous suicide first aid idea, the suggestions were used to construct new items for Round 2.

In Round 1 statements that were rated as "essential" or "important" by 80% or more of the members of both the professional and lived-experience groups of participants; or by 70-79% of one group and 80% or more of the other were included in the guidelines. Statements rated as "essential" or "important" at least by 70% by both groups, but not by 80% or more by either were re-rated in the Round 2 questionnaire. If a statement was rated as "essential" or "important" by less than 70% of the members of either group it was excluded from the guidelines.

The Round 2 questionnaire consisted of the items that were included for re-rating from Round 1 and new items that were generated from the comments and suggestions in Round 1. Participants received an email with an individualised link to the Round 2 survey. They were informed that they could change their responses when re-rating an item if they wished to do so. At the end of this round, any item that reached the 80% consensus criterion in one or both groups, or 70-79% in one group but 80% or more in another group, was selected for inclusion in the guidelines. The new items reaching between 70-79% of consensus by the members of one or both groups (but was not rated 80% or more by the other group) were used to create the Round 3 questionnaire and the rest were rejected.

In Round 3, a final questionnaire with items to be re-rated was sent to panel members, and items were either rejected or accepted based on the criteria indicated above.

All the items that were accepted across the three rounds were then used as the basis for development of the guidelines as in previous studies (e.g. Ross et al., 2014). The

draft guidelines were sent to all panel members and their final feedback was explicitly sought on the structure and readability of the guidelines. They were then reviewed by a professional proofreader who checked readability and modified difficult or complex statements into plain language format so that they could be understood by lay people with English as a second language

## Results

The Delphi process started with 473 statements and 80 new items were written based on suggestions from panel members (see Box 1 for some examples of such items). After three Delphi rounds, 345 items were accepted based on the criteria indicated in Method.

- An important warning sign for suicide is if a person is expressing (in words or actions) feeling of not fitting in, e.g. feeling of being caught between cultures or not fitting in with their peers.

- An important warning sign for suicide is if a person is expressing (in words or actions) their lives have been a failure, they would have been better off in their country of origin.

- If the person appears intoxicated but says they have not used alcohol or others drugs, the first aider should ask if they have consumed any special herbs, teas or other substances in religious or traditional rituals, as some of these can have intoxicating or hallucinogenic effect.

- If the person is not fluent in the first aider spoken languages, the first aider should speak slowly, use simple words and check for understanding.

- The first aider should ask the person if they have any mental health problems, keeping in mind that they may not share the first aider's understanding of what 'mental health' or 'mental illness' means.

- The first aider should find out how acceptable suicide is in the person's culture or religion as in cultures where suicide is more acceptable, the risk of acting on suicidal thoughts is increased.

- If the first aider has to call the police, they should explain the person is from immigrant or refugee background and may have distrust towards police.

- The first aider should ask whether religious, spiritual or cultural supports are important to the person and, if they are, offer to put the person in contact with these supports.

- The first aider should be aware that the means of suicide may not be immediately evident and should directly ask about available means, as these can vary from culture to culture.

- If the person engages in religious, spiritual or traditional practices such as reading religious texts, praying, meditating or chanting, the first aider should encourage them to do this.

- If the person is an adolescent, the first aider should ask if they have a supportive friend from outside of their culture or community who can act as a support as they may feel more comfortable accessing support where it is unlikely to get back to their family.

- The first aider should be aware of the different risk factors for males and females, e.g., the increased chances of abuse and violence among women and males' ideals regarding honor.

*Box 1*

Table 2 shows examples of statements endorsed for inclusion in the guidelines and the Delphi round in which the item was endorsed. A complete list of rated statements, including the percentage of panel members in both groups endorsing each item, is shown in the Supplementary File 1. [Caption for Supplementary File 1: Accepted and rejected items]

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INSERT HERE TABLE 2

To be usefully communicated, these statements were transformed into narrative text to form the Suicide First Aid Guidelines. These were presented in three formats: printer-friendly, infographic and booklet. The printer-friendly version and infographic are provided, respectively, as Supplementary files 2 and 3, and the booklet is freely available on request.

[Caption for Supplementary File 2: Suicide First Aid Guidelines booklet E-version]

[Caption for Supplementary File 3: Suicide First Aid Guidelines Infographic]

**Discussion**

Higher rates of suicide have been reported in some immigrant and refugee groups compared to the general population (Cochran et al., 2013; Colucci & Too, 2014; Ide et al., 2012). More accurate suicide deaths data and further research is necessary to fully understand how cultural and migration-related factors impact on suicidal behaviour and suicide prevention in these populations (De Leo & Ratkowska, 2013; Pavlovic & Marusic, 2001).

Suicide prevention strategies developed with a 'one-size-fits-all' approach are deemed to have limited, if not damaging, effects (Wang & Colucci, 2017) and cultural variability must be integrated in any approach. Although there are a variety of suicide gatekeeper programmes regarded as extremely promising initiatives (Isaac et al., 2009; Mann et al., 2005; WHO, 2014), the applicability of such trainings across populations needs consideration (Isaac et al., 2009). This was also demonstrated by the outcome of a recent study where the endorsement rates were compared across six Delphi studies on suicide first aid guidelines from different countries (Jorm, Ross, & Colucci, 2018). There

were only 18 statements that were highly endorsed across all eight of the Delphi panels and an additional 15 items highly endorsed across the panels from the three lower middle-income countries (India, Philippines and Sri Lanka). Correlations across panels in item endorsement rates were all 0.60 or above. This showed that, while some cross-cultural generalizability is possible, there is also some cultural specificity, indicating the need for local tailoring of suicide prevention tools.

### *Limitations and strengths*

To the best of our knowledge, these are the first guidelines based on the consensus of both professional and lived-experience experts specifically for people from immigrant and refugee backgrounds. One of the strengths of this study was that experts by lived-experience were given an equal voice to experts by profession and some participants shared both kinds of experience. The main limitation was that English-language questionnaires were used because the cost of translating them into the experts' several native languages would have been prohibitive. It is possible that a greater number of lived-experience advocates would have volunteered and, across panels, there would have been more culturally-specific responses if panel members were able to fill in the questionnaire in their native languages.

### *Implications*

The 345 items that formed the basis for the guidelines consist of key warning signs and a number of actions considered to be useful for members of the public who may encounter someone from an immigrant or refugee background who is experiencing suicidal thoughts or engaging in suicidal behaviour. These guidelines, freely available, may be used as

educational tools for suicide prevention among people from immigrant or refugee backgrounds, including the development of culturally-responsive gatekeeper training.

The guidelines have also been used to write the scripts and develop four short interactive theatre plays that could be used to develop a 'train-the-trainers' program to train members of the community and other gatekeepers on the suicide first aid guidelines, as has been done previously with the guidelines for the Philippines (Colucci et al., 2010). The plays developed are about a young unmarried student from an immigrant background who falls pregnant, a group of refugees who are struggling with visas and jobs, a woman from an immigrant background who is a victim of intimate partner violence and an elderly man from an immigrant background who feels a burden on his family. These plays were piloted and filmed, and provide a useful resource for role-plays that facilitate training on the guidelines.

**Conclusion**

These guidelines are the first that have been developed to improve the capacity of gatekeepers to identify and respond to the risk of suicide in a person from an immigrant or refugee background. Next steps will be to develop culture- and country-specific adaptations and translations, particularly in countries with large numbers of immigrants and refugees, such as Canada, USA, UK, Germany, France, Spain and Italy.

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Table 1

*Characteristics of panel members*

| Age | Median = 49 | |
| --- | --- | --- |
| | Range = 26 - 74 | |
| | *Number* | *Percentage* |
| **Gender** | | |
| Female | 29 | 66 |
| Male | 15 | 34 |
| **Clinical/personal experience** | | |
| From immigrant and refugee backgrounds | 26 | 59 |
| From immigrant background | 11 | 25 |
| From refugee background | 7 | 16 |
| **Country of activity** | | |
| Australia | 23 | 52 |
| United States | 5 | 11 |
| Canada | 3 | 7 |
| United Kingdom | 2 | 5 |
| Norway | 2 | 5 |
| Israel | 2 | 5 |
| New Zealand | 1 | 2 |
| Pakistan | 1 | 2 |
| Philippines | 1 | 2 |
| Sweden | 1 | 2 |
| Netherlands | 1 | 2 |
| Unspecified | 2 | 5 |

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Table 2

*Examples of statements accepted for inclusion in the guidelines*

| Items | Round |
|---|---|
| **Section 1: Warning signs** | |
| An important warning sign for suicide is if a person is expressing (in words or actions): | |
| Hopelessness (be aware of different cultural expressions of hopelessness and negative emotions) | 1 |
| Fear of being deported, especially if there is risk of torture or death | 2 |
| Feeling that death is an honourable solution to their situation | 2 |
| That their lives have been a failure, they would have been better off in their country of origin | 3 |
| **Section 2: Identification of suicide risk** | |
| The first aider should not assume that injuries the person has are self-inflicted, as in some cases they may be the result of religious or traditional practices | 2 |
| The first aider should not assume that injuries the person has are the result of religious or traditional practices, as these might be self-inflicted and an important warning sign for suicide | 2 |
| If the first aider thinks the person is uncomfortable interacting with them due to differences in age group, gender, religion or ethnic group they should ask the person if they would prefer to talk to someone of the same age group, gender, religion or ethnic group. | 1 |
| **Section 3: Assessing seriousness of the suicide risk** | |
| The first aider should ask the suicidal person if they have experienced a change in their spiritual/religious beliefs (e.g. an increase or decrease in prayer or church attendance.) | 1 |
| The first aider should be aware that those at the highest risk for acting on thoughts of suicide in the near future have a specific suicide plan, the means to carry out the plan, a time set for doing it, and an intention to do it. | 1 |
| **Section 4: Initial Assistance to a suicidal person** | |
| If the person is suicidal, the first aider should: | |
| Not make the person feel guilty about wanting to die | 1 |

Be aware that suicidal people differ in their chosen suicide methods so they should pay attention to the presence of any sort of potential suicidal means (not just guns, rope, pills but also knives, any kind of poison, kerosene etc.). 1

## Section 5: Talking with a suicidal person

The first aider should be aware that some people from immigrant and refugee backgrounds have developed fear and distrust about emergency services, statutory bodies and other in positions of power and should provide reassurance to the person before contacting or directing the person towards these services. 2

The first aider should ask whether religious, spiritual or cultural supports are important to the person and, if they are, offer to put the person in contact with these supports 2

## Section 6: Safety planning with a suicidal person

The first aider should ensure the person knows how to access safety contacts provided to help them, i.e. what will happen when they call the phone number. 2

The first aider should be aware that the means of suicide may not be immediately evident and should directly ask about available means, as these can vary from culture to culture 2

## Section 7: Ensuring safety for a suicidal person

The first aider should try to remove the means of suicide available to the suicidal person if it is safe to do so. 1

The first aider should help the suicidal person to decide who they can contact if they become suicidal again in the future. 1

## Section 8: Confidentiality

If the first aider decides to involve a professional or someone else, they should inform the suicidal person of their decision and explain that this is necessary to ensure their safety. 1

The first aider should not keep the person's suicidal thoughts a secret from potential helpers, but should discuss with the person whether other details should be confidential. 2

## Section 9: Passing time during a crisis

The first aider should offer to help the suicidal person with practical tasks, if they are willing and able to do so. 3

| | |
|---|---|
| If the person engages in religious, spiritual or traditional practices such as reading religious texts, praying, meditating or chanting, the first aider should encourage them to do this. | 2 |

### Section 10: What the first aider should know in providing suicide first aid

| | |
|---|---|
| The first aider should be aware that talking about suicide will not 'put the idea' into someone's head. | 1 |
| The first aider should know the local services available (if any) to people from immigrant and refugee backgrounds, e.g. transcultural mental health services or services for survivors of torture and trauma. | 2 |

### Section 10: Specific to adolescents

| | |
|---|---|
| The first aider should not leave an adolescent who is feeling suicidal on their own. | 1 |
| If the person is an adolescent, they may expect to get into trouble for sharing their thoughts or feelings and the first aider should reassure them that this will not happen. | 2 |

### Section 11: Gender specific

| | |
|---|---|
| The first aider should be aware that females from some cultural backgrounds may be expected to protect the family's and husband's names and this can act as a barrier to disclosing suicidal intentions | 2 |
| The first aider should be aware that females from some cultural backgrounds may not be permitted to make decisions regarding their health alone and this can act as a barrier to accepting help | 2 |

Suicide First Aid guidelines for immigrants and refugees

*Figure 1.* Stages in development of the guidelines



**Step 1**
**Experts recruitment**
Researchers sent invitation letters and PLS to suicide prevention organisations, conferences/symposiums, MHiMA networks.

**Step 2**
**Survey distribution - Round 1**
After obtaining expression of interest and consent to participate, researchers sent participation invitations to experts with link to survey.

**Step 3**
**Data collection - Round 1**
After 2 weeks, researchers sent a reminder. After another week they sent a final reminder.

**Step 4**
**Data analyses - Round 1**
Preparation of survey on the basis of agreement with items presented and including proposed additional items in step 2.

**Step 5**
**Survey distribution - Round 2**
Researchers sent participation invitations to experts with link to the second survey.

**Step 6**
**Data collection - Round 2**
Researchers sent reminders as for step 3.

**Step 7**
**Data analyses - Round 2**
Preparation of survey on the basis of agreement with items presented in step 5.

**Step 8**
**Survey distribution - Round 3**
Researchers sent participation invitations to experts with link to the last survey.

**Step 9**
**Data collection - Round 3**
Researchers sent reminders as for step 3.

**Step 10**
**Data analyses - Round 3 and Guidelines**
Final data analyses. Preparation of guidelines and distribution to experts for final comments.