

emergency department setting



square

suicide **qu**estions **an**swers **re**sources

ERISUPPS

square suicide questions answers resources

emergency department setting

ISBN 0 9752419 3 1

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Jointly funded by the Australian Government and the Government of South Australia

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An education resource for primary health care, specialist and community settings

Most people who die by suicide have sought help in the weeks before death. Therefore the nature and quality of response offered by workers in primary health care is crucial.

Even a simple interaction like listening can be significant.

Everyone can make a difference.





note

This Booklet is designed to be used with the rest of the **square** resources, not alone or as a substitute for an informed professional response. Its main focus is on adults although much of it is also relevant to young people. Those seeking specific guidance about working with young people should source relevant Australian, state government and local information.

You will find information in the service setting books that will be helpful in your own practice. This will be particularly relevant where referrals are made or received from these services or there is a shared care arrangement in place.

Your service will also have its own policies, procedures and protocols around suicide risk assessment and referral. It is very important to ensure that you are familiar with these as well as the information provided in this Booklet.

In addition it may be useful to consult the South Australian Emergency Demand Management policies, which cover best practice and specific procedures on matters such as admission, care and discharge, contingency planning, restraint and seclusion, emergency transport, assessment and crisis intervention service.

The experience of consumers and carers has been incorporated into these training materials. This reflects the priority placed on consumer and carer participation in decision and policy making. The contribution of these consumers and carers is gratefully acknowledged.

Note: All names used in quotes from consumers are pseudonyms to ensure anonymity and protect confidentiality.

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how to use this resource

This booklet is part of an integrated resource – **square** suicide **questions answers resources** developed for South Australia as part of the National Suicide Prevention Strategy (NSPS). **square** consists of 3 layers, each progressively providing more detailed information about suicide prevention.

- A** The first layer is the **Desk Guide**, a quick reference providing key information, tools, guidelines and questions.
- B** The second layer is a series of **9 booklets**
 - 1 Foundations for effective practice**
 - 2 Community setting**
 - 3 Primary health care setting**
 - 4 In-patient setting**
 - 5 Emergency department setting**
 - 6 Community mental health setting**
 - 7 Forensic setting**
 - 8 Mental health in-patient setting**
 - 9 Suicide postvention counselling.**

This booklet, **Emergency Department Setting**, is aimed at health workers in hospital emergency departments, who in their professional roles may encounter people at risk of suicide and self harm. It is designed to be used in conjunction with the **Foundations booklet** which has been written for a broad audience and provides the foundations which underpin the following 8 booklets addressing specific settings and audiences.

- C** The third layer is the **square** CD-ROM/Website **www.square.org.au**. It is intended for those readers who want a more in-depth discussion and application of the key topics covered in the Desk Guide and the booklets. It contains discussion papers, video clips, resource lists, some downloadable forms and plans, and pdf files of all the **square** print materials – the 9 booklets and the Desk Guide.



introduction

The role of the **Emergency Department** in hospitals is to treat patients who are suffering from an acute illness or injury that would lead to severe complications if not treated quickly.

Patients who attend an Emergency Department may have been brought in by ambulance, they may have self-presented, or they may be referred by a primary health worker.

The diversity of presenting problems means that one of the main challenges of this setting is to be able to respond and effectively treat anyone who comes through the door.

The context is often a highly pressured one in which many people arrive simultaneously. For all of these reasons **triage is crucial**. Triage aims to ensure that patients are treated in order of clinical urgency. It also facilitates the patient being seen in the most appropriate assessment and treatment area.

It is important to note that 'urgency' refers to the need for time-critical intervention – it is not synonymous with severity. Patients triaged to a lower category could still require hospital admission or require thorough health review and assessment.

The triage classification is clinical, coded and is designed, in part, to facilitate effective flow within this high demand setting. This point is relevant to the issue of suicide – because **suicidal ideation or intent of patients may not be revealed as a co-existing problem**. An important challenge will be to incorporate a psycho-social perspective in in-patient care within the pressures of the setting and the defined brief to prioritise emergency clinical situations.

In addition, there is a high level of flow-through of staff in Emergency Departments. At any given time in an Emergency Department, there could be Interns, Emergency Department Consultants, Registered Medical Officers, GPs and nurses.

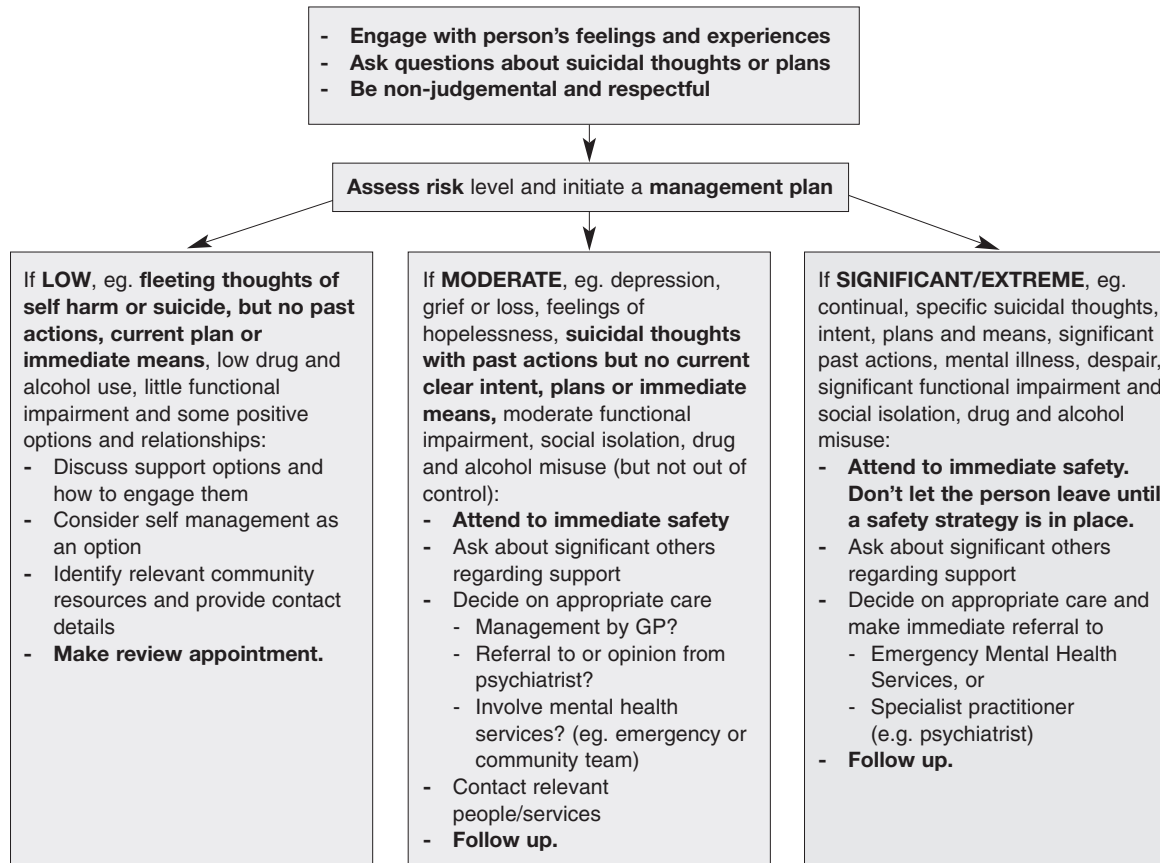
For suicide to be addressed effectively, everyone who works in the Emergency setting needs to have a **high index of awareness about suicide** and appropriate skills to respond in the best interests of the patient.

Key facts

- Despite a decline of 18% in suicide rates since a peak in 1997, suicide is still a major public health problem in South Australia and nationally. Approximately 2100 Australians were reported as taking their own lives in 2005 (ABS, 2007).
- People of all ages and from all walks of life may be suicidal.
- In the 1997 National Survey of Mental Health and Wellbeing, 3.5% of respondents aged 18 and over reported suicidal thoughts in the previous 12 months, and about 12% of that group also reported having made a suicide attempt (Pirkis et al., 2000).
- Attempted suicide may be 30-50 times more common than death by suicide (Martin et al., 1997). Admissions to hospital for intentional self injury are about 10 times as common as deaths due to suicide.
- The majority of suicide attempts are thought to go undetected, with only an estimated 5% to 30% of suicide attempts resulting in admission to hospital (Health Department WA, 2000)
- Most people who contact health services after a suicide attempt are seen by Emergency Departments. They may or may not be admitted as hospital in-patients, and the injury may or may not be recorded as intentional. Statistics therefore vary greatly between hospitals.
- Female hospitalisation rates for suicide attempts are consistently higher than for males. However, the death rates from suicide are about three to four times greater for males than females. There are some population groups which are particularly vulnerable. For example, the suicide rate for males aged 25-34 years has quadrupled over the past 30 years.
- Domestic violence is a contributing factor in suicidality, yet up to 70% of female domestic violence victims may not be detected by hospitals (Sherrard et al., 1994). Childhood physical and sexual abuse are also contributing factors in suicide and self harm.
- In a WA study, people discharged from hospital after deliberate self-harm were found to be over three times more likely to die and over 20 times more likely to suicide than the general population. (Health Department WA, 2000).

Assessment and management of suicide risk

The following diagram represents some general principles and options for assessing and managing suicide risk. Some of the care and referral pathways will need to be adapted for the Emergency Department setting.



Active, connected referral and follow up are essential for ongoing care.

Ensure a seamless, supported transition to the next stage in the person's care. Do not leave gaps in follow up.

responding effectively



Managing suicidality in the emergency department setting

Emergency Departments are often the first point of clinical contact for a suicidal person and they need to be able to provide or facilitate:

- A safe environment
- Integrated medical and psychiatric management
- Risk assessment
- Identification of psychiatric morbidity
- Adequate follow up.

Management of a person who has intentionally self harmed involves treating the effects of the injury or poisoning through coordinated multidisciplinary care. When the patient is stabilised they must receive comprehensive psychiatric assessment as soon as possible. Where Mental Health Services undertake this assessment, it should, if appropriate, take place within the Emergency Department. It is important that any possible collaborative information from relatives, GP or people accompanying the patient, is collected and documented.

Management involves:

- **Engaging** and establishing a therapeutic alliance with the patient. Regardless of whether the therapeutic relationship is short or longer term, it is important that the health worker engages with respect and empathy. Clinical judgement and effective engagement are fundamental in providing appropriate care to a distressed person.
- **Comprehensive assessment of risk** to self and others. A comprehensive assessment cannot be achieved until the patient's cognitive function (which may be impaired by medication, substance misuse or an overdose) has returned to normal. The patient interview should be conducted in a secure environment and the patient's safety, dignity and feeling of safety should be taken into account.
- **Management of co-morbidities.** This underpins much clinical assessment of deliberate self harm. These issues should also be addressed in the assessment of the person, as well as relevant social circumstances.
- **Initiating treatment planning**, with patients, their significant people and other health services.
- **Documenting** effectively the assessment status of the person's safety between transitions of care and at discharge from the hospital.
- **Ensuring that information 'travels'** to relevant care contexts in a timely way. This is crucial for patient safety – people are at increased risk at discharge and during transitions of care.

Suicide risk factors

Many people who die by suicide have a mental health disorder. There are also many psychosocial issues that are associated with an increased risk of depression, for example:

- Alcohol and drug misuse
- Having been sexually or physically abused, currently or in childhood
- Family violence, bullying, assault
- Poverty or financial stress
- Homelessness or unstable accommodation
- Imprisonment
- Significant loss – of person or status or esteem
- Chronic illness
- Living with social stigma in relation to aspects of identity or circumstance
- Environmental factors (e.g. drought).

For all of these reasons, it is important that health workers in emergency settings have a high awareness that suicidal ideation may be an underlying issue, even when it is not explicitly the presenting problem.

Deliberate self-harm is common and causes considerable distress to the person, their family and friends. It is not safe to assume that people who have self harmed are not at high risk simply because they are not triaged as a clinical emergency.

Engaging effectively with patients in the emergency department

To detect a patient for whom suicidality may be a risk, it is vital to engage with them. This requires willingness to listen to what they are saying, picking up signals or cues such as: *I'd be better off dead*, or *There's no point in fixing me up*, or *They'd be better off if I just disappeared*.

If a person expresses distress in this way, it is important not to simply give glib reassurance, or to trivialise or ignore disclosures of their emotional state. Show that you have 'heard' and that you are concerned about their wellbeing. This can be done in simple statements, e.g. *A lot of people experience strong emotions when they've been injured – how are you going with that?* From the basis of empathic conversation, a context is established from which to directly ask the question: *Have you had any thoughts of harming yourself?* (See **Foundations booklet** and the **Risk Assessment paper** on the **square** CD-ROM/Website **www.square.org.au** for advice on specific questions to ask.)

By listening in a receptive manner, without imposing or implying criticism, it is possible both to reassure the patient that you are 'present' for them – and to establish information that may inform an initial assessment. For example:

- How severe are this person's problems and is there a risk of harm to self or others?
- What information is already available about this person (from other people involved)?
- Does the person appear to be depressed, agitated, incoherent, despairing, or mentally unwell?
- Has the person got any supports and/or coping skills?

Having engaged in this way, it is important to follow through by enlisting appropriate professional support for the person's needs. Any concern that you have about suicide risk should be documented and reported.

Risk assessment

A comprehensive **Risk Assessment** process may include a mental health assessment to diagnose/confirm underlying mental health problems and/or identify associated problems such as drug and alcohol misuse, and may incorporate immediate treatment of these issues, e.g. medication. Particular vigilance may be necessary while a person is waiting to be assessed and immediately afterwards while consultation or referral arrangements are being made.

Risk assessment guide

This risk assessment is from the Mental Health in South Australia Emergency Demand Management Policy and Procedure Series (2002) that is used by staff in mental health services. It forms part of the risk assessment, referral and follow up form developed for private practitioners. The form and the accompanying guidelines can be downloaded from the **square** CD-ROM/Website www.square.org.au.

Please note form continues over the following pages.

risk of harm to: self others both

<input type="checkbox"/> none	<input type="checkbox"/> low	<input type="checkbox"/> moderate	<input type="checkbox"/> significant	<input type="checkbox"/> extreme
No thoughts or action of harm.	Fleeting thoughts of harming themselves or harming others but no plans, current low alcohol or drug use.	Current thoughts/distress, past actions without intent or plans, moderate alcohol or drug use.	Current thoughts/past impulsive actions/recent impulsivity/some plans, but not well developed. Increased alcohol or drug use.	Current thoughts with expressed intentions/past history/plans. Unstable mental illness. High alcohol or drug use, intoxicated, violent to self/others, means at hand for harm to self/others.

level of problem with functioning

<input type="checkbox"/> none/mild	<input type="checkbox"/> moderate	<input type="checkbox"/> significant impairment in one area	<input type="checkbox"/> serious impairment in several areas	<input type="checkbox"/> extreme impairment
No more than everyday problems/slight impairment when distressed.	Moderate difficulty in social, occupational or school functioning. Reduced ability to cope unassisted.	Significant impairment in either social, occupational or school functioning.	Serious impairment in several areas such as social, occupational or school functioning	Inability to function in almost all areas.

Risk assessment guide

level of support available

<input type="checkbox"/> no problems/ highly supportive	<input type="checkbox"/> moderately supportive	<input type="checkbox"/> limited support	<input type="checkbox"/> minimal	<input type="checkbox"/> no support in all areas
Most aspects are highly supportive. Effective involvement of self, family or professional.	Variety of support available and able to help in times of need.	Few sources of help, support system has incomplete ability to participate in treatment.	Few sources of support and not motivated.	No support available.

history of response to treatment

<input type="checkbox"/> no problem/ minimal difficulties	<input type="checkbox"/> moderate response	<input type="checkbox"/> poor response	<input type="checkbox"/> minimal response	<input type="checkbox"/> no response
Most forms of treatment have been successful, or new client.	Some responses in the medium term to highly structured interventions.	Responds only in the short term with highly structured interventions.	Minimal response even in highly structured interventions.	No response to any treatment in the past.

Risk assessment guide

attitude and engagement to treatment

<input type="checkbox"/> no problem/ very constructive	<input type="checkbox"/> moderate response	<input type="checkbox"/> poor engagement	<input type="checkbox"/> minimal response	<input type="checkbox"/> no response
Accepts illness and agrees with treatment, or new client.	Variable/ ambivalent response to treatment.	Rarely accepts diagnosis.	Client never cooperates willingly.	Client has only been able to be treated in an involuntary capacity.

Is the person's risk level changeable? **Highly Changeable** yes no

Are there factors that indicate a level of uncertainty in this risk assessment?
(e.g: poor engagement, gaps or conflicting information) **Low Assessment Confidence** yes no

overall assessment of risk

<input type="checkbox"/> none	<input type="checkbox"/> low	<input type="checkbox"/> medium	<input type="checkbox"/> high	<input type="checkbox"/> extreme
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For more information about each of the categories in this form and specific questions which can be asked of clients, see the **Foundations booklet** and the **Risk Assessment paper** on the **square CD-ROM/Website www.square.org.au**.

Note Risk assessment is not a precise 'science'. A form such as the one above is a valuable guide, but your professional judgement and experience are also crucial. Remember too, that a person's risk of suicide may be highly changeable, fluctuating at different times and in response to certain events.

Managing a patient with a mental health emergency

A comprehensive face to face assessment and management plan is required. It must include:

- A formal risk assessment
- A crisis management plan
- Input from psychiatry registrar and/consultant psychiatrist.

If admission is recommended, contact Emergency Mental Health Services with a bed allocation request.

- If the patient is known to mental health service, liaise with appropriate clinician/team.
- If referred by a GP, a summary of the assessment, treatment and management plan needs to be given to the GP by the next working day.
- GPs may provide a copy of the assessment/referral and follow up form which is included in the **square** materials. This can be downloaded from the **Management section** of the **square** CD-ROM/Website **www.square.org.au**.

Managing a patient with mental health needs (non emergency)

When an emergency pathway is not indicated, the following questions need to be addressed adequately before the patient leaves the Emergency Department:

- Who needs to be informed?
- Who has primary clinical responsibility?
- Who will monitor the patient's care?

If the patient is known to Mental Health Services:

- Liaise with the appropriate clinician or team.

If the patient is not known to Mental Health Services:

- Refer either to Mental Health Services or to private psychiatrist for follow up. (Be aware that the times in between service delivery are potentially dangerous times for suicidal ideation and behaviour).

If the patient was referred by a GP:

- Send the summary of assessment, treatment and management plans to the GP by the next working day.

If a patient returns to the Emergency Department within 4 weeks, the treatment plan must be urgently reviewed.

Guidelines for developing a management plan

- Have you ensured safety (i.e. considered supervision, removal of lethal means, backup assistance, security/police, if necessary)?
- Is the person able and willing to engage with treatment and support options?
- What protective factors are evident (e.g. support networks)?
- When reviewing risk assessment, consider if it is appropriate for the person to:
 - be self managed in the community
 - be managed as an out-patient, by a GP, or in a shared care arrangement
 - be managed in the short term in an Emergency Department or with specialist case management
 - be admitted into specialist in-patient care – (including detention).
- Are antidepressants or other medications indicated?
- What other therapeutic interventions (such as counselling, psychotherapy) are appropriate and available?
- Is referral to a specialist mental health service/ward a desirable option?
- Is there a contingency plan to address any potential escalations of risk and does it clearly identify appropriate and feasible roles and responsibilities?
- What community support services can be utilised (alone or to supplement other interventions)?
- What longer term management arrangements can be set in place?
- Who will provide follow up and review the plan?
- Who will be responsible for ensuring that the relevant documentation is relayed in a timely manner to others involved?

A Collaborative Management Plan has been developed for private practitioners as part of this suicide prevention initiative. It is useful as a guide, referral document and record. The management plan can be downloaded from the management section of the square CD-ROM/Website www.square.org.au.

best practice for the emergency department setting



Medico-legal recommendations for management of deliberate self-harm

- Every person presenting with deliberate self harm to any health facility is to be given appropriate medical, surgical and psychiatric assessment and treatment.
- Each case is to be considered on its merits, taking into account clinical, ethical and legal perspectives.
- Junior medical staff must consider involving senior consultant doctors in decision-making.
- Patients must be adequately informed about appropriate treatment options to enable them to reach a balanced judgement. However, a distressed, anxious, depressed, delirious, psychotic or demented patient, or a patient experiencing rejection, anger, guilt, grief, hopelessness or suicidal ideation, may not be able to form a balanced judgement.
- It may be necessary to involve family members, friends or cultural support in decision-making about appropriate treatment and support options.
- The treatment team must understand the specific requirements of the relevant Mental Health Act, Guardianship Act and Privacy Act (or equivalents).
- The treatment team must also understand any other legislation relevant to suicidal patients, e.g. legislation which makes it lawful to use force to prevent the suicide of a person.
- Local policies and procedures for the management of deliberate self harm should be available in every health service.
- Documentation in the clinical record is important for all stages of assessment, patient transfer, ongoing treatment and discharge planning (RANZCP, 2003).

Hospital protocols

Hospital protocols should specify lines of responsibility and information about accessing senior clinicians for second opinion, assessment, treatment and planning. These protocols should also include support strategies for care of family and loved ones. Management issues include:

- Assessing the competence of the patient to provide informed consent to treatment
- Facilitating informed consent to treatment
- Ensuring clinician knowledge about relevant mental health legislation
- Ensuring 'duty of care' for patient safety during episodes of care and during transfer to other settings
- Attending to confidentiality. (Risks to safety may mean that confidentiality cannot be preserved – but patients should be consulted about what may be told and to whom).

Key practice recommendations

1. Ensure prompt access to medical care in the Emergency Department, using appropriate triage procedures
2. Ensure prompt assessment and maintenance of safety
3. Ensure prompt access to medical/surgical assessment
4. Ensure prompt access to mental health (psychiatric) assessment
5. Treat underlying mental disorders optimally
6. Encourage engagement with treatment
7. Encourage follow-up attendance
8. Avoid treatments that might increase the risk of self-harm.

NB. The above management information has been adapted from the Summary of Australian and New Zealand Clinical Practice Guidelines for the management of adult deliberate self harm (RANZCP, 2003).

Support and self care for hospital staff

Self care is typically not given much emphasis in health worker training and consequently health workers in Emergency settings may not take sufficient time out to deal with their own stress or grief. Yet there are proactive ways in which practitioners may engage in self care to prevent burnout or other long term negative effects. Common stressors within the Emergency setting are:

- Understaffing/high client load/inadequate mental health resources
- Constantly having to make critical decisions
- High levels of emotion in interactions with clients
- The litigious context within which health care operates (Gundersen, 2001).

Emergency Department staff are working constantly with people in crisis, and often with patients whose behaviour is challenging. This can contribute to feelings of negativity and cynicism, and sometimes to high levels of drug and alcohol use, relationship problems and mental health problems.

People who self-harm may reject help from health professionals and many do not keep appointments. Others may be rejected by health professionals and may not find health services helpful. Dysfunctional coping styles and chaotic ways of seeking help can induce negative attitudes in clinicians. Those who regularly work with [self harming] patients need appropriate strategies for their own support, including supervision, peer discussion and specific training to manage patients. Inexperienced clinicians need to discuss and understand their own reactions... Health services should consider training their staff in the management of [self harming] patients (RANZCP, 2004, p.873).

Some reminders

- Remember that while you can assess the risk of suicide, you cannot always prevent it.
- It's OK to admit you don't know. Seek assistance from others with specific expertise.
- Debrief with a skilled colleague after a critical incident or seek trauma support.
- While maximising safety in the hospital must always be a short term priority, in the longer term supporting patients to develop their own skills may be the best strategy.
- Reflective thinking is integral to self care.
- Review your own needs with the same seriousness as you review patients' needs, and seek help if necessary.

consumer issues



Consumers who had self harmed (or were a family member of someone who had self harmed) were interviewed during the development of this resource. There were some consistent messages that emerged about their experiences in hospital. A major theme was their feelings about interpersonal interactions. When these had been positive, it was often memorable. For example:

And this one doctor, I remember he said to me, 'Yes I do believe that you hear voices, and we'll try to help you with that, we'll work together.' And it was amazing, because no-one had ever said that before. [Angela, Adelaide 2005]

Conversely, when people felt that they had not been believed or taken seriously, they still carried the memory of the experience. For example:

Even though people are supposed to be supporting you through these things, they've got their own judgements about it. And yeah, it's really, really hard to talk to someone about wanting to kill yourself when you know they are thinking: 'Wanting to kill yourself is stupid and you shouldn't do it and you are just wasting our time.' Like, it is that obvious when people feel like this. It is really apparent when they have those attitudes. [Sarah, Adelaide 2005]

It is important to recognise that people often come to Emergency Departments thinking they have limited choices. By asking questions you start to create choices.

The impact of stigma

Stigma surrounding mental illness is socially pervasive. Some people living with the burden of mental illness report that living with the consequences of stigma is as hard as dealing with the symptoms of the illness. Similarly, people who feel marginalised because of aspects of their identity or circumstance, e.g. sexual identity or ethnicity, report that social stigma is one of the hardest things to deal with.

In both of the above examples, the existence, or not, of positive factors in the person's life - for example supportive family and community, good problem solving skills, meaningful employment - will make a significant difference to the person's wellbeing.

Some people live with multiple issues that are difficult to handle in their own right, and at the same time are stigmatised. The outcome is both compounding challenges to healthy survival and compounding experiences of hostility and/or indifference.

A person may for example, live with any number of the following variables: poverty, alcohol and substance misuse, homelessness, mental health disorders, chronic illness, old age, illiteracy, experiences of violence and/or abuse, social dislocation/separation from family, or experience of incarceration.

Many people who carry health and wellbeing burdens, such as those described above, use several different public services and agencies in an attempt to access appropriate services. Sometimes it is unclear who is case-managing their needs – and often they will not have their own GP.

It is very important that people in these circumstances are not marginalised within the very settings from which they seek support. It is therefore helpful for health workers in Emergency Departments to be particularly reflective about those patients whose behaviour they find challenging.

In such circumstances there may well be factors present that contribute to suicide risk and this should be taken into consideration. The person should not be discharged from an Emergency Department without a management plan for follow up.

Some challenges

Australian Emergency Departments are among the most advanced in the world, reflecting the highest standards of service delivery. They also face increasingly complex systemic and practice demands that necessarily require timely and accountable responses. In this arena it is required that protocols are followed and that judgements are based on clinical evidence. This is the only way that the Emergency Department can efficiently and effectively undertake its work.

The environment and ethos that is produced by the various pressures of an Emergency Department can have some negative consequences, however. These may impact especially on patients who are most vulnerable, such as those who are at risk of suicide. These negative consequences can include:

- Documentation being inadequate for other care providers to make optimum use of it
- Documentation not following the patient in an appropriately timely or useful way
- Little or no collaboration with the patient's significant others, e.g. loved ones and other care providers
- Little or no engagement with the person about psychosocial issues, e.g. feelings, preferences, needs
- Lack of due attention to co-morbidity issues.



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for further information
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