

MANAGEMENT PAPER

MANAGEMENT

1. POLICY FRAMEWORKS

Suicide prevention and management in Australia exists within a framework of national and state mental health and suicide prevention policies which emphasise community-based and primary mental health care service provision. These policies acknowledge that the impact of mental illness extends beyond the individual to all levels of the wider community. Collaborative efforts across sectors and across agencies – a whole of community response – are therefore essential. Mental health promotion and suicide prevention are increasingly being seen as ‘everybody’s business’.

There is a range of both national and state prevention programs and initiatives which address suicide prevention, either directly or indirectly. While the health sector is crucial, so also are a number of other sectors including education, the law, community services and business. Current suicide prevention policies focus on reducing the risk factors associated with suicide and increasing the protective factors, such as promoting mental health and resilience within the community.

To be effective, suicide prevention initiatives require the building of partnerships between families, communities, and all levels of government and non government agencies. A comprehensive approach to suicide prevention includes broad mental health promotion as well as specific initiatives addressing suicide.

NATIONAL STRATEGIES

There are a number of key national strategies responding to suicide. These are described in more detail in the [Overview discussion paper](#).

The Australian Government’s Department of Health and Ageing implements the **National Suicide Prevention Strategy** (NSPS, www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-suicide-overview), which funds a number of major national initiatives, most of which address the high rates of suicidal behaviour among identified population groups and emphasise community capacity building in a range of settings. Some are jointly funded with the National Mental Health Strategy and seek to better integrate mental health promotion and mental illness prevention with suicide prevention.

The focus of the NSPS includes people of all age groups and those identified as being at high risk such as: young men, rural residents, the elderly, people with substance use problems, prisoners, rural communities, people with mental illnesses, and Aboriginal and Torres Strait Islander communities. There is an emphasis on promoting initiatives that aim to address risk and protective factors for suicide.

The [Living is for Everyone \(LIFE\) Framework](#) guides and informs the implementation of the NSPS. It was first developed and published in 2000 and then revised in 2007. The LIFE framework identifies the following as principles of effective suicide prevention:

1. It is a shared responsibility across the community, professional groups, government and non government agencies
2. A diverse approach is needed targeting the whole population, specific population subgroups and people at risk
3. Programs must be based on evidence, focus on achieving results and incorporate evaluation as an integral part
4. It must incorporate input from the community, carers and experts
5. It must be sustainable to ensure a continuous and consistent service.

Other allied national strategies with direct relevance to suicide prevention include:

THE NATIONAL MENTAL HEALTH STRATEGY.

This strategy was adopted by all Health Ministers in 1992 and reaffirmed in 1998 and again in 2003. It aims to promote the mental health of the Australian community, to prevent the development of mental health problems, and to provide improved treatment and support for people affected by mental health problems. It acknowledges that mental illness is the strongest and most consistent risk factor for suicide.

(see: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-strategy>)

THE NATIONAL DRUG STRATEGY.

This strategy provides a framework for a coordinated, integrated approach to drug issues in the Australian community and its strategies are aligned with the National Suicide Prevention Strategy.

In addition to these national strategies, the LIFE Framework incorporates partnerships with a range of other national programs in the areas of public health, sexuality and sexual health, health and wellbeing of Aboriginal and Torres Strait Islander peoples, people in rural and remote areas, older Australians,

culturally and linguistically diverse people, families and social wellbeing, homelessness, child abuse, young people and education, employment and Vietnam veterans. Its Framework document makes explicit the suicide issues involved in all of these areas.

(see: <http://www.nationaldrugstrategy.gov.au>)

BETTER OUTCOMES IN MENTAL HEALTH CARE PROGRAM

Introduced in 2001 and due for continued expansion from 2008, this program aimed to improve access to mental health resources and the ability to respond effectively to mental health problems in the community. It includes funding for its different components such as GP training and Medicare funded referrals onto allied health professionals under the management of GPs using Mental Health Plans.

<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-boimhc>

STATE STRATEGIES

Within each state and territory, different organisational structures and advisory groups are working on suicide prevention projects (see <http://www.livingisforeveryone.com.au/statecoord/default.asp>).

In South Australia, there is a steering committee of the National Suicide Prevention Strategy (NSPS) with the responsibility to provide advice on federal government funding decisions and opportunities. Organisations that are represented on the SA committee include SA Divisions of General Practice, Aboriginal Health Council, SA Department of Health, Uniting Care Wesley and the Australian Rotary Health Fund. Furthermore, a Ministerial Advisory Council on the Prevention of Suicide and Self Harm has advised the State Health Minister on the reduction of incidence of suicide and deliberate self harm amongst people of all ages in South Australia, while at the same time focusing on high risk population groups. At the same time, the SA State Government's approach to suicide prevention in population groups has clearly acknowledged the central role of GPs and other primary health carers, working in collaboration with the community and specialists.

In 2001 the SA Government published **Mental Health First Aid for South Australians** (written by Karin Myhill and Margaret Tobin). This booklet is based on the premise that just as first aid is given to an injured person before medical treatment can be obtained, so can mental health first aid be given to someone experiencing a mental health problem, before professional help is sought.

The booklet aims to increase the mental health literacy of the community and to help individuals and communities to be more resilient. It emphasises the fostering of cooperative relationships between members of the general public and mental health services. Its key principles and practical advice align closely with **square**. In particular, it recommends:

- Good self management strategies. ‘Be aware of your role and responsibilities, your personal limitations, how you can assist in the overall process and aim to achieve a good outcome.’
- Skill development. ‘Being able to communicate sympathetically, observe behaviours accurately and have flexible approaches to a variety of situations are skills that can be learnt and improved.’
- Developing networks. ‘Usually the combined efforts of a number of people – both professional and non-professional – are more effective than a person acting alone. If you live or work in a setting where health emergencies might occur then it is important to establish good networks and know whom to contact for assistance and/or advice before a crisis or emergency situation develops. Collaboration and co-operation are essential to the overall process’ (p.13).

2. SUICIDE MANAGEMENT CONSTRAINTS

The national and state policies, strategies and protocols, mentioned in Section 1 above, are consistent in their identification of what we might call the ‘prevailing wisdom’ about suicide prevention management. Few health workers or community members who have encountered suicide would argue with these principles. However, it should also be acknowledged that any suicide prevention strategy or program necessarily exists within certain constraints, which can mean that there are gaps between the ideal and the reality.

THE CONSTRAINTS OF TIME AND RESOURCES

The number of people with mental health problems exceeds the number of available health workers and the capacity of the system, to treat them. Therefore it is vital that there are multiple levels of response and that suicide prevention is recognised as a whole of community responsibility.

It should be acknowledged that GPs and other health workers are under time pressure. It should also be mentioned that some people at risk do not have a GP. There is a shortage of GPs across Australia – particularly in some rural areas – and often waiting lists of several days to see them even in highly serviced urban centres. In many medical practices patient case loads and schedules may mean that it is difficult to allocate sufficiently long appointments to all clients who may be at risk. .

And, despite some recent government initiatives and funding increases, it is widely recognised that mental health resources in states such as South Australia still don’t reach everyone at the right time and in the right place. Adequate follow-up and transfer of care after discharge from hospital or, in criminal cases after a court order allowing release into the community may not always occur. Accessibility to waiting lists for private and public mental health specialists is often difficult.

Some prisoners with severe mental health problems are not able to be treated in specialist institutions, and instead are located in detention and prison settings. In a recent opinion piece, Morgan (2005) suggests that prisons are increasingly becoming 'de facto psychiatric institutions' without adequate psychiatric personnel to respond. Even if increased resources were available in this context, it is questionable whether the prison environment could, at the same time, be an effective therapeutic setting. In addition, effective response to mental health issues and the risk of suicide for detainees seeking asylum in Australia, remains a question of concern.

All of the above relate to systemic weaknesses such as lack of integration of services. As well as these problems of structural arrangements and resourcing, there are also gaps in understanding of people's needs in relation to suicide risk and prevention. This is an issue that this Resource seeks to address.

For all of these reasons it is important to acknowledge 'up front' that the best management strategies, applied with the best intentions, do not always succeed in preventing an individual's suicide.

THE RELIABILITY OF RISK ASSESSMENT



(See also the video of Dr Randall Long introducing his [procedure of risk assessment](#).)

Suicide risk assessment is an inexact science. There is no golden rule – no 'one size fits all' assessment or series of questions. The [Foundation Booklet](#) has a comprehensive section on risk assessment and [a series of questions designed](#) by Dr Randall Long is included in these. However, it must be stressed that these questions are no substitute for, and should always be accompanied by, genuine engagement that recognizes that everyone is different, each person requiring a unique response and management plan informed by the practitioner's assessment.

A risk assessment and management plan assists health practitioners to document and summarise concepts and have been shown to be an effective means of communication with consumers and in referral to and between services, generating timely responses. However, it is important that the risk assessments and questions provided in this Resource be used as guides only. An overly mechanistic or formulaic use of them could impede the individualised response that is necessary. .

John, a psychologist who reviewed this resource, also emphasised the need for a client-centred, therapeutic approach that is sensitive to individual contexts:

...personal intuitive feeling and clinical judgement is more sophisticated than any protocol....If professionals are micro managed or put on rails, individual interpersonal skills and training do not have a chance to develop and are less available to clients.... (pers. comm. to Claire Ralfs, 13/10/05).

Randall Long argues in his [Risk Assessment discussion paper](#) that what is needed is a 'simple and informed method of questioning around suicidal thinking and behaviour' which professionals will adapt as a basis for their own style of enquiring about suicide. Different styles will be used with different clients and 'modified for various age groups and characteristics of the therapeutic relationship'. What is essential is that 'professionals develop their own style and confidence in discussing suicide as part of risk assessment', and that they overcome any anxieties that they may have about whether their questions may precipitate a suicide attempt. Instead, they should adopt the view that 'enquiry about a client's suicidality is therapeutic in itself' (Long, 2005). It is also essential, as Dr Long, stresses, that suicidal risk be seen as dynamic and constantly changing, and therefore in need of regular monitoring and re-assessment.

Risk factors as predictors

While this Resource, along with other suicide prevention materials, devotes some space to discussing the risk factors associated with suicide, it should be noted that these risk factors are really only useful on a population-wide basis – i.e. they tell us about statistical patterns over a certain period of time and they are constructed 'after the event'. There are, in fact, no satisfactorily reliable predictors of an individual's suicidal behaviour. Furthermore there is little evidence for predictors of lethality in individual cases.

Nonetheless, despite these qualifications, summaries of statistical risk factors do usefully draw our attention to the social and cultural factors which can contribute to mental illness and suicidal ideation. As discussed in other **square** resources, suicide is a complex problem involving a constellation of causes. Risk factors may be genetic, biological, psychological, social, cultural or environmental. The best explanations are likely to be based on information derived from a number of perspectives. While mental illness is the most important risk factor for suicide, there is also a range of demographic, physical and social situational factors which may be relevant and which may inform strategic planning.

It should be stressed again, however, that suicide cannot always be prevented. It is the responsibility of the health workers to ensure that an appropriate risk assessment is undertaken for clients thought to be at risk, and that such assessments are regularly updated and monitored, and management plans, appropriate to the assessment, are enacted. However, foreseeability does not equate with preventability (Simon, 2000). Risk assessments cannot be relied upon to predict suicide.



(See also the interview with Dr Peter Furze on [the role of pharmacology](#))

In the [Foundations Booklet](#) you will find a description of some of the psychotherapeutic interventions which exist in South Australia to treat mental illness and suicidal ideation. There are many different views about the relative efficacy of different psychotherapies, and practitioners will need to be guided by their own feelings and experiences with these.

Regardless of the particular therapy chosen, there seems considerable evidence that any focus on empathic engagement, effective listening and the instilling of hopefulness about getting better, is likely to be useful. For information about access to allied health services see, the Familiarisation Training GP and Practice Manual. Better Outcomes in Mental Health Care Initiative, (2000, p. 25.)
www.adgp.com.au/client_images/24395.pdf

Depression is sometimes associated with specific changes in the chemical message systems of the brain, and anti-depressant medication is therefore used very widely to treat depression. There is evidence for the efficacy of antidepressants in relieving depressed mood, poor sleep, anxiety, tiredness, agitation and anger, although it should be noted that it usually takes several weeks for the medication to take full effect. Antidepressants are usually prescribed for a period of time after symptoms have stopped (6 to 12 months) to prevent relapse of the depressive illness. Despite this important role for antidepressant medication, it is essential to ensure sufficient follow-up and to consider the underlying issues which have caused suicidal ideation. It is also crucial to empower patients by treating them as active partners in managing their depression (NPS, 2005b).

The [National Prescribing Service](#) (NPS) concludes that ‘Antidepressants do have efficacy in moderate to severe depression and are more likely to help than harm’. However, it also advises that:

1. In mild depression the evidence for using antidepressants is weak and non-drug treatments are first line
2. Be aware that individual response to antidepressants varies — only 50% of patients respond to the first drug chosen

3. Most efficacy trials are based on response (i.e. improvement) not remission, and residual symptoms are possible even after 6 weeks. (NPS News, 2005a)

The NPS recommends that antidepressants be used as part of the overall management of depression and that doctors offer non-drug treatments that are appropriate to the severity of the depression, even when antidepressants are prescribed.

Specifically, for mild depression it recommends that non-drug therapies (such as cognitive behavioural therapy, interpersonal therapy or problem solving therapy) be first line. In patients with severe depression, combined therapy is more likely to be effective than either antidepressants or psychological treatment alone. The NPS also suggests that antidepressants may be needed initially to improve functioning to a level where patients can engage in psychological therapy.

There have been reports in the scientific literature and the media that under some circumstances antidepressants may increase suicide risk. This relates to two situations: firstly, some people may respond to antidepressant medication with agitation. This is uncommon but when it does occur it indicates that this medication may not be suitable and a medical review should be arranged. Secondly, it is well known that people with severe depression may be very suicidal but not have the energy to carry through their intention, and when treatment first begins to work their energy levels may increase before their suicidality decreases. Therefore, there is a time period where close monitoring is needed.

There is some controversy about treating adolescents with antidepressants. There is evidence that the younger the person the less likely antidepressants are to be useful. It is now widely agreed that antidepressants should not be a first line option with young people and should be considered only after other strategies have been tried. For more information on the appropriate use of antidepressants and alternative treatments see the [beyondblue website](#).

3. STIGMA

Stigma surrounding mental health is a pervasive problem. It can make people reluctant to seek help at all or to discontinue use of services. Many people living with mental illness find that the associated stigma is as difficult to handle as the symptoms of their illness.

Stigma is not only related to individual behaviour. It is also a systemic issue that is reflected in the priority (or lack of it) that some groups of people receive in terms of civic concern, attention, funding and resources. This is of particular significance in relation to mental health because there are many people living with a mental illness who are also marginalised in other aspects of their life as well, thereby creating compounding problems and self stigma.

This issue of priority has been raised recently in relation to mental health at a local and national level. Nationally, the [Not For Service Report \(HREOC, 2005\)](#) found that people seeking primary health care or specialist mental health services ran a serious risk of having their basic needs trivialised or neglected. The first summary point of this report identifies the 'lack of access to basic services, particularly for those who did not fit a narrow band of diagnostically-driven group of persons to be assisted', as being of major concern.

Another Australian example of the invisibility of mental health is the fact that:

...it is unlawful under anti discrimination acts to vilify people on the grounds of race, religion, sexuality or gender identity. In NSW it is also unlawful to vilify people with HIV/AIDS. Under current Australian legislation however, (apart from Tasmania), people with a psychiatric or other disability do not enjoy this protection (Morgan, 2005)

The consequences of stigma can affect a wide range of central issues in a person's life, for example, housing, employment and quality of service delivery and social acceptance. Stigma can also play a part in influencing a person's experiences when accessing health and health related services. For example, a person's physical health requirements may be overlooked because of more obvious mental health issues. Or mental health issues can be overlooked because of more obvious presenting issues such as problems associated with drug and alcohol use.

Stigma is not simply a matter of using inappropriate words or labels to refer to a person and/or their health problem. It involves a bigger issue of respect. When people experience stigma they can feel:

- Dismissed
- Misunderstood
- Worthless
- Alone
- Hostile
- Frightened.

Such feelings can contribute to existing mental health problems and potentially to suicide risk.

Stigma around mental health problems exists not only in the general population, but can also be encountered in health and allied settings. For example, during the development of this Resource, a number of people were interviewed about their experiences of accessing help for their suicidality. Several women commented on feeling that they felt they were ‘wasting people’s time’. One hospital inpatient had been explicitly told that the bed could be used by a ‘real’ patient’. Sarah, an interviewee, described her feelings in the following way:

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 so obvious when people feel like this. It is really apparent when they have those attitudes. (Sarah, Adelaide 2005)



(See also the video interview with ‘Sarah’ for [a consumer perspective.](#))

The above example of stigma relates to notions that attempted suicide is ‘attention seeking’ or ‘acting out’. These imply that the person is playing some sort of game and should grow up or ‘pull themselves together’ – and further, that they do not warrant or need professional help. This is not only a mistaken attitude, but it could prove to be a fatal one (See the [Risk Assessment discussion paper](#) by Dr Randall Long).

Dianne, a former nurse interviewed for **square**, put it in this way:

I think when I had a seizure I wasn’t treated like I was when I took the overdose, and it was really annoying because I actually worked in the head injuries and overdose ward as a nurse. And I don’t remember treating people who’d taken overdoses as if they were in some way inferior or annoying or like I was wasting my time. But I definitely feel like that is how I was treated. It was like; it was some really gross inconvenience for the medical system that they had to look after me. (Dianne, Adelaide 2005)

Avoiding stigma requires health workers to reflect on their practice and that of their workplace culture generally. People who may be at risk of suicidality could be living with multiple and compounding risk factors. In addition, these factors could also bring with them various other burdens of social stigma – for example, old age, homelessness, a mental illness, drug use.

It is likely to be especially useful to consider whether there are any client groups or individuals who are less likely to receive open and respectful responses than others – and on what this is likely to depend. It is vital that health workers take responsibility for the attitudes they convey and ensure that they do not contribute to the problem of stigma. The process of developing best practice in relation to the issue of stigma may be assisted by the combination of self reflection, dialogue and reference to other material related to this topic. (See the [Engagement discussion paper](#), the [Diversity discussion paper](#) and the [Current Issues discussion paper](#).)

4. PRINCIPLES OF EFFECTIVE SUICIDE MANAGEMENT

Communication, Collaboration and Co-ordination are integral elements of **square**. Communication refers both to interactions with particular clients, as well as with other stakeholders, for example, the client’s family and referral agencies. In terms of the client and significant people in his/her life, it is important that the style of communication is empathic and that it has the client’s needs and experiences as the focal point of the interaction. (See [Engagement discussion paper](#).)

Let the individuals talk about their thoughts, fears and hopes so that you know what they want and can provide reassurance or correct any misconceptions. Make sure that everyone understands what has been said and agrees with the need for change. (WHO, 2000, p.35)

When communicating with other agencies and services, it is important that there are no gaps in the communication loop and that documentation ‘travels with’ the client. As has been mentioned previously, best outcomes are likely to be achieved when carers or significant others are involved in the assessment of a client’s current and future needs (which are likely to be highly changeable), rather than focusing only on the health worker’s obligations at the time of interaction.

It is particularly important that a client who is discharged from care is followed up and has clear and appropriate options for accessible ongoing care. This is an especially high risk time for suicidality. Coordination requires clearly connected pathways for referral and mechanisms for coordinated planning, review and feedback. The responsible health worker or person taking over care must be contacted and the current or interim management plan discussed prior to client discharge (See the [Management and referral video by Dr Tori Wade](#) or the Management section of the [Foundation booklet](#).)

Goal planning

The following guidelines for structuring and applying goal planning techniques are adapted from the World Health Organisation's Management of Mental Disorders, 2000 (pp.35-41) and are included among their core management skills for mental health care. They may be particularly useful for GPs assessing patients and preparing a Mental Health Plan under the Better Outcomes in Mental Health Care program.

Problem solving skills are a useful thing to teach people who are suicidal or self harming. It enables them to appraise situations more accurately and cope with particular stressors or change in circumstances that may have contributed to their current situation. Developing problem solving skills may also prevent a relapse.

Identifying problem areas and needs

- Ask the individual and his or her family to list problem areas.
- Help them decide collectively which goals are to be given priority.
- Rephrase the problems in positive terms and define the needs.
- Identify strengths and resources from the list generated.
- Decide upon appropriate goal(s) that are realistic, specific, achievable, broken down into small steps and 'owned'. The best goals are those that are high enough to be motivating and rewarding, yet are not so high that they are impossible to achieve.
- Once the set goal has been achieved, another slightly harder goal can be set.
- Break down longer term goals into smaller steps.
- Goal setting is much more effective if the individual 'owns' the goal and plays the central role in goal planning.
- Use a structured problem solving approach* for planning complicated goals.
- Review progress.

***Structured Problem Solving**

1. Define problems or goals in an everyday manner
2. Encourage people to seek a wide range of ideas
3. Define solutions in terms of current strengths
4. Give consideration to practical constraints.

Teaching Problem Solving Method

The skills required are not complicated and most people will require little more than encouragement and practice. Initially try to avoid problems which are very difficult, emotional or long-standing. Deal with easier issues until the person is used to the method.

Encourage them to write things down. This will put problems and solutions into better perspective and ensure that a record of the decisions is always available.

The 6 steps

1. Identify problems
2. Generate solutions through brainstorming
3. Evaluate the solutions
4. Choose the optimal solution
5. Develop a detailed plan of action
6. Review – steps may need to be changed or new ones added.

Collaboration

Collaborative support is of key importance in the prevention and management of suicidality. Ideally this will involve the whole community becoming more informed about the detection and appropriate response to someone who has mental health problems, as is advocated in Mental Health First Aid for South Australians (see Section 1, p.2).

The support of a person at risk might involve community agencies, families and significant people in the person's life as well as primary health workers and specialists in the mental health field. Clearly, to achieve this level of awareness, cooperation and civic concern for those with mental health problems, governments will need to continue to address the question of how to achieve effective community care models. Questions need to be posed and answered about community relationships of care, identifying in which settings and for which people care will be facilitated, and whose interests are being met.

Many people at high risk of suicide are marginalised and isolated by their mental illness or co-existing issues. More than 80% of people with a mental illness are unemployed (Hughes, 2005) and this factor, in itself, means that connections with meaningful work and associated relationships are usually not available to this group of people. In addition, the constellation of factors that may be present in people's lives, and their compounding effects, may well mean that people in these circumstances cannot be comprehensively served by arrangements that require the navigation of several different agencies for different needs. It is during this journey between government agencies that the responsibility for management of an individual's care can become a confusing landscape in which the individual can be lost – sometimes fatally.

Carers play a pivotal role in management and prevention of people who are suicidal but they too need the support of accessible pathways of referral and support both inside and outside of the medical framework.

Responding to self harm

Deliberate self harm, which includes attempted suicide, is a predictor of death by suicide with the greatest risk being in the initial weeks after discharge from hospital (Government of WA Report, 2001)

It is also important to note at this point, that there has been concern in recent years about appropriate response to deliberate self harm and injury. Key concerns include: opportunities for clients to 'slip through the cracks' at a number of points, e.g. during waiting periods in Emergency departments; inadequate level of service provision; patients not always receiving appropriate risk assessment; and unclear duty of care requirements.

Jo, who was interviewed for this Resource about her son's suicide, confirms the relevance of self harm in the following way:

One big thing I realise now that I feel we all misinterpreted – the importance of the self harm. Even though it wasn't severe, within itself the last and most serious act of cutting himself probably required stitches. We didn't stitch it, we pulled it together with butterfly closures and it healed quite well. But you know, it really probably should have had stitches and perhaps if we had had stitches it might have gone down a different track, because someone else might have picked up on it and alerted and said, hey look I think this needs to be treated more seriously. But because there wasn't any medical intervention at that point, maybe that was a missing link. Who knows? (Jo, Adelaide 2005)

The potential seriousness of the issue of deliberate self harm, including behaviours such as cutting or burning, may also be underestimated in primary health care and community settings. Such behaviours should alert health workers and other people to the possibility of risk of suicide.

5. SPECIAL POPULATION GROUPS

Awareness of particular population groups is an important consideration in managing people who are suicidal. What is required is the ability to avoid generalisations or assumptions about people based on particular identifiers – and, at the same time, to be open to the possibility of particular vulnerabilities that an individual may have, because of their social location. This process is explored in the [Diversity discussion paper](#).

In Australia, the suicide rate among males aged 15 to 24 years is among the highest in western industrialised countries. There is also a suicide problem in some small rural towns. This data, in terms of management and awareness of risk, should not serve to cloud the fact that women attempt suicide more often than do men.

Indigenous Australians have a suicide rate estimated to be up to 40% higher than the general population. The rates are not distributed evenly across communities and much of the related research points to the consequences of colonisation, namely, despair and social disadvantage, as being linked to these high rates. In consultation for this resource Professor Lowitja O'Donoghue commented:

The figures speak for themselves. Many Aboriginal people have been so traumatised by their circumstances that they can't see a positive future. It's important to understand this in broad social and historical ways. I have known people who have been given a tag [diagnosis] and it just becomes one more whitefella label to live with.

It's important for health workers to be responsive to Indigenous people – don't become paralysed because issues feel too hard or too confronting. Be respectful, open and look for options that are relevant to the person's life – even if it is a life you don't know much about. Also remember that your working environment may feel very alienating – think about ways to make it welcoming.

The topic of Aboriginal suicide, including the range of meanings that it has for Indigenous people, is discussed by Colin Tatz (2001). In the Introduction to his book, Tatz says that 'Suicide is suicide, but Aboriginal suicide is different'. It is true that an understanding of suicide within Aboriginal communities is a whole topic in itself and one that needs urgent, focused attention.

It is also important to note that people may affiliate with more than one population group. Sexuality issues may add to a person's vulnerability because of the stigma and social rejection that can accompany them. At the same time, a 'gay' person may also be part of other group/s that have been identified as being at increased risk from a demographic point of view. For example:

- War veterans
- Immigrants
- Older adults
- Prisoners.

In all of the groups mentioned above it is significant that social attitudes towards that 'category' are often hostile or dismissive. Certainly people with a disability often report that attitudes toward their disability are as constraining as the disability itself.

It is not safe to make the assumption that a person who affiliates with any of the groups mentioned will be at risk, because there are too many other variables to take into account. However, it is sensible to think about the additional pressures that may affect any given individual, especially when compounding issues such as chronic ill health or substance use, are present.



(See also the video by Jill Chapman on [the importance of postvention](#) or go to the [Postvention booklet](#).)

It is estimated that each year around 10,000 people in Australia experience the death of a loved one through suicide, and are often severely affected by grief. Other more distant relatives, friends, colleagues, and sometimes strangers, may also be strongly affected. Most full time GPs will encounter a suicide every 4 to 5 years, and this number will be greater if the GP has a special interest in mental health issues. 'At any one time a GP's practice is likely to include 4 or 5 patients bereaved through suicide' (Martin *et al.*, 1997, p.50).

Effective support for people bereaved through suicide – what is often called postvention – is therefore an important element of suicide management. The after-effects of suicide for the survivors are usually complicated and especially traumatic and those grieving may have special health service needs, including mental health support. Postvention is seen as suicide prevention for the next generation.

The [Overview discussion paper](#) summarises some of the reasons why it is important to pay attention to suicide bereavement and the complicated array of emotions a suicide may elicit, including shock, horror, guilt, shame, regret, anger, loss of faith. (See also the [Postvention booklet](#).) The grief following a suicide may in turn be associated with depression, suicidal ideation and behaviour, substance abuse and family breakdown.

Postvention activities around Australia broadly focus on:

- enhancing and coordinating access to mainstream services and support mechanisms
- building the capacity of health, welfare and education workers and communities to initiate and facilitate suicide postvention interventions, and
- providing a range of direct interventions and resources for those bereaved by suicide. [National Advisory Council on Suicide Prevention, 2004].

Information and practical advice on supporting those bereaved by suicide can be downloaded from the Grieflink website www.grieflink.asn.au

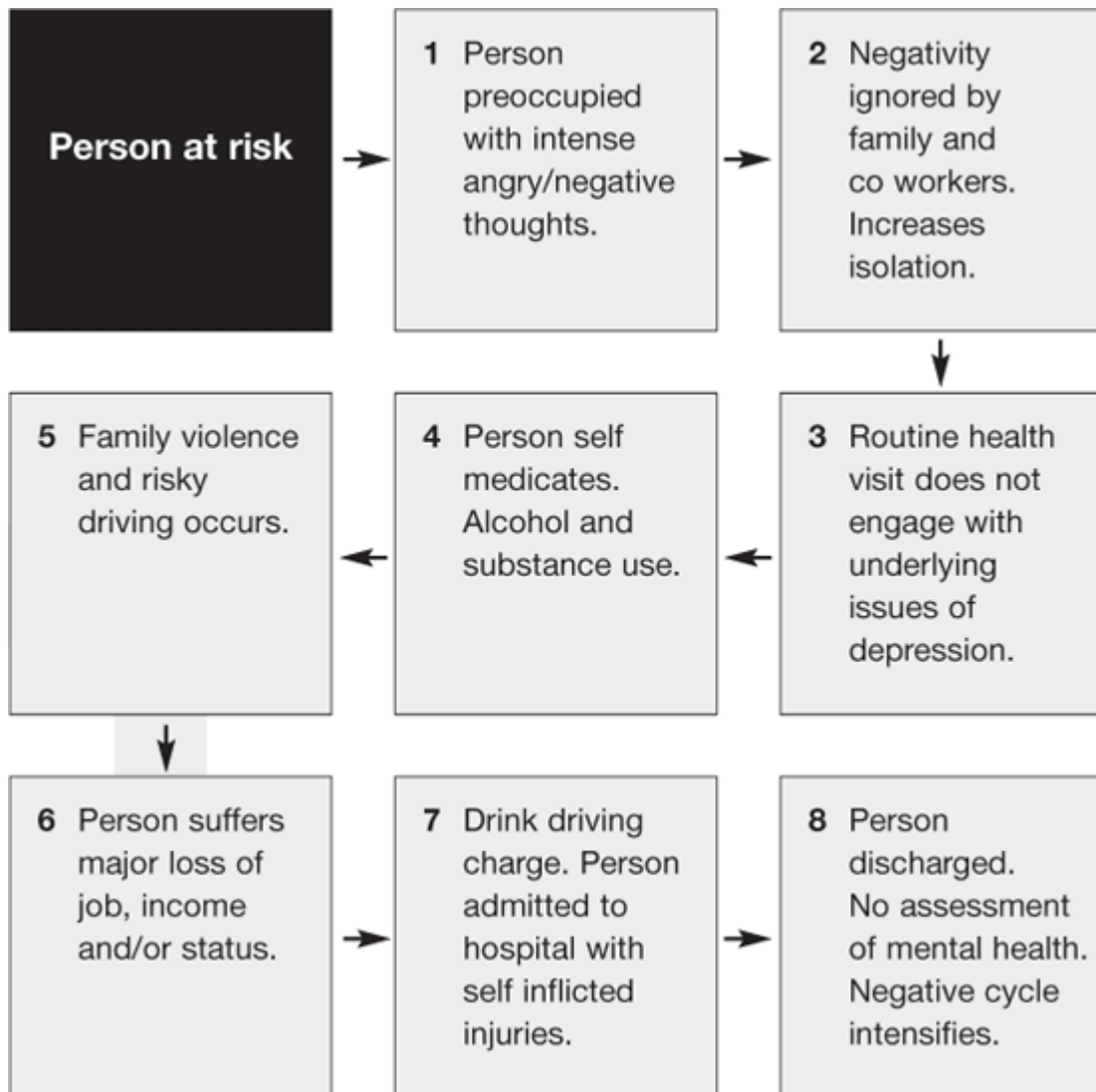
In South Australia people can contact the Bereaved Through Suicide Support Group on 8332 8240 from 8 am~8 pm or email support@bts.org.au. The facilitator of the group, Jill Chapman, talks in this video about [the importance of postvention](#).

WHAT WORKS AND WHAT DOESN'T

This paper has provided a brief overview of some of the management issues involved in suicide prevention. Other discussion papers available in **square** address more thoroughly various specific components of management – such as [engagement](#), [risk assessment](#), [legal issues](#) and the [collaborative practice model of management, referral and follow up](#) – suggesting specific strategies for dealing with these.

In this final section we provide and discuss two scenarios – one where the system has worked and the other where the system has failed – and tease out some of the management issues at stake in these.

Firstly let us examine the following scenario of a negative cycle of events which results in deliberate self harm, when not interrupted. (There are, of course, hundreds of possible scenarios with different contributing factors which could have been chosen).



Taking each point one by one, it is possible to identify interventions which could possibly have interrupted this negative cycle. This is not to imply, of course, that self harm and suicide are always preventable. As discussed earlier, it is not always possible to predict suicide, and neither is it always possible to change a person's attitudes and/or patterns of behaviour. This particular scenario of Mike does not, for example, address the possibility of genetically or biologically determined mental illness or disorder. It is offered for illustrative purposes only, to highlight possible points of intervention in the management of suicide.

Point 1:

Mike preoccupied with intense angry/negative thoughts.

Although it is sometimes obvious when someone is preoccupied in this way it can also be the case that an individual may mask such feelings. Some may even go out of their way to appear 'normal'.

Point 2:

Mike's negativity ignored by family and co-workers.

In our immediate work, social and family contexts, each of us may at some time encounter an individual whose negativity is concerning. This may manifest as very low self esteem, expressions of hopelessness about the future, or sometimes as extreme anger. It can sometimes be difficult to respond positively to such individuals and an understandable response may be to withdraw, thus potentially increasing the individual's negativity and heightening their sense of social isolation. An expression of concern, encouragement to talk (without insisting), the willingness to listen empathically, and support to seek professional help, may be enormously beneficial.

Remember: Even a simple interaction like listening can be significant – everyone can make a difference.

Point 3:

Routine health visit does not engage with underlying issues of depression.

Patients suffering from depression may not present this as their problem when they visit their GP. They may instead speak of tiredness, lethargy, insomnia, headaches or other physical ailment. Some patients may feel that there is a stigma attached to mental illness and may not wish to name what they are feeling as depression. In addition the patient may have presented regularly for certain prescriptions or physical checks without underlying mental health issues ever being raised, e.g. stress.

Point 4:

Mike self medicates with alcohol and substance use.

Social and recreational drug use is common in our society. Some people use them as a way of dulling pain or in an attempt to lift their mood, and this use can be hazardous.

Point 5:

Family violence and risky driving occurs.

Not everyone who engages in speeding or drink driving is at risk of suicide, although they may be at risk of death or harm. However, these may also be forms of self harming behaviour which are early warning sign for suicide risk. It is believed that many motor vehicle deaths could have been intentional. Both risky driving and family violence are behaviours which can be seen as out of control and a danger to human life.

Point 6:

Person suffers major loss, e.g. partner, job and/or status.

If a person is out of control in the ways mentioned above, they are less likely to be resilient when life crises occur. It could even be argued that the behaviours they are engaging in could precipitate a life crisis. Let's assume for example that Mike loses his job. Status and money become pressing concerns. His sense of social isolation may be exacerbated.

Point 7:

Violence escalates. Police and emergency involvement.

Mike becomes more desperate, and becomes more violent when his wife refuses to reconcile. The family feels the need to call the police and an Apprehended Violence Order is obtained. Nobody to this point has offered any information to Mike about possible support options, e.g. anger management, men's groups, counselling re loss of job.

Point 8:

Drink driving charge. Mike admitted to hospital with self inflicted injuries.

After a drinking session Mike gets involved in a road rage incident and then deliberately smashes into another car. Although he says 'I'd be better off dead' to an attending health worker, this is not followed up.

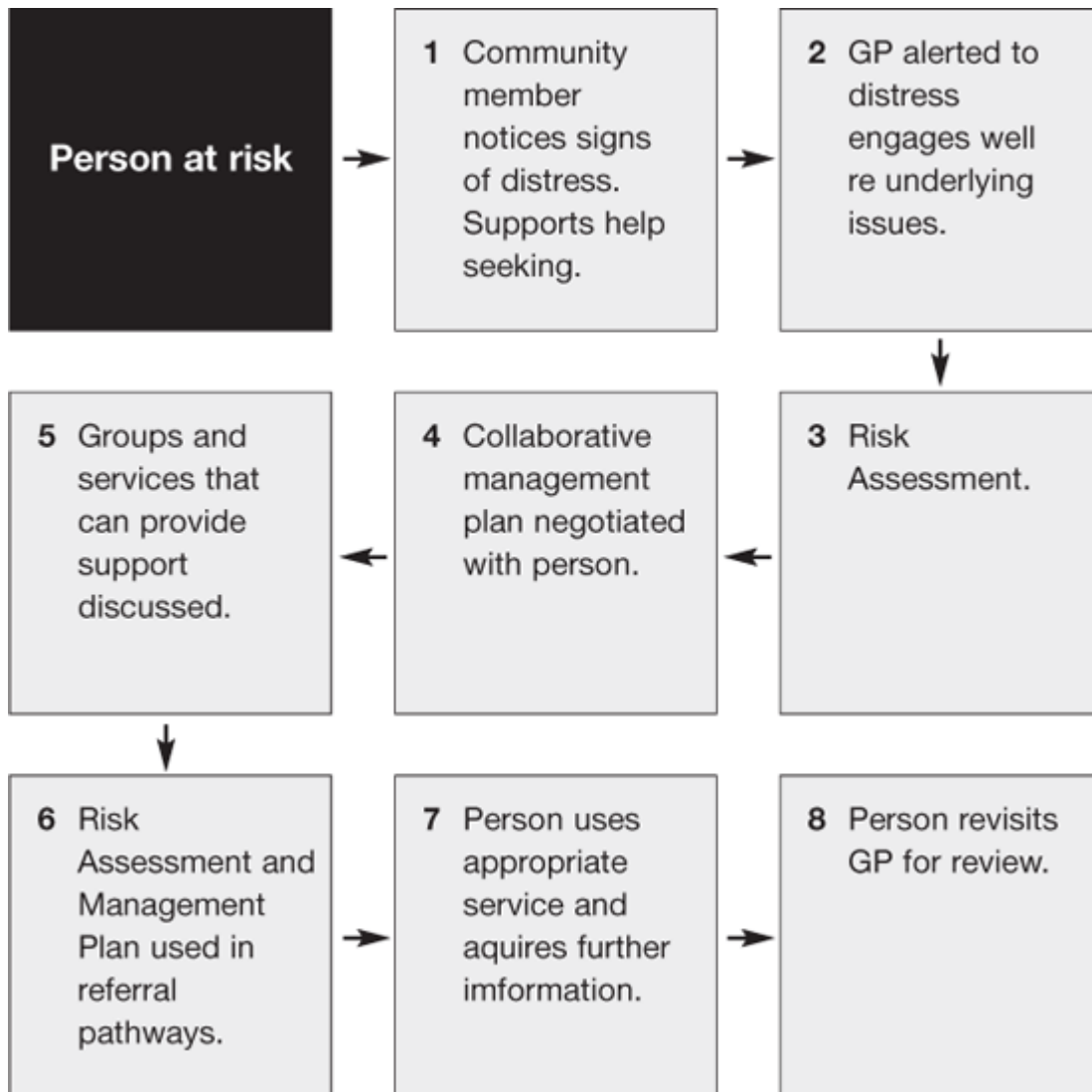
Point 9:

Mike discharged. No assessment of mental health. Negative cycle intensifies.

Although the hospital has attended appropriately to Mike's physical injuries, there has been no attention paid to his mental or emotional state. The obvious deliberateness of his car crash (as reported by a witness at the scene and relayed by the ambulance driver) is ignored by everyone. His intoxication is not addressed as a problem for him but is seen entirely in terms of its legal ramifications.

WHEN THE SYSTEM WORKS. CASE STUDY: TANIA

Below is another scenario which illustrates how appropriate interventions and a shared care pathway are set in place to assist Tania, a person of low/medium risk of suicide. You may want to consider whether these principles are equally applicable in a high risk or acute scenario? If not, what additional or alternative interventions might be necessary?



Point 1:

Community member notices signs of distress. Supports help-seeking.

Tania, a 24 year old woman has a workmate who notices that Tania is unresponsive to any social invitations and that she seems withdrawn, anxious and sometimes unable to handle ordinary ‘ups and downs’ in the workplace. When she asks Tania if there is a problem about going out socially, Tania cries uncontrollably and says she ‘just can’t cope’. The workmate suggests a very responsive GP whom Tania might like to see, and offers to make the appointment.

Point 2:

GP alerted to distress. Engages well re underlying issues.

The GP is open and empathic, and without pressing, encourages Tania to talk about her concerns. During this conversation Tania is able to 'externalise' some of her experiences of shyness and loneliness. The GP takes her distress very seriously.

Points 3 & 4:

Childhood abuse disclosed. Risk assessed. Options discussed. Information given re groups & services. Crisis contact details given.

In telling her story Tania discloses (for the first time) that a possible reason for her extreme shyness and vulnerability is that she was sexually abused by her step-father. The GP conveys that Tania is believed and that this is a serious matter. At an appropriate moment during the conversation the GP asks Tania whether she has had any thoughts of harming herself and ascertains that, although the idea has gone through her head, Tania has no thoughts or plans of acting on these ideas. The GP discusses some support options including brochures, online information and a counselling service specifically designated for survivors of childhood sexual abuse. The GP also gives her a phone number to ring should she need crisis help, and establishes who Tania feels safe and comfortable with. The GP makes a follow-up appointment in ten days.

Points 5 & 6:

Collaborative management plan negotiated. Confidentiality issue discussed. Documentation is effectively used for person's care pathway.

It is agreed between the GP and Tania that the GP may contact the counselling service to request an early appointment and may reveal some of the issues that Tania is dealing with. The GP negotiates an initial management plan and referral in collaboration with Tania's friend (with her consent) and a member of the counselling service. At her request nobody in her family is informed and neither are the police.

Point 7:

Person uses appropriate service and accesses more information.

The counselling service takes Tania's experiences seriously and assists her to work through the issues and her feelings. She is given some appointments for face to face counselling and the opportunity to join a group in her area with people who have had similar experiences.

Points 8 & 9:

Person revisits GP after an appropriate interval for review. GP reviews issues. Seeks advice from relevant service and team.

The GP is prepared for this visit and remembers the presenting issues and Tania's emotional state at their first meeting, and is aware of where they were up to in terms of recommended options, i.e. Tania being given appropriate information about support services. The GP re-assesses progress and suicide risk. On hearing that the counselling service has been extremely helpful and supportive, in dealing with the sexual abuse issues for the first time, the GP also checks how confident Tania is currently feeling about social interactions. They mutually agree that an outing with her workmate would be a positive thing to arrange. They agree to make another appointment for review in a month's time, or earlier if needed.

(See also the video by Dr Tori Wade on [management and referral of people at risk of suicide](#).)

REFERENCES

- Commonwealth Department of Health and Ageing (2003). *Familiarisation Training GP and Practice Manual. Better Outcomes in Mental Health Care Initiative*. www.adgp.com.au/client_images/24395.pdf
- Government of WA (2001). Report No 11 to Parliament, *LIFE Matters: Deliberate self harm in young people*. www.audit.wa.gov.au/reports/report2001_11.html
- HREOC (2005) *Not for Service Report 2005* www.mhca.org.au/notforservice/report/exec.html
- Hughes, V. (2005). Mental health – it's time for a new paradigm. *ON LINE opinion*, 10 October 2005, www.onlineopinion.com.au/view.asp?article=82
- Martin, G., Clark, S., Beckinsale, P., Stacey, K. & Skene, C. (1997). *Keep Yourself Alive: Prevention of suicide in young people – A manual for health professionals*. Adelaide: Foundation Studios.
- Morgan, Paul (2005). *Stigmatising mental illness: Our 'heart of darkness'*. ON Line opinion, 24th Oct 2005. www.onlineopinion.com.au/view.asp?article=3828
- Myhill, K. & Tobin, M. (2001). *Mental Health First Aid for South Australians*. Government of South Australia.
- National Advisory Council on Suicide Prevention (2004). *National Planning Forum*, Theme Paper: People bereaved by suicide.
- National Prescribing Service (NPS) (2005a). Newsletter 42, *Managing depression in primary care*.
- National Prescribing Service (NPS) (2005b). Prescribing Practice Review (PPR) 32, *Managing depression in primary care*.
- Simon, R.I. (2000). Taking the 'sue' out of suicide: A forensic psychiatrist's perspective. *Psychiatric Annals*, 30, pp. 399-407.
- Tatz, C. (2001). *Aboriginal suicide is different: A portrait of life and self destruction*. Canberra: Aboriginal Studies Press.
- World Health Organization (WHO) (2000). *Management of Mental Disorders, Vol 1* (3rd edition). World Health Organization Collaborating Centre for Mental Health and Substance Abuse, Treatment Protocol Project.