

foundations for effective practice



square

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

ERISUPPS

square suicide **questions** **answers** **resources**

foundations for effective practice

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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.

acknowledgements

This project has been developed through the efforts of a great many people over three phases. They included staff from SA Divisions of General Practice, The Department of Health, Mental Health and Hospital Services, The Department of Health and Ageing, and consumers. Following Phase One, SA Divisions of General Practice Inc (SADI) contracted Relationships Australia South Australia (RASA) to write the curriculum for the education and training and content for the final **square** package.

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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.

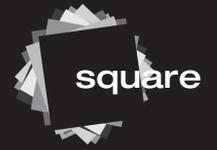
- A** The first layer is the **Desk Guide**, a quick reference providing key information, tools, guidelines and questions.
- B** The second layer is a series of **9 booklets**
- 1 Foundations for effective practice**
 - 2 Community setting**
 - 3 Primary health care setting**
 - 4 In-patient setting**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

This booklet, **Foundations for effective practice**, is aimed at primary health care workers, community health workers, allied health workers, Indigenous health workers and community members who may encounter people at risk of suicide in their professional roles or daily life. It provides the foundations for the specific service setting booklets.

- 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:
- Six discussion papers
 - An annotated resource list, including print and website links
 - A glossary
 - Seven video clips, including risk assessment interviews with 'clients', a presentation from a carer's perspective, a presentation regarding management and referral, an interview on pharmacology, and an interview with a young woman who had attempted suicide
 - Several forms (e.g. risk assessment and referral forms) and a collaborative management plan
 - PDF files of all the **square** print materials: the Booklets and Desk Guide.



section 1 | **overview**



overview: at a glance...



See also the *Overview* and *Current Issues* papers on the **square** CD-ROM/Website www.square.org.au.

Statistics

- Suicide is a major public health problem. In 2005 about 2100 Australians took their own lives – more than the number of deaths from road accidents, industrial accidents and homicides, together.
- The actual number of suicides is likely to be higher than this, due to under-reporting. There are also many more people who harm themselves or attempt suicide.
- Males kill themselves more often than females, but there is a higher level of attempted suicide and self harm among women.

Principles of suicide prevention and management

- Effective response requires an awareness of social, cultural, and biomedical factors.
- Listening well and engaging effectively is the single most important therapeutic response.
- Risk assessment for suicidal thoughts and plans is essential for people with mental illness or where other risk factors are present.
- Asking specific questions about suicidal thinking will not increase the likelihood of suicide.
- There are a range of options and people who can be involved in the management of a potentially suicidal person.
- Practitioner self care is vital for working effectively with people with mental health problems.
- Postvention – providing counselling and support for people bereaved through suicide – is a crucial element of suicide prevention.

Risk Factors

- Suicide is a complex problem involving a number of compounding factors.
- Mental illness, particularly depression, is the most important risk factor, especially where drug or alcohol misuse is also involved.
- Social disadvantage – poverty, unemployment, homelessness – has an effect on suicide rates.
- Other contributing factors include: major losses (including bereavement through the suicide of a loved one), concerns about sexual identity, financial problems, impending legal issues, social isolation, sexual abuse (in childhood or as an adult), domestic violence, post-war trauma and chronic ill health.

Protective factors

- These are factors that minimize an individual's risk. They include:
 - early detection and management of mental health problems
 - connectedness to friends, family, workplace
 - a sense of meaning in life
 - economic security.

Some contemporary issues

- The Internet can be a useful resource for help seeking. There are also sites that may encourage suicide by providing information about lethal means or by romanticising the suicides of celebrities.
- Hazardous use of alcohol or other drugs can contribute to suicide risk.
- Many people have experienced domestic violence or sexual abuse. This is often not disclosed. Such abuse may contribute to feelings of despair and the possibility of self harm.
- Risky behaviours such as dangerous driving may be an early warning sign for suicide risk.

Diversity

- Responding to people in culturally appropriate ways is important. It involves being open to a range of factors that contribute to identity, e.g. gender, sexuality, age, ethnicity, and social and economic position.
- Being culturally appropriate means respecting differences and being open to understanding experiences and the meanings people give to them.
- Avoid stereotypical judgements and perpetuating the social stigma that some people experience.
- Be aware that the 'culture' of medical environments can be very intimidating for some people.

Myths about suicide

- A common myth is that suicide attempts are 'acting out', attention seeking or 'just' cries for help.
- The fact is that many people who attempt suicide, later go on to complete it. The attempt could be a rehearsal and the cry for help could indicate profound despair.

Legal issues

- Health care workers have a duty of care to the people they treat. This means taking steps to ensure that their clients do not come to foreseeable harm due to their actions or their failure to act.

Assessment and management of risk

- The judgement about risk level is a professional one, often made in the first instance by GPs.
- There are guidelines, flow charts, and specific questions that may assist in arriving at an accurate assessment.
- There is also a range of services and support options for the management of a person at risk.
- Referral should not be 'one way' only. It is important to stay involved in care and to follow up.

Postvention

- Providing support for people who are bereaved by suicide is a necessary part of suicide prevention and response.
- People bereaved by suicide may themselves be at risk. Postvention support or counselling can therefore be a form of suicide prevention.
- There are particular issues involved for people in this area of grief – such as self blame, stigma or a loss of trust in themselves.



Why square has been developed

Suicide is a major public health problem in Australia. Approximately 2100 Australians were reported as taking their own lives in 2005 (Australian Bureau of Statistics, 2007), **more than the number of deaths from road accidents, industrial accidents and homicides, together.** However, the actual number of suicides is likely to be greater than this, due to under-reporting. Furthermore, there are many more Australians who harm themselves or attempt suicide.

While people from all walks of life may be suicidal, there are certain population groups who are statistically most at risk of dying from suicide. These include young males (30-34 years), older men, Indigenous young men and rural residents. Other at-risk groups include: people experiencing a mental illness; people who have experienced childhood sexual abuse; and people who have experienced domestic violence (the vast majority of whom are women). It should also be noted that while males kill themselves more often than women, there is a higher level of attempted suicide and self harm among women.

Suicide is costly to communities, both economically and socially. Many people are affected by an individual's suicidal behaviour, with significant loss, pain and grief suffered by family, friends and the community – distress which cannot be quantified in economic terms.

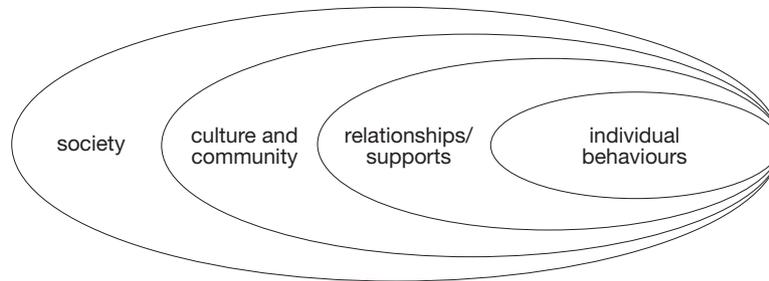
square has been developed in recognition that an active approach to suicide prevention is the best strategy for dealing with this significant public health problem. Successful interventions can be made by family members, friends, neighbours, community workers, GPs and other primary health care workers and mental health specialists.

Suicide is everybody's business. An effective and active approach to suicide prevention means that both community members, primary health care workers and specialists need to **notice** when people they interact with are at risk.

This **Foundations booklet** aims to provide information about suicide and to encourage the reflective thinking that will assist you in noticing the signs of risk. In addressing a broad audience of community members, community workers, primary health care workers and mental health specialists, it acknowledges that suicide prevention is a whole of community responsibility and that the best interventions will be collaborative responses. It aims to foster a culture in which further progress can be advanced.

Foundation principles

In understanding suicidal behaviours and thoughts it is essential to adopt a broad approach which takes into account social and cultural factors as well as biological and medical factors. It is important to acknowledge that individual behaviours are determined in a complex interaction between 'the person, their mental state, their support network, their culture and their society' (Australian Government's LIFE Framework, 2000. p.3).



Explaining suicidal behaviour

...under adverse social conditions, when individuals' social contexts fail to provide them with the requisite sources of attachment and/or regulation at the appropriate level of intensity, then psychological ...health is impaired, and a certain number of vulnerable, suicide-prone individuals respond by committing suicide [Hassan, 1995, p. 3].

Suicide is confronting, and especially so for a person who is in a relationship of care and/or responsibility. There is the immediate issue of what to do – and that is a complex question in its own right. There is also the added difficulty of being exposed to the pain and hopelessness of a fellow human being.

Suicidal ideation and behaviour cannot simply be thought of as a medical illness. It challenges health workers and carers to engage empathically with complex psychosocial issues and to be open to understanding some of the deepest meanings people have about their life (and potential death).

- **Mental health problems** are common. A GP is likely to have 20% or more of consultations relating to anxiety or depression (and some instances may not be recognised). However, the National Survey of Mental Health and Wellbeing (1999) found that **only 60% of people with depressive disorders receive professional help.**
- **Depression** has risen from the tenth most common problem managed by Australian GPs in the year 1990-91 to the fourth most prevalent in 1998-99.
- **Anyone can be at risk** of suicide at certain times in their life.

The importance of social and cultural factors

There are some groups of people in Australia who may feel, at times, especially marginalised from the dominant culture. For example, many Indigenous Australians are experiencing social and economic disadvantage which may heighten their risk of suicide. Discrimination may lead to feelings of inadequacy or futility. A lack of culturally appropriate support may result in people having nowhere to turn in times of crisis.

- Social inequities such as unequal access to education, health care and community support have an effect on suicide rates.
- Some marginalised people (e.g. some refugees) are suffering from post traumatic stress which may mask the symptoms of mental illness and suicidal ideation.
- Reconnecting people to one another and challenging ways in which social systems may fail individual people are therefore integral parts of an ethical framework for suicide prevention.
- Prevention initiatives are most effective when they take into account the diversity of cultural attitudes and beliefs.

Diane, a consumer interviewed for this resource, commented on the value of community support in this way:

Because what you're actually teaching people is new strategies. And I think what happened with me was I actually taught myself those. I got hold of some books and I read them and then I started running a group for people who have got depression, because there were no resources in the western suburbs. And so my minister and I decided that we would set something up....To try and give people with depression somewhere to go where they had supports, but which had a function of not allowing people to live within their illness.... I didn't feel that I wanted it to be a place for people who go in and say 'I'm depressed so I can't do this'. I actually wanted to use it as a resource to get people to come in and have expertise that would enable people with depression to have some ways of starting to live again. [Diane, 2005]

Causes

There is no single cause of suicide. It is a complex problem with many contributing factors. Risk factors may be genetic, biological, psychological, social, cultural, or environmental. They may be ongoing, such as chronic physical or mental illness, or shorter term, such as experiencing a significant loss.

Some explanations of suicide focus on individual psychological characteristics or genetically determined factors. Others focus more on social and cultural factors. The best explanations are likely to be based on information derived from several perspectives.

...the evidence strongly suggests that suicidal behaviour is not simply a response to single stress but related to complex and compounding vulnerabilities... Our best understanding suggests that suicide is the tragic outcome of a build-up of stresses and risk factors in a person with relatively few protective factors and whose resilience, perhaps, is poor [LIFE Framework, Towards an Understanding of Suicide, 2000, p. 4].

Nonetheless, there are some risk factors that will make it more likely that an individual might contemplate or attempt suicide. There are also some protective factors which enable people to be resilient in the face of adverse situations.

Risk factors

Mental illness (particularly depression) is the most important risk factor for suicide, especially where alcohol or other drug misuse is involved (World Health Organization, 2006). A sense of hopelessness is common among people who contemplate suicide. One estimate is that up to 90% of people who suicide have a mental disorder (World Health Organization, 2006). People who have previously attempted suicide are particularly at risk, as are people in prison. Almost 900 asylum seekers tried to deliberately harm themselves while in Australian Immigration detention centres between 2002 and 2005 (reported in The Age, 19 September, 2005).

Other contributing risk factors include:

- Childhood abuse, either physical or sexual
- Poor parent-child relationships
- Physical illness
- Concerns about sexuality
- Major losses, including loss of employment, health, marriage/relationship, death of significant others
- Socioeconomic disadvantage, including low education achievement, unemployment, homelessness
- Financial problems
- Impending legal prosecution or child custody issues
- Social isolation, lack of a social support network and difficulty accessing help
- Alcohol or drug misuse
- Ease of access to lethal means of suicide (e.g. a gun) is also an important factor in suicidal thoughts being enacted
- Environmental factors (e.g. drought).

Protective factors

There are a number of factors which can provide people with the resilience to cope with stress or act as buffers against adverse life events and consequent risk of harm. These protective factors may be individual, or derived from families, friends and community networks.

Protective factors include:

- Connectedness to family, workplace or school
- Responsibility for children
- Presence of a significant other
- Personal resilience and problem-solving skills
- Good physical and mental health
- Economic security in older age
- Strong spiritual/religious beliefs or sense of meaning in life
- Community and social integration
- Early identification/treatment of mental illness
- Belief that suicide is wrong.

Suicide rates are considered by some analysts to be a measure of a society's social cohesion. The implication of this is that suicide prevention strategies must target particular at-risk groups through public health interventions that improve levels of social support.

Many broadly based social programs – for example programs that address violence or crime prevention, substance misuse, or depression – will also be useful in helping to prevent suicide.

I think I probably had a tendency to depression because we migrated here when I was about eight. My mother didn't really adjust that well to migrating and I think she was probably quite depressed, like when I was growing up. So I think there were factors that maybe might have made me predisposed towards not having terribly good coping mechanisms and ways of dealing with things. [Diane, 2005]

Myths and facts about suicide

Myth	Fact
Suicidal people want to die.	People who have attempted suicide often say they wanted to end their pain. Most people are ambivalent and often fluctuate between wanting to live and wanting to die. Some people, especially young males, often indulge in risky behaviours that could result in death, and may appear indifferent to this potential.
If you ask about suicidal intent you could encourage a suicide.	Not true. In fact your concern is likely to lower anxiety and reduce the likelihood.
People who talk about killing themselves rarely suicide.	Most people who suicide have given some signal of their intention.
People who talk about suicide when under the influence of alcohol or drugs do not need to be taken seriously.	Anyone who talks about suicide should be taken seriously. Alcohol and other drugs are involved in many suicides.
Suicidal people rarely seek medical help.	Most suicidal people visit a GP in the days, weeks or months before they attempt suicide.
Suicidal attempts are just attention-seeking, 'cries for help' or 'acting out'.	Many people who attempt suicide go on to complete it, sometimes much later. The attempt may be a rehearsal. Also, a suicidal attempt may well be a cry for help from someone in profound distress, and this should not be ignored.
Suicide is an extremely rare occurrence.	Suicide statistics are likely to be an under-estimate of the real number. There are also many more people who harm themselves or attempt suicide.
Suicide only affects certain sorts of people.	Anyone may be vulnerable when confronting difficult circumstances or when experiencing feelings of depression or hopelessness.
When someone seems to be suicidal, someone else is probably taking care of it. It is not my business to interfere.	Suicide is a community responsibility. Any concerned person can make a difference. Many distraught people do not have networks of support.
If someone talks about their suicidal intent, for confidentiality reasons you must honour this confidence.	You have a duty of care to ensure safety if you believe that the person presents an immediate risk to themselves or others. Ideally, you should always try and seek permission from the client to inform or involve relevant others.

Contemporary issues

The media and Internet

New forms of communication and relationships offered by the Internet and the increasingly explicit coverage of suicide in the media, are trends which can affect suicide rates and exacerbate distress to the bereaved.

Those at risk of suicide may use the Internet to:

- Gain information about effective suicide means
- Feel supported in their decision to suicide
- Formulate and share suicide plans/pacts.

On the other hand, the media and the Internet can also assist help-seeking and raise awareness of suicide prevalence and risk assessment. There are many excellent mental health websites – see **Resources section**.

Alcohol and drug use

The hazardous use of alcohol and other drugs may be the result of a complex set of life circumstances and may constitute a risk for suicide. Drugs and alcohol may:

- Destabilise a person's sense of hope or social value
- Promote depression leading to impulsive behaviour
- Exacerbate other problems such as mental illness or domestic violence
- Interact with each other and thus cause non-intentional but potentially lethal overdoses.

The use of illicit party drugs such as cannabis, ecstasy and amphetamines has been shown to be associated with mental illness, suicidal ideation and suicide, especially among young people. A Western Australian study (see <http://www.mcsp.org.au/docs/WADrugs.pdf>) on youth suicide in the period 1986 - 1998 found that 30% of young people who died by suicide during this period had illicit drugs in their toxicology analysis. The most common substance detected was cannabis, followed by stimulants and opiates. Alcohol was also frequently present, alone or together with illicit drugs.

It is therefore essential that primary health care workers and specialists include assessments for drug and alcohol use in their suicide risk assessment.

Domestic violence and sexual abuse

There has been growing recognition of the prevalence of domestic violence and high rates of sexual abuse (both adult and child rape). When assessing risk, health practitioners should note that those primarily at risk within the context of domestic violence and sexual abuse are women, who may also be at risk of suicide or self harm. People who have experienced violence and abuse may have feelings of despair or hopelessness. People who use violence may also be at risk both for suicide and murder-suicide, for example after a relationship ends or they lose custody of children.

Practitioners must be informed about appropriate referrals to support services to ensure that people experiencing domestic violence are afforded the opportunity to access help as required.

Risky behaviours

Engagement in risky behaviours may constitute an early warning sign for suicide risk. High risk behaviours might include binge drinking, dangerous driving, unprotected sex or 'playing chicken' with cars or trains. Historically, while many of these behaviours have been engaged in by young men, there is growing evidence of young women and adults 25 years and over, engaging in risky behaviours, especially binge drinking.

Such behaviours are therefore an important site for intervention for primary health care workers and specialists who may be able to identify them in a clinical setting.

Legal issues

Duty of care

Health workers have a duty of care to the people they treat. This means that they must take steps to ensure that the people they care for do not come to foreseeable harm by their actions or their failure to act.

Health workers are expected to be up to date with current duty of care protocols and practices and to take reasonable care in undertaking their duties. If a health worker fails to adopt and use the standard of care and skills that a court would reasonably expect from someone with professional skills, appropriate training and experience, they may be found guilty of negligence.

Negligence

If a health worker fails to use the standard of care and skills that a court would reasonably expect in the circumstances from someone with their professional skills, training and experience, they may be found guilty of negligence. For a health worker to be found negligent, the patient (or representative) must demonstrate that they have suffered an injury or loss and that the health worker caused the loss/injury because of a failure to take reasonable care in the circumstances.

Liability

Foreseeability and preventability

There are a number of key elements that may result in litigation in regards to suicide. These include negligence by commission (doing something that shouldn't have been done), and negligence by omission (not doing something that should have been done). Some examples of these include:

- Failure to adequately predict suicide risk
- Failure to control, supervise or constrain
- Failure to take proper tests and evaluations of the patient to establish suicidal intent
- Failure to treat appropriately (see Packman et al., 2004, p. 700).

The health care worker must ensure that an appropriate risk assessment is undertaken, and that such assessments are regularly updated and monitored (Simon, 2000). While risk assessments cannot infallibly predict suicide risk, it is important that practitioners regularly assess suicide risk and that this risk is addressed with appropriate intervention.

At the same time, however, foreseeability does not equate with preventability (Simon, 2000). An individual will most likely not have a case against a practitioner who took all possible steps to assess risk and engage in prevention, but the end result was still death by suicide.

Legal action may occur when a practitioner fails to intervene when suicide means and plans are known. Occasionally when a practitioner's grossly harmful actions lead a client to suicide there may be an important legal liability issue.

Assessing and documenting risks

Risk assessment also requires an assessment of potential risks that the client may not be aware of. Thus, as Simon (2000) suggests:

...it is a serious clinical error to equate the absence of suicide risk with a patient's denial of suicidal ideation, even if the patient is telling the truth. A patient may be at high risk for suicide because of the presence of other significant suicide factors (p.401).

Risk documentation

The literature on litigation and suicide suggests that it is of key importance that health workers adequately document their actions and choices in regards to suicide risk. In addition to adequate documentation, it is important that practitioners:

- Consult with colleagues to ensure the validity of decisions. (Various support is available for GPs in this regard, including peer support groups and access to one-off psychiatric assessments within 24 hours)
- Know their legal and ethical responsibilities
- Are adequately aware of risk factors for clients
- Obtain previous risk assessment data or conduct risk assessments
- Honestly determine their own competencies in regards to suicide risk assessment and, if necessary, seek further training
- Consult with family members, carers and significant others.

While such actions will not always fully protect health care workers from litigation, they will certainly ensure that a high standard of care is provided, and that such care is well documented and maintained.

Confidentiality

Information about a client or patient should not be given to anyone else without the person's permission. A disclosure in the absence of a strong belief that the client presents an immediate risk, to themselves or others, potentially creates a situation in which the therapist could be sued by the client for breach of confidentiality. On the other hand, failure to disclose where there is a strong belief that the client presents an immediate risk to themselves or others, and if the client subsequently takes his/her own life or hurts another, may lead to practitioners having to defend themselves against the accusation of failure in their duty of care.

Ideally, practitioners will be able to discuss with the person, confidentiality and duty of care issues that may arise when information needs to be provided to other agencies requiring a patient history. It is also advisable that practitioners document (in relevant electronic or hard copy file records) conversations regarding confidentiality and release of information. In this way practitioners would be able to avoid this potential legal dilemma.

A GP, consulted for this resource, explained some of the complexities surrounding confidentiality:

It's really difficult to judge when to break confidentiality. First of all, I feel really strongly compelled to keep it, not only because it's in our own professional ethics, but also because it's about maintaining the trust between patient and GP. Once that trust is gone, the person usually doesn't come back, and I worry about what is happening to them, and whether or not they are getting adequate care somewhere else, or if they have withdrawn from the system.

But on the other hand, we also have a duty to protect life and health when there is an immediate risk. Ideally, it's important to discuss these issues at the start, so that the patient knows that you will do everything possible to keep confidentiality, but there are certain circumstances where this won't hold. But sometimes the topic of suicide comes up really quickly, or unexpectedly, then you haven't had time to discuss it and you just have to do the best you can at the time.

Consent

In relation to treatment, consent means informed consent – Mental Health Act 1993 (SA) s3. For consent to be informed, the person needs information that enables him or her to understand the procedure or treatment, the consequences of not having or agreeing to the treatment and also alternative treatments. The person must also be deemed well enough to be able to give informed consent.

A person at risk of suicide can consent to voluntary admission in an approved treatment centre dictated under the Mental Health Act. A person may also be made subject to an order for detention under the Mental Health Act 1993 (South Australia) Section 11. A registered medical practitioner may detain a patient. A Detention Order activates a comprehensive psychiatric treatment program including a series of detailed reviews of the patient and the need for ongoing detention.

Detention

Orders for admission and detention can be made when the following criteria are satisfied:

- Person has a mental illness that requires immediate treatment
- Such treatment is available at an approved treatment centre, as gazetted in the Mental Health Act
- The person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety and/or for the protection of other persons.

When can a person be given medical treatment without consent?

- In an emergency
- If unconscious
- If someone is required by law to make decisions on the person's behalf
- If a guardian has been appointed to made decisions on the person's behalf
- When there is a Detention Order (see above).

For more guidance on these matters see the SA Department of Health Policies, including Policy EDM P6-02: *Restraint and Seclusion in Health Units (including Mental Health situations)*, 2002.

Working with diversity: some useful reminders

We know that many people are unable or unwilling to seek help. This may be due to lack of confidence, intimidation, language differences or perceptions of cultural 'unfriendliness'. For all of these reasons it is important that those working with people from diverse cultural and linguistic backgrounds are mindful that:

- Our own cultural assumptions influence our interpretations of what people say.
- There are as many individual differences between people from other cultural groups and contexts as there are within our own. Generalisations and stereotypes do not acknowledge these differences.
- Responding in a culturally appropriate way is not about learning a formula. Rather, it is about an approach. It involves being open to the process of understanding the meanings that others make and connecting with the unique 'stories' they tell about their life.
- Everyone is 'diverse'. Identity is developed in a number of complex ways involving, for example, gender, age, socioeconomic status, ethnicity, physical ability, sexual identity.

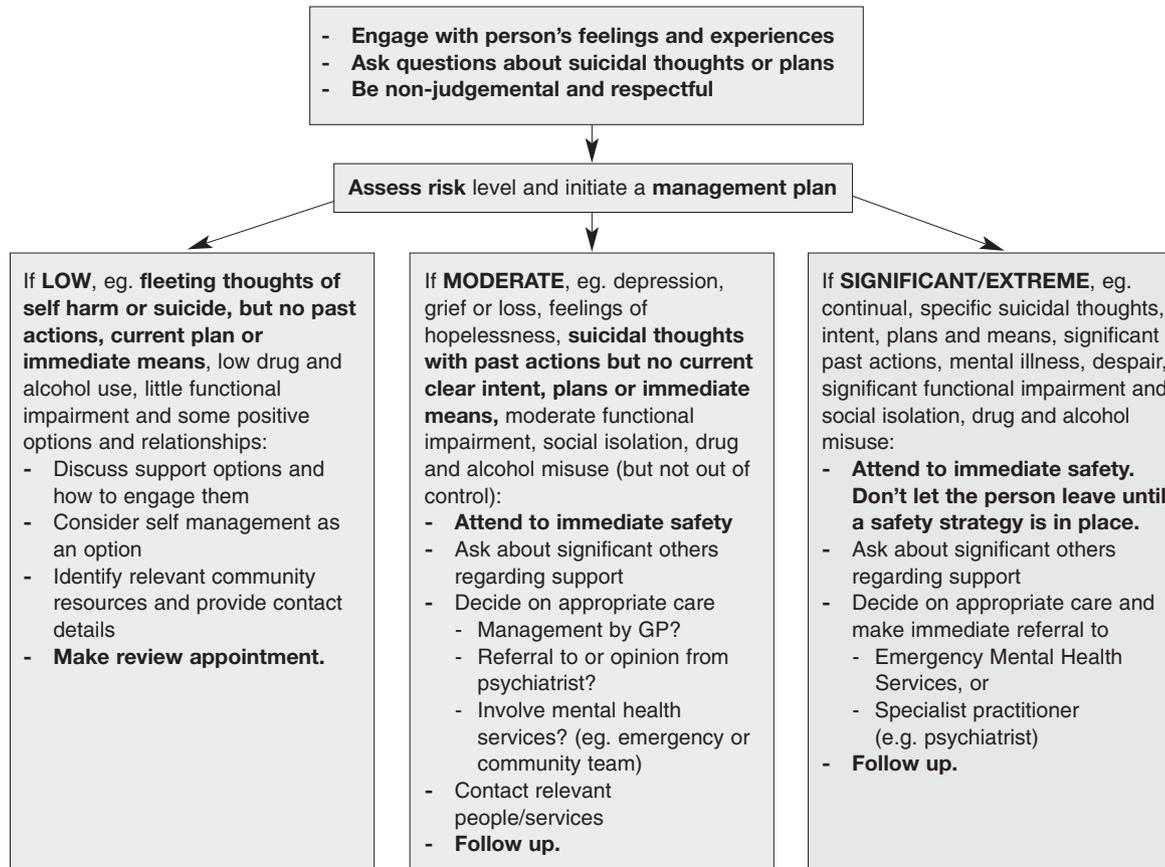
There is an understandable reluctance by health workers to discuss suicide, and this may be compounded in culturally unfamiliar contexts. What is important is not to be paralysed by a sense that it is all too difficult – or that there are 'experts' who should handle these matters. It is taking on the process of respecting other people's reality that is important, rather than measuring only the 'successful' outcomes.

Remember, talk to your colleagues, your professional association or others who may be able to help. You do not always have to manage on your own.

In much of black Australia, suicide is no longer something alien, for which no Aboriginal language or dialect has a word. The human act of self-inflicted, self-intentional cessation of life has become a pattern – [the] outside of custody suicide rate that was among the lowest has become among the world's highest in a little more than 25 years. [Colin Tatz, *The Age*, 5th Jan 1996].

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 individual clients.



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.

Prevention strategies

In Australia there was an 18% reduction in reported suicides between 1997 and 2003 (ABS, 2004). The age standardised suicide rates for both men and women in 2003 were the lowest they had been for a decade. The overall per capita rates in 2003 were one of the lowest rates since the early 1950s. However, it should be also noted that suicide rates have been cyclical with a peak in the 1960s, then a low point in the mid 70s followed by an increase again in the 1990s.

Despite the overall decline in suicide in recent years there are some population groups in which rates have increased. Suicide, which was previously almost unknown in Aboriginal and Torres Strait Islander communities, has become more common in recent years, for example. The figures in other groups are still disturbingly high. While there has been a consistent reduction in suicide rates among young men (15-24 years) since 1997, Australia's young male suicide rate is still the fourth highest in the Western world.

Many factors are likely to have contributed towards the declining suicide rate. It is reasonable to assume that a growing awareness of suicide, comprehensive primary health care strategies, and concerted community suicide prevention activities during the past decade, have contributed to this reduction.

Primary care and community-based services are at the forefront of suicide prevention efforts. It is crucial that groups at increased risk can readily access appropriate support, care and referral through these mainstream services, and that the services foster a culture that accepts and caters for the needs of high-risk groups, including young people, homeless people, people who are gay, lesbian, bisexual or transgender, Aboriginal and Torres Strait Islander peoples, people involved in harmful drug use, children of Vietnam veterans, and individuals and families affected by suicide (LIFE Framework, 2005).

It is essential that the support, care and referral provisions, mentioned above, be as effective as possible.

I guess I wouldcertainly encourage people to overcome the stigma of mental illness and the stigma of attempted suicide, to get help and to keep pushing until they get help. If they feel that they're not being taken seriously or their loved ones are not being taken seriously, the same as with any illness, if you felt that there was something wrong with your body and your GP wasn't taking it seriously, keep going until you find someone who will.

[Jo, whose son Samuel suicided, and who is now actively involved with bereavement support for others].

Postvention for those bereaved

Providing prompt and effective support for people bereaved through suicide – that is, suicide postvention – is a necessary element of suicide prevention and response. Postvention is prevention for the next generation.

Shneidman (1999) describes postvention as:

Those things done after the event has occurred. Postvention deals with the traumatic after-effects in the survivors of a person who has committed suicide (or in those close to someone who has attempted suicide). It involves offering mental health and public health services to the bereaved survivors. It includes working with all survivors who are in need [cited in Wilson and Clark, 2005].

There are a number of reasons for paying attention to postvention. People bereaved through suicide may:

- grieve differently and possibly more intensely, and have different needs from those bereaved through other modes of death
- experience stigma, social rejection and alienation
- feel unsupported by friends who may be fearful and uncertain how to respond
- experience a high level of grief for a number of years – often associated with depression, substance misuse and family breakdown
- have a higher risk of suicidal ideation and suicide than others
- experience anger and guilt in addition to pain and shock
- regret not having had the opportunity to say goodbye
- experience loss of faith and trust in themselves and others
- have a higher risk of suicidal ideation and suicide than others.

Postvention activities aim to ‘reduce the after-effects of a traumatic event in the lives of those affected and to help those bereaved live longer, more productively and less stressfully than they are likely to do otherwise’ [National Advisory Council on Suicide Prevention, 2004].

An Information and Support Pack for those Bereaved by Suicide or Sudden Death has been disseminated nationally since September 2003. It contains information about dealing with practical matters such as funeral and coronial processes; very helpful material on the emotions associated with grief and mourning; suggestions about what helps; a section on grief and mourning the Nunga way; ideas for helping children and teenagers deal with bereavement; and a section specifically on suicide. It also contains a comprehensive list of relevant books, websites and services. A South Australian version of this is downloadable from the LIFE website

http://www.livingisforeveryone.com.au/files/clife/kit_sa.pdf or is available from the Coroner’s Office.

Bereaved through Suicide is a South Australian support group for those grieving the loss of someone through suicide. Phone 08 8332 8240 or email support@bts.org.au



section 2 | engagement



engagement: at a glance...



See also the Engagement paper on the **square** CD-ROM/Website www.square.org.au.

Engage effectively

- Effective engagement is the single most important response that you can offer a person who may be at risk of suicide or self harm.
- Noticing that a person may be at risk involves being highly aware that mental health problems may be present – even if these are not the presenting issue.

Respond

- Be open and respectful (take seriously) people's experiences and feelings even if they are very different from your own. Listening well is fundamental. It involves giving your full attention and showing that you are interested.
- Provide opportunities for people to talk about how things are going for them. Many people do not raise mental health concerns because of the stigma surrounding mental illness and 'not coping'.
- Use open questions that encourage discussion, rather than closed questions which can encourage simple Yes or No answers.
- Do not be afraid to ask specific questions about suicide if you think the person may be at risk, e.g. *You've said that you sometimes feel 'there's no point'. Are you having thoughts about suicide?*

Be aware

- It is not helpful to give glib advice, argue or criticise when a person expresses distress, confusion, agitation, hopelessness or suicidal feelings.
- Stigma is an important issue in mental health and suicide prevention. When anyone experiences stigma they can feel dismissed, misunderstood, alone, hostile, or frightened. This contributes to mental health problems.
- It is crucial that people do not experience stigma in the settings from which they seek help. Stigma can surround issues such as age, gender, ethnicity, sexual preference, poverty, disability as well as mental health.
- Many people who live with a mental illness report that the associated stigma is as difficult to cope with as the illness itself.

Appropriate responses

- It is vital that a person at risk gains some hope for the future. An important skill therefore, is to be able to reassure someone, without dismissing the distress they are experiencing. A key message is that there are many options for care and support.
- Ask the person whether there is someone who they would like to have with them during discussion of options. If possible, contact and involve any person who is nominated.
- Appropriate care is important and this will vary from person to person, and change for individuals at different times depending on circumstances.
- Notify the most relevant person or service (e.g. a GP or Emergency Mental Health Services) about the person's risk (unless you are case-managing yourself). Remember that a disclosure about suicidal thinking or planning should never be kept secret.
- It is important that people who may be at risk are connected to a range and continuum of support options in ways that involve them and maintain respect for their individuality and wishes.
- Remember that people know and often remember when someone is genuine, interested and respectful. This quality of engagement creates trust and may be enough in itself to save a life.
- It is important that the environment and 'culture' of care contexts are appropriate for people who may be feeling alienated and distressed. This means thinking about the physical environment as well as the communication skills of all workers who may come into contact with distressed people.
- Anyone can be at risk at certain times in their lives. Risk factors e.g. depression, major loss, family violence, should be taken seriously. Asking people about their suicidal thinking will not increase the likelihood of suicide.
- Reject unhelpful myths about suicide such as: suicide attempts are 'just' attention seeking or 'acting out'. Many people who self-harm or attempt suicide go on to complete it. A 'cry for help' may be coming from someone in profound distress and always needs to be respected and taken seriously.
- Remember that there are several people who can assist you to care and manage effectively. You can stay involved and at the same time, involve others who have particular skills, e. g. psychologists, psychiatrists, social workers, GPs with particular experience, community workers, family members, friends and support groups.



Steps to engagement

There are a number of steps involved in responding well to a person who is potentially suicidal. The following steps are adapted from those outlined in the *Mental Health First Aid Manual* (Kitchener & Jorm, 2002).

Step 1 Noticing when someone may be at risk and being alert to the possible mix of risk factors is a vital first step of engagement. Notice especially changes in behaviour like sleeping or eating patterns. It is possible that many of the following factors could be present in a person's life at a given time:

- Depression
- Anxiety
- Psychosis
- Negative view of self
- Sense of hopelessness
- Expression of desire or threats about suicide
- Negative ways of thinking, e.g. anger, shame, guilt.

Social and cultural factors may also be relevant:

- Experiences of marginalisation or stigma about aspects of identity
- Drug and alcohol misuse
- Responses to major or chronic physical illness
- Major life event, e.g. loss of significant relationship or job
- Domestic violence (including psychological abuse) and/or sexual abuse.

Sarah a 'consumer' interviewed for this resource, talks about aspects of engagement at different times when she was hospitalised:

One of the major things is that [hospital] staff...don't find out what does it, like what causes that. Like you know it's all well and good to tell you how you shouldn't do that [attempt suicide] and all the medical repercussions. But the thing is it's not even about even killing yourself, it was about getting away from something. And that's what I needed help with. Like you know I'm not just going to tell my deepest darkest secrets to anyone, just because they say 'how are you?'

...Even amongst the staff there was lots of stigma, lots of judgement about suicide, like you know, you're just wasting our time trying to kill yourself. That's not a real mental illness.....

It took a while for it to be good. Like the first few months were really hard and after a while I found that some of the nurses there were really connecting to me and took me on as a person rather than just a client.

...I really appreciated that and found it really useful you know. Even the locked ward you're there not by choice, so it was really good to have some people that were really interested in me [Sarah, 2005].

Step 2 Engage the person in a serious conversation (as opposed to an in-passing one) about how they are feeling. Encourage them to describe what is going on for them. Show the person that you are interested and concerned for their wellbeing. Being genuine in the way that you invite people to talk is a potent communication skill that is intuitive for some people, but may need to be practised by others. It is important for example, to show interest without being intrusive, judgemental or patronising. It is important not to give glib advice, or argue, or criticise. Some features of positive engagement include:

- Non-judgemental listening which ‘hears’ how the person is experiencing their world without thinking about your own views about these experiences.
- Questions and prompts that invite further description of feelings, for example:

That sounds extremely stressful...

How do those events affect you and the children?

Loss of a loved one is a major event for anyone to deal with. How are you going with that?

These sorts of questions are open-ended and allow the person to disclose in ways, and to the extent, that is comfortable for them. Closed questions, on the other hand, can invite closed answers. For example: *You were made redundant last month weren't you?* (to which the person may well simply answer Yes). It is not that there is anything necessarily ‘wrong’ with such questions. But unless the person is encouraged to talk in ways that offer opportunity to discuss what **meanings** such an event has in their life, we may be unaware of its implications (e.g. possible financial catastrophe, loss of identity, status, sense of worth etc.). Alternatively, we may assume that such an event must have negative implications when in fact it doesn't. Perhaps the person is delighted to be free of the workplace.

If you think the person may be at risk, ask the person about this possibility (see the Clinical Questions in the **Risk assessment** section, following).

It is also helpful to find out whether there is anyone in the person's life with whom they feel safe and/or supported. If it is appropriate, it is often helpful to involve such people in processes of care. With permission of the person, speaking to such people can be very useful in providing additional information – as well as support.

These approaches are as important after an attempted suicide as they are in the ‘detection’ stages.

And now I go to a female GP, who I've been going to, really for the last ten years, and I would contribute part of wellness to the fact that she is open, understanding, knows that if you've had depression it doesn't necessarily devalue you totally as a person for the rest of your life. You know, she's wonderful. [Diane, 2005]

Step 3 Give reassurance and information

It is crucial for the person at risk of suicide to have hope for the future. It is helpful, therefore, to be able to give reassurance without dismissing the distress that a person is feeling. Key messages include:

- That they are not alone
- That there are many ways in which help and support can be accessed, and different types of support
- That you as a health worker believe that the person can be helped.

Information about possible care plans and options are important. And it is helpful to give people access to relevant information. This will depend on the needs of individuals and may include:

- Internet resources
- Booklets and brochures
- Courses and support groups
- Self help books
- Information about exercise, exposure to sunlight or any other relevant factors.

For further information see Section 5: Resources, or the Resource paper on the **square** CD-ROM/Website www.square.org.au for a comprehensive list.

Step 4 Encourage the person to get appropriate professional help

It is important that a person at risk receives appropriate care – and what is appropriate will vary from person to person and vary for a particular individual at different times. Notify the most relevant person or service of the person's risk – unless you are managing the person yourself.

A GP is often the appropriate first person to be consulted and there is a range of ways in which GPs can provide support. These include:

- Conducting an assessment that includes both physical and emotional health
- Explaining symptoms
- Treating underlying issues such as depression or anxiety
- Referring appropriately.

As has been emphasised throughout these resources, there are multiple factors that influence a person's life at any given time. These are also dynamic and changeable and so any given scenario may be complex. In addition to these complexities, the person who is offering care and engaging with a person at risk is also working within multiple constraints and variables – not to mention the complexities that may exist in their own lives. It is not possible in these human circumstances to offer strategies that will work for all. However, **one fundamental message that is consistent, from researchers and practitioners alike, is that effective engagement followed by appropriate action is the single most important intervention in community, primary health care and specialist settings.**

Step 5 Encourage self help

This can involve:

- Resources and references
- Collaborating with trusted people for support
- Exercise
- Classes such as relaxation or support groups.

[Adapted from Kitchener & Jorm, Mental Health First Aid Manual, CMHR, ANU, 2002]

Stigma

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

The consequences of stigma can affect a wide range of central issues in a person's life, for example housing, employment and social acceptance. It can also impact on a person's experiences when they access health and health-related services. For example, a person's physical health requirements may be overlooked because of more obvious mental health issues.

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, several women interviewed about their experiences of accessing help for their suicidal behaviour, commented on feeling that they were 'wasting people's time'. One hospital in-patient had been explicitly told that the bed could be used by a 'real' patient'.

The above example of stigma relates to perceptions of suicide attempts as 'attention seeking' or 'acting out'. They imply that the person is playing some sort of game – and therefore does not need professional help. This is not only a mistaken attitude – it could prove to be a fatal one.

Avoiding stigma requires health workers to reflect on their practice and that of their workplace culture generally. People who may be at risk of suicide could be living with multiple 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 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 why this may occur. 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.

Key messages

In engaging with a person about suicidal thoughts or behaviour:

- **Provide the opportunity for the person to talk.** There are many distressed people who do not talk, simply because they are not given an appropriate opportunity.
- An **appropriate question** asked in the right way, at the right time, could save a life.
- Many people do not disclose suicidal thoughts or desires because of the stigma that is attached to 'not being able to cope' or to being diagnosed as having a mental health problem.
- **Responding appropriately** is vital in determining whether or not that person receives appropriate support – or even whether they disclose their thoughts and feelings at all. Listening attentively and non-judgementally, as well as opening possibilities for the person to describe their feelings and experiences in their own ways, is the first step of appropriate engagement.
- Being **open, respectful and empathic** are crucial for developing trust.
- **Do not panic or be afraid** of the issue. Raising it in an appropriate way will not escalate the possibility of suicide. If you think that someone may be at risk, do not avoid the issue or assume that someone else must be dealing with it. Ask questions that directly address suicidal thoughts or plans.
- Remember that **support is available** to you as well as to the person in question. Reporting your concerns might, in some contexts, be the end of your involvement.



section 3 | risk assessment



square

risk assessment: at a glance...

See also the *Risk Assessment* paper and the videos of risk assessment interviews with clients on the **square** CD-ROM/Website www.square.org.au.

Taking a holistic approach

- Safety and prevention is the purpose of risk assessment. A first principle is to notice when there may be a possibility of suicidal thinking or behaviour. This requires a high level of awareness, especially if mental health is not the presenting issue.
- In some instances risk is obvious, but in others suicidal thinking or behaviour may not be apparent.
- Risk assessment cannot be an exact science. Risk is likely to involve a complex range of factors. Therefore, a holistic approach is necessary. This involves being open to understanding a person's experiences and circumstances and the meanings they have about them.
- The more comprehensive a risk assessment is, the more valid it is likely to be. Engagement with a person should precede paperwork and the use of risk assessment tools.
- Engagement – especially attentive listening – will provide a richer information base to inform risk assessment and is likely to build a relationship of trust with the person.
- Even in a context where an interaction with a person is necessarily brief, it is possible to engage with them in a genuine way and to become aware of potential risk. In such a situation steps should be taken to 'follow up.' There are various people, depending on the setting, who can be approached for assistance.
- Asking questions in an open way rather than in an 'interview style' is likely to encourage a person to describe their feelings. It also gives them a proactive role in deciding what is relevant information. Examples of an open style of questioning are:
 - *I'll attend to those cuts and then perhaps we can have a chat about what was going on for you at the time?*
 - *Everyone has a hard time after a major loss, how are you going with that?*
- Any disclosure of suicidal thinking indicates the need for professional risk assessment. Suicidal thinking may be signalled in informal ways such as: *They'd all be much better off without me.*
- It is important to remember that asking someone specifically about suicidal thinking or planning will not increase the risk of suicidal behaviour. The right question at the right time can save a life.

Factors in suicide risk assessment



Suicidal thoughts and desire. Relevant factors include:

- A history and/or current mental illness, e.g. depression
- Despair, hopelessness, shame, guilt or anger
- Are suicidal thoughts occurring and if so, how frequent and controllable are they?
- What meanings does the person have about suicide, i.e. what will it 'achieve' for them?

Life factors. Relevant factors include:

- Protective factors e.g. friends, family, supportive networks
- Beliefs that would prevent suicide being an option
- Degree of marginalisation, e.g. does the person have to deal with stigma attached to aspects of their identity or life?
- Have any major events created motivation for suicide, e.g. significant loss, legal or financial problems.

Formulated suicide plans. Relevant factors include:

- How determined the person is
- How detailed the planning is
- Has another person expressed concerns about the safety of the person you are assessing?
- Does the person have the means available to them?

Included in the **Risk Assessment** section which follows, are:

- A risk assessment guide
- A risk assessment process involving specific clinical questions (designed by Dr. Randall Long from the Flinders Medical Centre, as part of a risk assessment process to assist medical practitioners).
- Risk assessment review questions.

Remember that risk assessment tools are to assist you in forming a professional judgement. They should never take the place of professional involvement and judgement.

A holistic approach



Risk assessment is not an exact science. The most effective way of approaching it is to take a holistic approach, i.e. consider a complex range of factors, meanings and experiences that constitute a person's world. The more comprehensive the assessment is, the more valid it is likely to be. It is also important to assess the safety of other people, e.g. of the person's family.

Primary health care workers and specialists who are applying best practice principles in assessing suicide risk will listen and engage respectfully with a person before filling in forms. Not only does this process provide a richer information base which can inform assessment, it also builds a relationship of care and trust with the person in question. It is very important to take seriously what people tell you about their suicidal ideation or attempt.

Angela, a consumer interviewed for this resource, who had attempted suicide, commented on the importance of being listened to and being taken seriously:

When I got that night in [the hospital], I vaguely heard the next day when doctors were talking about me, and they said, I think they even said this to my family but I can't be sure, but I heard it ... Oh it was only an attention seeking attempt... And I thought to myself, 'now that's really unfair' because it wasn't.... That's what I heard. Oh it's just an attention seeking thing. And I thought...I was lying there, I couldn't talk too well because [I was] so heavily drugged up and I just thought, no that's terrible. It wasn't just attention seeking. If I had died I just know that at that time, not now, but at the time, it's what I wanted. [Angela, 2005]

Intersecting factors in suicide risk assessment

Suicidal thoughts and desire

Relevant factors include:

- A history of and/or current mental illness
- Degree of despair, inner pain, hopelessness, anger, shame, guilt
- Are suicidal thoughts disclosed?
- If so, how frequent and controllable are they?
- Do the thoughts include planning actively or in the imagination?
- Is it possible that this person is practising and building courage to successfully carry out the act?
- What meanings does the person have about suicide – what it will ‘achieve’ for them?
- Have there been previous attempts?

Life factors

Examples of relevant factors include:

- Protective factors e.g. friends, family, supportive networks, connection to groups or organisations, beliefs that would prevent suicide being an option
- Ability to seek help and solve problems
- Degree of marginalisation or isolation experienced. For instance, does the person have to deal with stigma attached to aspects of their identity and life?
- Have any events created motivation for suicide, such as loss or change in an important relationship?

Formulated suicide plans

Relevant factors include:

- How determined is the person?
- How careful and detailed is the planning e.g. means, place, time?
- Are the means available to the person?
- Does the person own a firearm?
- Has the person prepared for the event, for example, finalising arrangements, giving away possessions?
- Has another person expressed concerns about the safety of the person who you are assessing?

Any disclosure of suicidal desire indicates the need for professional risk assessment. Some people have suicidal ideas or plans but do not disclose them to anyone.

Ways of asking assessment questions

It is helpful if questions can be asked in ways that allow space for a person to describe their feelings and lived experience (rather than simply responding to a prescribed checklist).

For example:

- *It sounds as though things are very distressing for you - can you tell me more about how you are feeling?*
- *I'll attend to those cuts first and then perhaps we can talk about what was going on for you at the time?*
- *You've said that you sometimes feel that 'there's no point'. Does this mean that you have thought about suicide?*

What these questions have in common is that they offer the opportunity for people to describe their world in their own ways. They may talk about external life events, or their inner world of feelings and meanings, or a mix of these. They may choose not to say much at all. Nevertheless, there are several advantages to this approach.

For example:

- In being encouraged to talk in their own ways, an individual can gain more clarity about his/her own situation
- The person has a proactive role in deciding what is relevant information
- Those undertaking the risk assessment are more likely to gain insights about the individual's experiences and responses, and are less likely to make assumptions based on their own views and values.

Angela described the importance of genuine concern in this way:

The most important thing is to be first of all understanding and caring. If you've got a nurse or a doctor who does, who displays those traits, it puts you at ease for a start and you feel you could open up to this person. And it's, just speaking from my own experience, because the voice is putting me down so much and making me feel terrible as a horrible person, to have somebody caring you think: 'Hey, why is this person caring and the voices aren't?' And you think, 'Maybe the voices haven't got it right'. [Angela, 2005]

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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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.

You will find an explanation and discussion of these questions in Dr Long's **Risk Assessment** paper on the **square** CD-ROM/Website www.square.org.au.

Action

A person who assesses an individual as being at actual or potential risk of suicidal behaviour should always take action. Depending on the context, this may mean managing the situation oneself, discussing it with someone else, reporting to someone else, e.g. a manager in a workplace, or a GP, or calling Assessment Crisis Intervention Services (ACIS). It may also be helpful to find out whether there is someone with whom the person feels safe, who could be supportive while further assessment is being arranged.

A series of questions which will assist you to complete the risk assessment, follow.

Note Your own service or agency may 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.

Clinical questions

The following questions were designed by Dr Randall Long from the Flinders Medical Centre as part of a risk assessment process to assist medical practitioners. It is a series of questions within a spectrum of suicidal ideation and behaviour and he advises that they be used in the sequence outlined, with each affirmative response to a question indicating that the next question should be asked. The more affirmative responses that there are indicates an intrinsically higher level of suicide risk. For discussion of these see the **Risk Assessment paper** on the **square** CD-ROM/Website **www.square.org.au**.

Suicidal thoughts

Passive suicidal thoughts

- Do you wish you didn't have to go on living?
- Do you have thoughts of wanting to die?

Active suicidal thoughts

- Do you have thoughts of wanting to take your own life?
- Do you have suicidal thoughts?

Suicidal threats

- Have you talked with others about killing yourself?
- Have you told anyone that you were going to kill yourself?

Suicide Plans

- Have you thought about methods to kill yourself?

If Yes

Decision

- Have you decided on a method to kill yourself?

Details

- Have you made a plan of exactly what you might do to kill yourself?

Resistance

- Have you been able to resist carrying this out?
- What stopped you putting the plan into action?

Preparations

- Have you started preparations to suicide?

Time Profile

- For how long have you had the plan?
- Have you set a date to kill yourself?

Affairs

- Have you put your affairs in order?
- Have you made arrangements for after you die?
- Have you written a note?

Suicide attempt

Circumstances

- What were the circumstances of this attempt?

Method

- What did you do?

Intent

- What did you want to achieve (to die/to sleep/euphoria)?

Lethality

- Did you think it would kill you?

Reattempting suicide

- Have you ever tried to take your own life before?

Willingness for help

Desire for help

- Do you want help to avoid killing yourself?

Acceptance of care

- Will you accept my help to avoid suiciding?
- Will you accept specialist mental health care?

Current Safety

Immediate harm

- Do you have thoughts of wanting to suicide immediately?

Harm in hospital or clinic

- Do you have thoughts of wanting to suicide here in this office/clinic?
- Are you thinking of actively wanting to hurt yourself here?

Help eliciting

- If you feel like hurting yourself here while you are waiting for me to make some arrangements, could you come back to me and indicate this before doing anything?

Dangerous items

- Do you have anything you can use to harm yourself?
- Are you thinking of using something in the immediate vicinity to harm yourself with?

Homicidal thoughts

Homicidal ideation

- Do you want to take anyone with you?
- Do you have thoughts of harming or killing others?

Homicidal Plan

- Do you have a plan to do this?

Weapons

- Do you have access to guns or other weapons?

Reviewing the assessment

Some relevant review questions:

- How confident do I feel about talking to a client about suicide risk?
- How confident am I in my assessment e.g. low, medium, high confidence?
- Which factors mainly informed my assessment e.g. mental health problems, what the person said?
- Are there any questions relating to these factors that I should have asked?
- Are there any dimensions that I missed altogether?
- Can I identify any assumptions based on my own values that may not be appropriate for this person?
- What actions will I take?
- What follow up will I do?
- Are there individuals I have interacted with recently who, in retrospect, would have benefited from the opportunity to talk about suicidal thoughts?
- How possible has it been for me to engage effectively with people whose lived experiences are very different from my own, e.g. people who may be living in poverty or people who have a different sexual identity or preferences?



section 4 | management



management: at a glance...



See also the *Management* paper on the **square** CD-ROM/Website www.square.org.au.

Key management principles

- Priorities are **safety**, addressing of **underlying issues** and **continuity of care**
- Tailor interventions to the person's needs and circumstances in consultation with them
- Communication, collaboration and co-ordination are key components of good management
- Effective engagement is vital.

Immediate and ongoing management

- Crisis intervention will involve ensuring the immediate safety of the suicidal person and any others at risk. (This could involve back up support and/or detaining the person)
- Immediate management will be followed by a more comprehensive risk assessment to determine the most appropriate management options
- There are multiple levels of management options.

Management plans

Management plans are a formal record of decisions about interventions to be taken. They should be developed in conjunction with the person at risk if possible. They will outline:

- issues to be addressed
- roles and responsibilities for action
- time frames and review dates.

A Collaborative Management Plan can be downloaded from the Management section of the **square** CD-ROM/Website www.square.org.au.

Contingency plans

- Effective management involves having contingency plans which anticipate and address escalations of risk or relapses. All individuals are subject to change and this may be especially so for someone who is at risk.
- Contingency plans need to be specific, e.g. in the event of _____ the GP/family/friend/agency will contact _____/escort the person to _____/call ACIS.

Referral and follow up

- Anyone who is, or has been at risk, needs ongoing review (as with any other potentially changeable condition)
- If referral is only 'one way', a person may receive crisis intervention but no follow up
- People are especially vulnerable during transfers of care, e.g. discharge from a specialist care context.

Psychotherapeutic interventions

- It is usually advisable to offer counselling, alongside other options (such as medication) to people who are at risk of suicidal behaviour.
- In General Practice several focussed psychological strategies are available, including: Psychoeducation; Cognitive-Behavioural Therapy (e.g. behaviour management, relaxation, problem solving, social skills); Interpersonal Therapy; and Narrative Therapy (specified circumstances). They may be delivered by Trained GPs or GP referral to allied health professionals.
- It is very important to ensure that pathways of care are connected and not simply one-way referrals with no follow up.
- For reasons of confidentiality, it is necessary to ask people what information may be conveyed, and to whom. However, duty of care also requires that where there is an immediate risk of harm to self or others appropriate action and reporting must occur.

Involving community

- Effective engagement with the person will assist you to know what supports are most relevant and what protective factors the person already has in their life.
- It is helpful to know about local community services, relationship and interpersonal skills courses, support groups, advocacy groups and other relevant organisations.
- It is important that a holistic approach is taken in considering management options. This also relates to the key management issue of addressing underlying problems. For example, if sexual abuse or drug and alcohol misuse are underlying factors, there are relevant community agencies that could be helpful to the person.
- Some people may need to use several agencies for assistance – such as Centrelink, Housing Authority or other community services. Where a number of people are involved in a person's care it is vital that roles and management responsibility are clarified and agreed.

Questions for reviewing management and follow up are included in the management section which follows. Examples are:

- *How 'user friendly' is my working environment and style of management? Would most people feel comfortable regardless of gender, age, ethnicity, economic circumstances?*
- *Have I kept track of people at risk to make sure that they do not 'drop out' of a care continuum?*



Key issues

A first priority of good management is **attending to safety**.

People at risk may not present as being obviously unsafe or exhibit acute behaviours or make explicit disclosures. Many people at risk will not reveal distress or mental illness as a presenting problem. Attending to safety therefore requires astute observation and vigilance. It also requires recognition of the potential for changeability in people's mental and social wellbeing.

Good management involves **addressing underlying issues** and **continuity of care** for the person. This means that although multiple options and pathways of care may be used, effective managers will stay involved with the person's progress and current and changing needs.

Management plans should reflect tailored interventions that have been decided in consultation with the person (and any nominated person who is significant to them). Clear documentation and timely transfer of information are vital if the person's needs are to be understood and effectively addressed.

Collaborative practice is an effective strategy for the person's wellbeing and it is also a cost effective way to use community resources. Successful collaboration involves:

- sharing information
- valuing the skills and expertise of other workers/carers
- including the client as part of the team.

Effective management also requires coordination. This involves:

- Clearly articulated pathways of referral
- Establishing mechanisms for coordinated planning, review and feedback.

Working with people who are suicidal creates a great deal of psychological and emotional pressure. It is important to monitor (and address) your own health care needs and to seek professional support and advice when you feel unsure of some issues or decisions involving client management.

Crisis intervention

Crisis intervention addresses the special needs and concerns of a client who is in acute psychological crisis. It is applicable when the functioning of an individual or family has been suddenly and dramatically affected by a personal loss or tragedy. It is used during a four to six week period following the event that precipitated the crisis. The purpose of crisis intervention is to help the client resolve the crisis in a positive way and to prevent the development of more serious and longstanding problems. The steps involved are as follows:

- Listen actively and provide emotional support
- Involve others and encourage the client to reach out to others
- Allow expression of emotion
- Communicate hope
- Be actively involved in examining details of their situation
- Help break down the problem into smaller problems to be addressed.

Crisis intervention will involve ensuring the safety of the suicidal person and any others at risk, including the primary health care worker or specialist. This will necessarily involve a quick initial judgement of risk, before a more formal risk assessment process is undertaken. Depending on the risk level ascertained, it could mean ensuring back up assistance is available and the removal of lethal means. It may also involve ensuring an appropriate level of observation and supervision, e.g. making sure that a person at immediate or high risk of self harm or suicide is not left alone.

Following crisis intervention and comprehensive risk assessment, there is likely to be a mental health assessment to diagnose/confirm underlying mental health problems and/or identify associated problems such as drug and alcohol misuse. This will be followed by initial treatment and the devising of a management plan for ongoing management.

Management plans

A **management plan** is a formal record of decisions about interventions to be taken. A management plan will change as a person's situation changes or if they are seen by a different service provider.

A **management plan** will:

- provide a brief history of any previous presentations and the precipitating factors involved
- outline issues to be addressed
- identify roles and responsibilities for actions
- establish timeframes and review dates
- include contingency plans (e.g. to cope with a changeable degree of risk or non-compliance)
- include contact details of supportive persons/family
- provide consent to plan by client
- list other people to whom plan has been copied.

Guidelines for developing a management plan*

- Have you ensured safety? Does the person need supervision or removal of lethal means? Is there immediate danger requiring the police?
- Should the person be hospitalised? If you think so, contact the Assessment and Crisis Intervention Service (ACIS) or the Emergency Triage and Liaison Service (ETLS), to discuss urgently. Remember that if the person refuses voluntary admission, they may be detained and admitted under the Mental Health Act.
- Is the person able and willing to engage with treatment and support options?
- Does the plan involve the person as part of the team and consider their wishes?
- What therapeutic interventions (such as counselling, psychotherapy, medication) are appropriate and available?
- Is referral to a mental health specialist (e.g. a psychiatrist) an option?
- Are the pathways of referral connected (not just one way)?
- What community support services can be utilised (alone or to supplement other interventions)?
- What aftercare/longer term care arrangements can be set in place?
- Who will provide follow up and review the plan? Avoid gaps in care.
- Have you accessed relevant support if unsure of your decisions? (e.g. ACIS, ETLS or support from a psychiatrist).

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.

Contingency plans

Management includes **contingency plans** which anticipate and address any likely escalations of risk or relapses precipitated by such things as:

- greater severity of symptoms such as depression
- adverse life events which compound feelings of hopelessness
- deteriorating relationships or disruption of social connections
- temporary unavailability of clinical help, or
- cessation of prescribed medication.

Contingency planning requires quite specific documentation of roles and responsibilities in a range of potential scenarios. For example:

In the event of _____, the GP/family/friend/agency will contact _____,/ escort person to _____ / call ACIS etc.

Jo, speaking of her son Samuel, alerts us to how difficult it can be to see the warning signs:

And there were times where he really looked like he'd turned a corner, and in the last couple of weeks before he died, that appeared to be one of those corners. And ... in terms of advice, that's another thing I would say to people, that just because they appear to be okay, don't take your eye off them. Because it's a very common...response that we get from people who are survivors, as in the people they left behind afterwards ...saying 'but he was so good for the last couple of weeks'. That's a very common thing to hear people say. And so it's a hard one because do they appear to be really good because they are good? Or do they appear to be good because they've already decided what they're going to do? [Jo, 2005]

Referral and follow up

General principles

- If a person is, or has been, at risk of suicide, they need ongoing review (in the same way that any other chronic and potentially changeable condition would be monitored).
- The decision of whether to hospitalise or not should be made on clinical grounds with the involvement of the person and any nominated other/s that the person feels safe with, e.g. family, significant friend.
- There can be some people at risk for whom hospital is not the best option. It may offer little predictable benefit and may even, in some circumstances, introduce an element of increased risk.
- Coordination of support and appropriate re-assessments are vital. If referral is only 'one way,' a person may receive crisis intervention but little or no follow up.
- People are especially vulnerable when transferring out of a particular context of care or when apparently out of the 'crisis' or acute stage.
- Referral options are likely to be most appropriate when they are based on comprehensive information both about the person and available local services.

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

* See SA Department of Health policies on admission, care, and discharge in mental health in-patient units.

Referral options

Self Management for person assessed as Low Risk

This is an option if:

- Person has good social supports
- Can discuss management
- Has good rapport with health workers
- Strategies are negotiated for vulnerable times (may involve community/family and/or medical)
- Useful information has been supplied about community resources that can be accessed
- Review arrangements are negotiated and agreed with health worker.

Shared Care for person assessed as Moderate Risk

This requires:

- Management plan in place
- Access to appropriate community resources is facilitated
- Plan is clearly understood by the person and their support person/s
- Plan includes details of a rapid response capacity for reassessment and appropriate escalation of care level, and circumstances in which this may occur
- Contact details are clearly negotiated with person and support people, and this is documented
- Face to face re-assessment (within suitable time frame for risk level) is arranged and conveyed to the person and people providing support
- Plan documents review arrangements.

Specialist care for person assessed as Significant or Extreme Risk

This requires:

- Immediate and continued monitoring
- Referral to appropriate specialist mental health services, if appropriate
- Consideration of detention and possible admission to hospital
- Plan should be developed collaboratively between mental health service and primary health care worker.
- Plan includes:
 - Steps to ensure safety
 - Specific strategies for ongoing review and care.
- Documentation should flow to all relevant people involved in the person's care in a timely manner.

Referral of a particular person may involve one or several of the above options at a particular time. Just as the categories of Significant/Extreme, Moderate and Low risk are subject to change, so are the management and referral options.

Psychotherapeutic interventions

There are many therapeutic approaches which are useful for the treatment of depression and suicidal ideation and behaviour. Some of the main psychotherapeutic interventions which are widely used and available in South Australia are described below. Many therapists use a combination of these. It is important to be aware of the particular background and credentials of anyone who is offering therapy.

Cognitive behaviour therapy (CBT)

CBT is a 'short term focussed counselling approach that uses active methods to alter the way a person thinks about themselves and their current circumstances' (Martin et al, 1997, p.33). CBT addresses negative thought patterns which are held to cause mental illness and assists people to redefine their world view more positively and optimistically.

Interpersonal psychotherapy (IPT)

IPT aims to help people to learn to manage interpersonal relationship difficulties that can lead to mental health symptoms. It holds that improvements in interpersonal functioning lead to symptom relief. It focuses on interpersonal and social functioning contexts.

Psychodynamic psychotherapy

Psychodynamic psychotherapy recognises that problems and behaviours in the present may be motivated by feelings from past experiences. The treatment consists of developing a therapeutic conversation focussing on a range of issues throughout the person's life and working through responses. The aim is to increase the person's awareness of unconscious factors that influence their thoughts, feelings and behaviours.

Motivational interviewing

Motivational interviewing is a client-centred counselling method which focuses on enhancing motivation for change by exploring and resolving ambivalence. It is frequently used in counselling for drug and alcohol problems.

Narrative therapy

Narrative therapy regards people as the ‘experts in their own lives’. The word ‘narrative’ refers to the emphasis that is placed upon the stories that people tell about their own lives and the possible ways these stories might be reframed.

Family therapy

Family therapy targets the improvement of communication between family members. Family therapy considers the problems people face in the wider context of life and the identities they have constructed through family relations and through history and culture.

Solution focussed brief therapy

Solution focussed therapy is a short-term goal oriented therapeutic approach which works with the strengths of people by identifying and making the best use of their resources.

Problem solving therapy

Problem solving therapy involves identification and analysis of the specific problem, the setting of goals to be achieved by solving the problem, the generation and evaluation of possible solutions and the selection of the most appropriate course of action.

Group therapy

There are a range of group therapy services available, including groups for anxiety disorders, depression, borderline personality disorder, and other problems such as dealing with drug and alcohol misuse. The particular therapeutic emphasis of such groups will depend on the background and training of the facilitator.

Involving community

When someone has suicidal thoughts or undertakes self harming behaviour, attention necessarily is on that individual and what should occur to achieve the best outcomes for them. Often, management of the person occurs mainly within a medical paradigm.

It is also important however, to consider individuals in terms of the different community affiliations they have – e.g. as part of a workforce, family, location, peer group or social group.

All of these social contexts could potentially play a role in suicide prevention if the people involved have relevant support and information. For example, if a person's behaviour changes in worrying ways, any person from these contexts could notice this and act appropriately if they knew what to do (and if mental health issues were not as stigmatised as they are). Sometimes an appropriate intervention could be as simple as someone noticing that a person hasn't attended their usual social venue for a while and bothering to check whether everything is OK.

Similarly, primary health care contexts can also be seen as communities, involving a range of staff with different roles holding key shared interests in working with a group of people who are part of their community – namely, clients. Ideally, suicide prevention could become everyone's business with appropriate communication and information in and between communities.

For interaction between different communities to occur effectively, there needs to be a proactive approach that enables and encourages pathways of communication. People in the general community need accessible information about how to respond to mental health concerns they have about anyone they know. And, primary health care, specialist and community settings need to convey a culture and ethos that invites people to feel comfortable in disclosing their feelings and fears if they need to. Ongoing training may facilitate this process and encourage the development of such a culture.

Jo speaks of her son's suicide:

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, 2005]

Connecting with clients and community

It is possible to make a difference within a particular community, primary health care or specialist context, in spite of systemic and social constraints. Some of the ways in which this might happen include:

- Reviewing to what extent the environment is inviting. For example, what messages appear in leaflets and posters about discussing mental health concerns?
- Reviewing the general ethos of the environment to ensure people feel comfortable. Have reception staff had any mental health awareness training? And are they aware of the possible implications of mental illness in terms of need for urgent appointments?
- Reviewing suicide awareness training needs for other staff who work with clients in any capacity.
- Having an understanding of who are significant people in a person's life.
- Knowing of, and having information for clients, about available community services – for example, support services, advocacy groups, community education and relationship skills, religious and other organisations offering counselling and other support.
- Having contact networks, for example, with people involved in:
 - Financial planning assistance
 - Counselling and relationship building
 - Drug and alcohol services
 - Employment services
 - Community participation organisations (e.g. Rotary, Lions clubs).

Connecting people with communities is an important part of management and care of people who are or have been at risk, especially when this is facilitated appropriately. It is important that people who deliver primary health care think about referral in ways that are holistic rather than mechanistic. In some situations 'referral' may well involve utilising community skill, knowledge and expertise. It can be viewed as an alliance of care.

Similarly, it is important that people who deliver primary or specialist care can also connect with the communities in which they work, to learn about the issues and services which can affect people's lives. Adopting this approach to mental health issues can assist in building protective factors for individuals. It can also assist in building capacity for communities to respond effectively to people who may be at risk.

For more information go to:

Community LIFE: A Framework for effective Community-based Suicide Prevention www.community-life.org.au and www.wesleymission.org.au/centres/lifeforce/about.asp.

Some questions for reflection

Reflect on your confidence and skills in suicide prevention

- How confident do I feel about talking to a person about his or her suicide risk?
- How do I feel generally about working with people who have suicidal thoughts or plans?
- Are there any additional skills or knowledge that would assist me in the area of mental health and suicide prevention work?
- Do I tend to notice cues and respond appropriately to issues that may be contributing to distress – e.g. family violence, poverty, sexual abuse, sexual identity issues?
- On reflection, are there particular people for whom it would have been appropriate to ask specific questions about suicidal thoughts or plans?

Reflect on how well you care for yourself

- How well do I take care of my own health and wellbeing needs especially in relation to the stress of working with clients who have mental health problems?
- Do I have particular strategies and activities in place to support my own mental health care – and are they adequate?

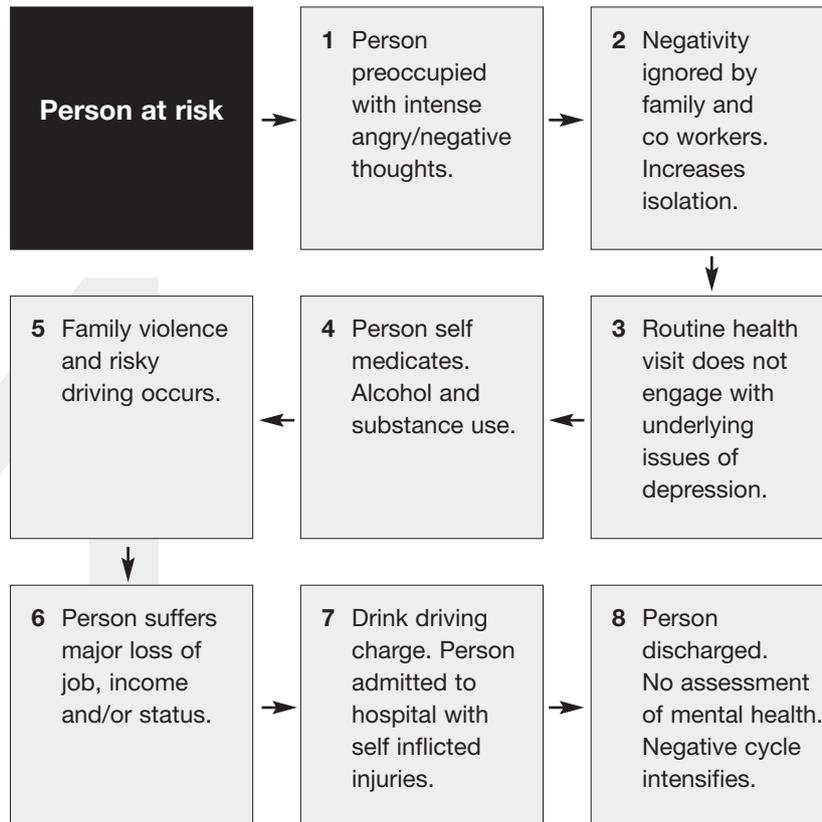
Reflect on the quality of suicide management in your practice

- Have I thought about other people who might be involved in management options?
- Is there information about community resources or options that could be gathered to assist me in managing clients with mental health problems?
- Are all staff in my practice, who have contact with patients, trained in basic communication (and safety) skills for responding appropriately to people who may have a mental illness?
- Is the work environment welcoming to a diverse range of people and is there anything that could be done to indicate that diversity is important and that everybody is valued?

Scenarios

In this final section we provide and discuss two hypothetical 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.

When the system fails. Case study: Mike



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.

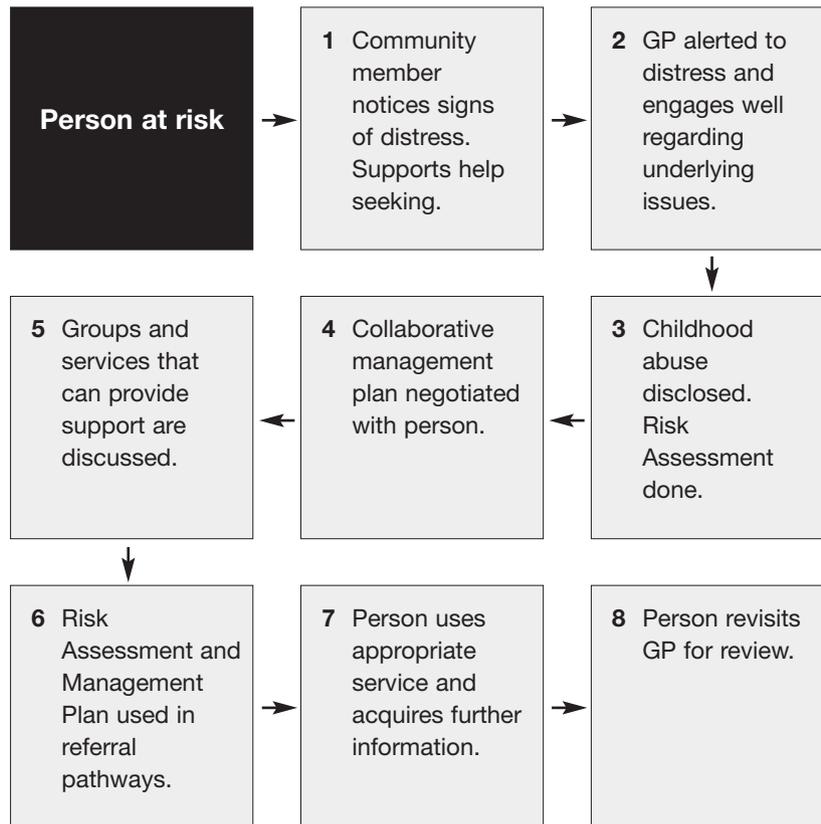
- Point 1: Mike preoccupied with intense angry/negative thoughts.** Although it is sometimes obvious when someone is preoccupied in this way, it can also be the case that an individual may mask such feelings. Some may even go out of their way to appear 'normal'.
- Point 2: Mike's negativity ignored by 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.** People 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 people 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 person 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: 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. Nobody to this point has offered any information to Mike about possible support options, e.g. anger management, men's groups, counselling regarding loss of job.
- Point 8: 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.

Scenario 2

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?

When the system works. Case study: Tania



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 help her 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.

Point 3: Childhood abuse disclosed. Risk assessed.

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. The GP enquires about other issues that might be happening for Tania and about the social support she has. 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 current thoughts or plans of acting on these ideas.

Point 4: Tania agrees to address the issues that are causing distress. Collaborative management plan is negotiated.

Tania agrees that she would like address the issues. Options and confidentiality are discussed.

Point 5: Groups and services that can provide support are discussed.

The GP discusses some support options including brochures, online information and a counselling service for survivors of childhood sexual abuse. Arrangements are made should Tania become further distressed.

Point 6: The risk assessment and management plan are used appropriately so that Tania can access the services.

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.

Point 7: Tania uses appropriate service and accesses more information.

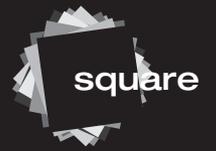
The counselling service takes Tania's experiences seriously and assists her to work through the issues and her feelings. She is given some appointments for face to face counselling and the opportunity to join a group in her area with people who have had similar experiences.

Points 8: Tania revisits GP after an appropriate interval, for review. GP reviews issues.

The GP 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. The GP re-assesses progress and risk of harm. On confirming that the counselling service has been extremely helpful and supportive in dealing with the sexual abuse issues, the GP also checks how confident Tania is currently feeling about social interactions. They mutually agree that additional social activities would be a positive thing for Tania to arrange. They agree to make another appointment for review in a month's time, or earlier if needed.



section 5 | **resources**



resources



A comprehensive Resource List can be found on the **square** CD-ROM/Website www.square.org.au.

Useful phone numbers

SA Emergency Mental Health Service	131 465 (Statewide)
After Hours Crisis Care	131 611 (4pm - 9am and 24 hours on weekends and public holidays)
Lifeline	131 114 (24 hour counselling service)

Useful suicide related websites

Auseinet

<http://auseinet.flinders.edu.au/>

Auseinet informs, educates and promotes good practice in a range of sectors and the community about mental health promotion, prevention, early intervention and suicide prevention across the lifespan.

Australians Creating Rural Online Support Systems (ACROSS)

<http://www.acrossnet.net.au/>

The ACROSSnet website aims to help members of rural and remote communities to access information, education and support regarding suicide and its prevention. ACROSSnet is a Queensland based pilot specially designed for rapid downloading for rural Australians.

ACROSSnet provides a comprehensive online resource for Australians looking for information in relation to suicide and suicide prevention. The resources available here are of three types:

- Documents (books, fact sheets, journals, websites etc.)
- Services (counselling, disability services, crisis management etc.)
- Organisations (Kids Help Line, Lifeline, Centacare etc.)

The website also has a comprehensive list of links for all aspects of suicide

Bereaved Through Suicide

www.bts.org.au

An Adelaide based group aiming to: provide support and care to those grieving the loss of someone through suicide; provide an understanding of the process of grief; help with healing and recovery; increase the understanding of suicide grief in the community. *Note:* At the time of writing their website was still under construction.

Ph: 08 8332 8240. Email: support@bts.org.au

beyondblue

www.beyondblue.org.au

beyondblue is the national depression initiative, a bipartisan initiative of the Australian, state and territory governments with a key goal of raising community awareness about depression and reducing stigma associated with the illness.

The website includes information about depression and anxiety, treatments, assistance with staying well, frequently asked questions and links to other sites. There is a section on Depression and Suicide.

The Black Dog Institute

<http://www.blackdoginstitute.org.au/>

The Black Dog Institute is an educational, research and clinical facility offering specialist expertise in mood disorders – a range of disorders that includes depression and Bipolar Disorder. Its website includes information for clinicians as well as for the community. There are sections on causes, treatments, getting help, fact sheets and frequently asked questions and answers.

CommunityLIFE

<http://www.community-life.org.au/>

The CommunityLIFE project is part of the National Suicide Prevention Strategy and is funded by the Australian Government Department of Health and Ageing. The project aims to support groups in the community to plan and develop suicide prevention activities and programs. Community groups may include sporting clubs, neighbourhood groups, schools, religious communities, service clubs, student groups – in general, people who are interested in a better understanding of suicide and its causes.

GriefLink (SA)

<http://www.grieflink.asn.au/frameset.html>

GriefLink is a resource on death-related grief for the community and health workers. As the site is based in South Australia some information about support services and educational activities is specific to SA. Has a page on 'Resources for Grief Associated with Suicide'.

LiFe

<http://www.livingisforeveryone.com.au/aboutlife.php>

The LiFe website has been developed by the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) as part of its commitment to facilitating networks for information exchange and learning under the Australian Government National Suicide Prevention Strategy (NSPS). On the LiFe site you will find:

- Access to online and print-based resources
- Australian statistics
- National and state/territory government policies
- Information about Australia's National Advisory Council for Suicide Prevention
- Information about suicide prevention projects in all states and territories funded through the NSPS.
- Resources related to the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples
- Access to the CommunityLIFE website which supports community based suicide prevention approaches
- Links to related sites, conferences and media reports.

Lifeline

<http://www.lifeline.org.au>

Lifeline is committed to enhancing the wellbeing of the community through the provision of services, the core of which is a 24-hour crisis telephone counselling service. Its website also includes information about suicide prevention, risk factors, and suicide bereavement and postvention.

For help finding services, call Lifeline's Just Ask on **1300 13 11 14**.

LivingWorks (Australia and Canada)

<http://www.livingworks.org.au/>

LivingWorks provides learning programs that help caregivers play a role in preventing suicide. LivingWorks focuses on increasing the awareness, knowledge and skills of caregivers – resourcing them to play a more informed, active suicide prevention role.

Mental Health Resource Centre (SA)

<http://www.mhrc.org.au/>

The Mental Health Resource Centre is a non-government umbrella organisation of mental health support organisations sponsored by the Government of South Australia for the people of South Australia. The Mental Health Resource Centre aims to assist all sections of the community by providing information and assistance to:

- Consumers
- Carers
- Advocates
- Students
- Relatives and friends
- Service providers
- The general public.

Mental health and wellbeing publications

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

A - Z listing of mental health and wellbeing publications.

Multicultural Mental Health Australia (MMHA)

<http://www.mmha.org.au>

Multicultural Mental Health Australia (MMHA) provides national leadership in mental health and suicide prevention for Australians from culturally and linguistically diverse (CALD) backgrounds. MMHA links a wide range of state and territory mental health specialists and services, advocacy groups and tertiary institutions to promote the mental health and wellbeing of Australia's diverse communities.

National Advisory Council for Suicide Prevention

http://www.livingisforeveryone.com.au/about_nac.php

The National Advisory Council for Suicide Prevention (NACSP) was first established in 2000 to set priorities and progress initiatives under the National Suicide Prevention Strategy (NSPS). The Australian Government has recently restructured and reformed the NACSP. The new NACSP Board is comprised of experts in the fields of mental health, research, issues for Aboriginal and Torres Strait Islander peoples, business, counselling, and cultural diversity.

National Self-Harm Network (UK)

<http://www.nshn2.co.uk/index2.html>

The National Self-Harm Network (UK based but available to everyone from any country) has been a survivor-led organisation since 1994. It comprises committed campaigners for the rights and understanding of people who self-harm.

SANE

<http://www.sane.org/>

SANE Australia is an independent national charity helping people affected by mental illness through campaigning, education and research. SANE conducts innovative programs and campaigns to improve the lives of people living with mental illness, their family and friends. It also operates a busy Helpline and website.

Suicide Prevention Australia

www.suicidepreventionaust.org

Suicide Prevention Australia is a non-profit, non-government organisation working as a public health advocate in suicide prevention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting:-

- community awareness and advocacy
- collaboration and partnerships between communities, practitioners, research and industry
- information access and sharing
- local, regional and national forums, conferences and events.

Together We Do Better

<http://www.togetherwedobetter.vic.gov.au/>

VicHealth's Together We Do Better website is full of ideas and information for people interested in their own mental health and wellbeing and that of the community. It contains ideas about activities and organisations to contact for help.

It provides information on mental health issues, news, case studies, and access to campaign resources, as well as tips for taking action to help strengthen the social fabric of the community.

Your professional association may also have useful information.



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for further information
www.square.org.au

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