primary health care setting

square

suicide **qu**estions **a**nswers **re**sources

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

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

Even a simple interaction like listening can be significant.

Everyone can make a difference.

note

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

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

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

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

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

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

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how to use this resource

This booklet is part of an integrated resource – **square s**uicide **qu**estions **a**nswers **re**sources 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, **Primary Health Care Setting**, is aimed at primary health care workers, community health workers, allied health workers and Indigenous health workers who may encounter people at risk of suicide in their professional roles. It is designed to be used in conjunction with the **Foundations booklet** which has been written for a broad audience and provides the foundations which underpin the following 8 booklets addressing specific settings and audiences.

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

introduction

Health workers in primary health care settings – whether GPs, allied health workers, community or Indigenous health workers – play a vital 'front line' role in early intervention and prevention of suicide.

In Australia and many other countries mental health is being recognised as a broad social issue. It is no longer just the responsibility of specialist professionals and acute treatment services, although their intervention and care will be needed in most cases involving severe mental illness.

Most mental health care is now delivered through general practice and other primary health care and community services. It is therefore important that GPs recognise the role that they can play in improving mental health and the value of working with other professions and services.

We know that most people who suicide, or attempt it, have contact with their GP (or other health worker) in the weeks or month beforehand. The primary health care setting is therefore an ideal 'window of opportunity' for suicide prevention and response – whether it be identifying people at risk of suicide, intervening to minimise risk and maximise immediate safety, managing ongoing treatment, making appropriate referrals to specialist mental health services, or assisting with social supports and services.

> Many people who have been seriously affected by mental illness manage their illness with only the support of a GP; for other people the GP will form an essential part of a wider team of mental health service providers. [Rickwood, 2004, p.13]

People with mental illness are often also physically unwell and the GP or other primary health care setting is an ideal site for the provision of holistic health care which meets the physical as well as mental needs of patients. GPs are ideally placed to develop a comprehensive understanding of someone's personal and family circumstances and to help them access local community services. With adequate training and support GPs are the most appropriate first choice for initiating mental health treatments.

In 2005 a range of South Australian service providers, including GPs and Mental Health Services, developed and trialled a risk assessment/referral and follow up form. These people found that the form assisted in a thorough and accurate assessment, that it was a good prompt to identify issues and ask questions, that it increased their confidence in assessment and management of issues and that the process streamlined referrals, clarified roles and increased communication and feedback. This form can be **downloaded from the management section of the square CD-ROM/Website www.square.org.au**

Primary health care workers also have a key role to play in postvention, either in assisting with the recovery and rehabilitation of someone who has attempted suicide or assisting those who are bereaved by the suicide of a loved one.

Key facts

- While there has been a decline of 18% in suicide rates since a peak in 1997, suicide is still a major public health problem in South Australia and nationally. Approximately 2100 Australians were reported as taking their own lives in 2005 (ABS, 2007). This is more than the number of deaths from road accidents, industrial accidents and homicides, together.

- People of all ages and from all walks of life may be suicidal.

- Many more people attempt suicide or deliberately harm themselves. Admissions to hospital for intentional self injury are about 10 times as common as deaths due to suicide. While men kill themselves more often than women, there is a higher level of attempted suicide and self harm among women.

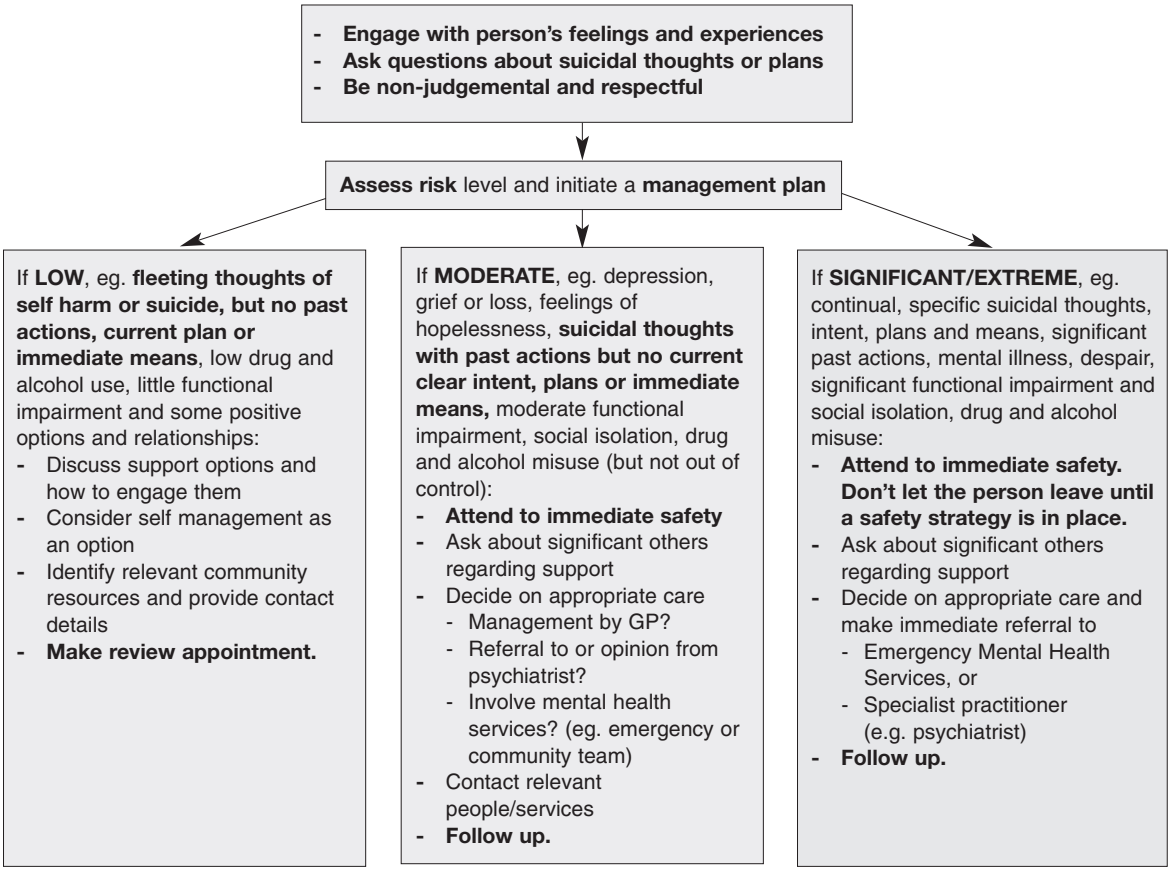
- Suicide and attempted suicide have a high economic and social cost. When an individual suicides, or attempts suicide, there is a ripple effect throughout the community. Family members, friends, colleagues and acquaintances all may experience significant pain, loss and grief.

- Postvention is the care and support of those who are bereaved through suicide. People in these circumstances are at a higher risk of suicide themselves. Their mental health and wellbeing should be assessed and monitored in primary health care settings whether or not bereavement is the presenting issue (see Booklet 9: Suicide Postvention Counselling.)

- Prevailing stigma surrounding mental illness and suicide may also produce feelings of shame and guilt. Those who survive a suicide attempt and those who are bereaved by suicide may seek help in primary health care and community health settings.

assessment and management of suicide risk

It is possible to miss suicidal ideation or self harm unless you build into your practice doing a risk assessment on those who may be at risk. Everybody with any degree of suicidal ideation or behaviour needs a mangement plan and follow up. The Risk Assessment will give you an indication of the degree of risk and therefore guide you in what should be in the management plan and the type of follow up required.



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.

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**

☐ none	☐ low	☐ moderate	☐ significant	☐ 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

☐ none/mild	☐ moderate	☐ significant impairment in one area	☐ serious impairment in several areas	☐ 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

☐ no problems/ highly supportive	☐ moderately supportive	☐ limited support	☐ minimal	☐ 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

☐ no problem/ minimal difficulties	☐ moderate response	☐ poor response	☐ minimal response	☐ 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

☐ no problem/ very constructive	☐ moderate response	☐ poor engagement	☐ minimal response	☐ 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

☐ none	☐ low	☐ medium	☐ high	☐ extreme

For more information about each of the categories in this form and specific questions which can be asked of clients, see the **Foundations booklet** and Dr Randall Long's **Risk Assessment paper** on the CD-ROM/Website.

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.

Management options

Primary health workers are involved at each stage of the assessment and management of suicide risk process, whichever management and referral option is chosen.

1. Self management for person assessed as Low Risk.

This pathway is appropriate when:

- The person has good social supports
- The person has rapport with the health worker and is able to discuss management
- Strategies are negotiated for vulnerable times (may involve community/family and/or medical)
- Useful information about accessible community resources has been supplied
- Review arrangements are negotiated and agreed with the health worker.

2. Primary health care or shared care for person assessed as Moderate Risk.

This pathway requires:

- Facilitation of access to appropriate community resources
- Management Plan which is documented and clearly communicated to the person and their support person/s. It will include contact information and details of a rapid response capacity for reassessment and appropriate escalation of care level, if required
- Face to face re-assessment (within a suitable time frame) is arranged and conveyed to the person and people providing support
- Specific strategies for ongoing review and care and active follow up if the person fails to attend.

3. Specialist Care for person assessed as Significant or Extreme Risk.

This pathway requires:

- Immediate and continued monitoring
- Consideration of detention and possible admission to hospital
- Referral to appropriate specialist mental health services
- Plan developed collaboratively between mental health service and primary health care worker
- Plan includes steps to ensure safety, specific strategies for ongoing review and care, and active follow up if the person fails to attend

In all pathways documentation should flow to all relevant people involved in the person's care in a timely manner.

Management plans

A **management plan** is a formal record of decisions about interventions to be taken.

A **management plan** will:
- provide brief history and the precipitating factors
- 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 attempted to ensure 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 Emergency Mental Health Services 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 or 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.

mental health care assistance for GPs

There are a number of ways in which GPs can provide mental health care, both on their own and in collaboration with allied health professionals and psychiatrists. One option is that GPs will themselves manage the mental health care needed by people who may be suffering depression or some other mental health problem and who may have suicidal thoughts. This treatment option is not ideal for high risk clients, but could be appropriate for people at low to medium risk, if the GPs have had relevant mental health training.

The ***Better Outcomes in Mental Health Care*** initiative provides support for GPs in providing mental health care. The five integrated components of this initiative are:

1 Education and training for GPs (From November 2006 this component has been integrated with new education and training associated with the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benfits Schedule Initiative.) – Level 1 training provides GPs with the skills to use the 3 step mental health process and Level 2 training promotes skills and knowledge that enable GPs to deliver focussed psychological strategies. Level 1 training is no longer mandatory however it is strongly recommended that GPs participate in appropriate mental health training such as that accredited by the General Practice Mental Health Standards Collaboration.

2 3 step mental health process – provides a framework for best practice management of mental health problems that comprises an assessment, preparation of a mental health plan and a review of the mental health plan. (From November 2006 new Medicare Items under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benfits Schedule Initiative have superseded this process.)

3 Focussed psychological strategies – the delivery by GPs of specific mental care treatment strategies: psycho-education, cognitive behaviour therapy (including behavioural interventions, cognitive interventions, relaxation strategies and skills training) and interpersonal therapy.

4 Access to Allied Psychological Services (ATAPS) – enables GPs who are registered with the *Better Outcomes in Mental Health Care* program to refer patients to allied health professionals who deliver focused psychological strategies through their local Division of General Practice.

5 Access to psychiatrist support – broadens the role of psychiatrists in providing mental health care through a Medicare Benefits Schedule (MBS) rebate which enables psychiatrists to take part in case conferencing on a patient's behalf, and the provision of patient management advice to GPs within 24 hours. This service is provided through *GP Psych Support* (ph 1800 200 588) and has recently been expanded to provide advice from specialists in both child & adolescent and drug & alcohol psychiatry (this advice may be provided in more than 24 hours). See the website for more information: *https://www.psychsupport.com.au/default_home.asp*

In South Australia consultation-liaison is available through the GP-PASA 291 service where a one-off psychiatric assessment and management advice is provided for patients who can be managed by the GP. See the website for more information: *http://www.sadi.org.au/activities.html*

Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS

The Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative provides better access to mental health care by GPs, psychiatrists, clinical psychologists and other appropriately trained allied mental health professionals. It encourages team-based mental health care in the community, through:

- Encouraging GPs to participate in early intervention, assessment and management of patients with mental health conditions and to streamline access to appropriate psychological interventions through new referral pathways to allied mental health service providers. This support is delivered through GP Mental Health Care MBS items which are based on a similar model of care as the *Better Outcomes in Mental Health Care* initiative's 3 Step Mental Health Process – Assess, Plan and Review.

- Encouraging private psychiatrists to see more new patients through MBS items that complement the GP and allied mental health items.

- Providing referral pathways for appropriate treatment of patients with mental disorders, including by psychiatrists, GPs, clinical psychologists and other allied mental health professionals through the introduction of Medicare rebates for individual and group allied mental health services.

- Supporting primary health care service providers with education and training to better diagnose and treat mental illness.

For more information about the Better Access program go to:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-betteraccess-1

South Australian Mental Health Shared Care Initiative

Divisions of General Practice in South Australia are funded to implement activities state-wide addressing the needs of consumers with chronic and complex mental health needs. The funding is provided in the areas of shared care and allied health services with a strong emphasis on partnerships with State Government health services.

Particular areas of interest include:
- chronic disease self-management involving referral to allied health workers
- addressing physical comorbidity by linking patients of mental health services with a GP
- psychological strategies designed to increase level of functioning
- early intervention to avoid crises
- specific population groups.

Further information is available from your local Division of General Practice.

Chronic Disease Management Medicare Items

A range of MBS items support GPs to manage the health care of patients with chronic medical conditions, including patients who need multidisciplinary care. GPs have access to Medicare rebates for preparing and reviewing GP Management Plans for patients with chronic medical conditions. For patients requiring multidisciplinary care, GPs can also claim from Medicare for coordinating team care planning and review services.

The Chronic Disease Management (CDM) items apply to treatment of people with asthma, cancer, arthritis, diabetes, heart disease and other chronic medical conditions. They complement the new GP Mental Health Care items for treatment of patients with mental disorders. The relevant item numbers appear on the Collaborative Management Plan form that accompanies this resource (it can be downloaded from the Management section of the **square** CD-ROM/Website **www.square.org.au**). Divisions of General Practice support uptake of the MBS items, provide education in these areas and work closely with practices on information management for patient register and recall and the utilisation of practice nurses. For more information go to:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease

Mental Health Nurse Incentive Program

The Mental Health Nurse Incentive Program provides incentive payments to community based general practices, private psychiatrist services and other appropriate organisations (such as Divisions of General Practice) who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. Further information is available from the website:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/coag-mental-prog-nurse

Medication management

Ensuring that patients are taking their correct medication is an important aspect of follow up. It is estimated that medication-related problems result in 80,000 hospital admissions and 900 deaths in Australia each year, 69% of which are considered avoidable. These problems arise from a variety of causes, including confusion (e.g. about changes to medication, multiple prescribers, multiple brands), poor compliance, difficulty in managing medication, interactions with other medicines etc.

Domiciliary Medication Management Review (DMMR) (also known as Home Medicines Review) can be a component of an Enhanced Primary Care (EPC) Multidisciplinary Care Plan if the patient is eligible (has chronic, complex medical condition) and if his/her health care needs require a pharmacist to be a member of the Multidisiciplinary Care Team.

GPs can use the DMMR to involve community pharmacies in ensuring that patients are managing their medicines adequately at home. The GP provides the patient with a referral to the community pharmacy of their choice and the pharmacist talks with the patient, preferably in the privacy of their home, about their medication. Advice can be given about matters such as how to take medicines correctly, appropriate storage, checking that prescription medicines and over the counter medicines are compatible etc. The pharmacist then provides a written report with recommendations to the GP who develops a Medication Management Plan, a copy of which is then sent back to the pharmacy. **There are MBS rebates for Medication Management, DMMR and EPC care planning.**

GPs may consider that some people who are suicidal would benefit from a DMMR, a GP Management Plan or Multidisciplinary Care Plan. Fact sheets, patient information sheets, referral forms and Medication Management Forms can be obtained from the Department of Health and Ageing:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-dmmr.htm

consumer issues

This resource acknowledges the pivotal nature of primary health care provision in the continuum of care for mental health consumers, especially that provided by GPs. Their role is especially important in rural and remote settings and in the prevailing climate of wider workforce and resource shortages within mental health services.

Consumers coming to a primary health care setting with depression or suicidal thoughts may feel intimidated and inhibited about disclosing the nature of their problem. They may present with physical problems such as tiredness, lethargy, insomnia or headaches, which may mask underlying mental health issues. Because of widespread stigma about mental illness they may feel a sense of shame or guilt about 'not coping', and may be reluctant to name feelings of hopelessness or despair. It is therefore very important that disclosure of such feelings is 'normalised' and encouraged in primary health care.

An environment should be established in which mental illness is accepted as a common occurrence, and deserving of the same care and concern as physical illness. It is also important that consumers feel a sense of optimism about their recovery and that they are made aware of the range of medication and psychotherapeutic interventions which are available. Such a climate of acceptance and positive thinking needs to be established and apparent in all primary health care settings.

Consumers need to feel that they are not wasting a GP's time by talking about depression or suicidal thoughts. They need to feel that this is a serious issue worthy of serious attention, just as they would feel if they had a physical injury.

Jo, whose son Samuel suicided, and who is now actively involved with bereavement support for others, explains her views on the importance of seeking help and being taken seriously:

> I guess I would ….certainly 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, interviewed for this resource, 2005].

A holistic response

Throughout the **square** resource it is emphasised that suicidal ideation/behaviour is not simply a medical illness. Effective responses require a holistic approach. In this process practitioners will engage with people about fundamental aspects of who they are, what is important to them and what is distressing them. This is challenging and confronting work for primary health care workers, and its significance cannot be underestimated. Health workers should be reassured that the very act of talking and listening to a distressed patient is therapeutic and can make a real difference.

A scenario
Sometimes the GP will need to uncover quite complex beliefs and attitudes surrounding depression and attitudes to treatment. For example, Peter, a GP whom we spoke to while developing these resources, recounted the story of an elderly man, suffering from chronic depression after his wife's death, and who was reluctant to accept any antidepressant medication or other treatment because he thought that his recovery would somehow be a betrayal of his wife and their life together. Identifying this belief required sensitive engagement and attentive questioning, listening and reassurance. The man had presented with physical health issues but after attending to some basic blood pressure and other tests, Peter devoted most of the consultation to listening to the man's story and the feelings he had about his need to maintain his grief. This strategy was deliberately used as a psychotherapeutic intervention, although it was never named as such. Knowing that this man had a number of suicide risk factors (elderly, male, isolated, bereaved by loss of a loved one) the GP sensed that the most appropriate way to proceed was to engage the man in therapeutic conversations as an ongoing strategy, so he could keep an eye on him. This was achieved by setting up subsequent regular appointments to check his blood pressure and renew his prescriptions.

The model supported by **square** emphasises the significance of consumers having support and a personal sense of control. To achieve optimal health outcomes, interventions will be collaborative and where possible, will include self management options. The inclusion of carers and significant others, where consent is given, is therefore recommended in the development of management plans, as are partnerships with community agencies.

best practice in the primary health care setting

- Firstly, **engage** with the person at risk to determine the issues (assessment) and the most appropriate management plan. **Tailor interventions**, actively involving the client's wishes and needs.

- Key considerations are:
  - The **immediate safety** of the person (and others involved)
  - Identification of issues
  - Collaborative management to **address the underlying issues**
  - **Continuity of support.**

- **Decisions about management options** should be made on clinical grounds, preferably with the involvement of the person.

- If referral to a specialist service is desirable, but not available as soon as you would like, **arrange to see the person again, as soon as possible, in the primary health care setting.**

- **Coordination of care** and appropriate reassessments are vital. If referral is only 'one way,' a person may receive crisis intervention, but little or no follow up.

- Recognise the client's own resources and **encourage self management** and use of community resources and services, if appropriate.

- If a person is or has been at risk of suicide, they need **ongoing review**. Levels of risk can change at different times and will require different levels of support.

- A knowledge of **community services** and **relevant state mental health policies, procedures and protocols** are important components of good management.

- **Familiarise yourself with relevant resources** such as interpreter services, Mental Illness Fact sheets, AGPN Information Sheets and useful brochures such as Toughin' it Out (see Resources at the back of this booklet).

- **Reflection on one's own practices** and decisions is vital for dealing with the psychological and emotional stress and uncertainty which may be involved in some decisions regarding suicidal persons.

Self care

Self care is typically not given much emphasis in health worker training. Because the dominant Australian culture does not condone public displays of grief, and because of notions of 'professionalism' and 'objectivity' within the medical profession, practitioners may hide their feelings or not take sufficient time out to deal with loss and grief. If practitioners engage in proactive self care this may prevent burnout or other long term negative effects.

Burnout
Common stressors within the primary health care professions, which may lead to burnout, are:
- Understaffing/high client load/inadequate mental health resources
- Constantly having to make critical decisions
- High levels of emotionality with clients
- The litigious context within which health care operates (Gundersen, 2001).

Working constantly with clients in crisis can also contribute to negativity and cynicism, high levels of drug and alcohol use, relationship problems and mental health problems. The prevalence of practitioner suicide, which is higher than in the general population, is also a cause for concern. Female practitioners are at greater risk than male practitioners, possibly because of: lack of female role models; institutional and individual sexism; and inadequate female-specific support.

If primary health care is to be fulfilling and sustaining for both clients and practitioners, we need a system that is both community building and individually supportive. It is important that health care workers, just like those at risk of suicide, focus on the protective, as well as the causative factors.

Some reminders
- Remember that while you can assess the risk suicide, you cannot always prevent it.
- It's OK to admit you don't know. Seek assistance from others with specific knowledge and experience.
- Debrief or seek support from skilled collegues after a critical incident.
- Supporting clients to develop their own skills may be more productive than attempting to 'rescue' clients who are at risk.
- Reflective thinking is integral to self care.
- Review your own needs with the same seriousness as you review client needs, and seek help if necessary.

references and resources

References

Australian Bureau of Statistics (2004) Suicides: *Recent Trends Australia,*
http://www.abs.gov.au/Ausstats/abs@.nsf/0/a61b65ae88ebf976ca256def00724cde?OpenDocument

Australian Divisions of General Practice (ADGP) (2003) *Familiarisation Training GP and Practice Manual,* 2nd edition, June 2003

Gundersen, L. (2001) 'Physician burnout'. *Annals of Internal Medicine*, 1135: 145-148.

Rickwood, D. (2006) Pathways of Recovery: Framework for Preventing Further Episodes of Mental Illness Summary Sheet *http://www.auseinet.com/files/recovery/4a_summary.pdf*

Resources

For a comprehensive list of suicide prevention resources see 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)

AGPN Information Sheets
The Australian General Practice Network has produced a number of relevant information sheets, including:
- *Better Outcomes in Mental Health Care Initiative*
- *Psychiatry Support Services to GPs*
- *Your mental health & alcohol: Managing the mix*

These can be downloaded from: *http://www.adgp.com.au/site/index.cfm?module=DOCUMENTS&leca=69*

Bereaved through Suicide
A South Australian counselling service for those grieving the loss of someone through suicide.
Ph. 08 8332 8240 or email support@bts.org.au

beyondblue
www.beyondblue.org.au
beyondblue is the national depression initiative, 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.

Department of Health and Ageing
http://www.health.gov.au/internet/wcms/publishing.nsf/content/mental-pubs
This site provides information about Australian Government mental health initiatives and an A-Z listing of mental health and well-being publications.

Doctors' Priority Line: Telephone Interpreter Service
http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/english-speakers/doctors-priority.htm
Doctors have preferential access to telephone interpreters, in major community languages, which they can access within 3 minutes. Interpreters are available 24 hours a day, 7 days a week and are usually free of charge. You can organise a telephone interpreter by calling 1300 131 450. For more information go to website.

LiFe
http://www.livingisforeveryone.com.au/aboutlife.php
Developed by Auseinet, this site includes:
- Links to online and print-based resources
- Australian statistics
- National and state/territory government policies
- Information about NSPS suicide prevention projects in all states and territories
- Resources about the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples
- Link to the CommunityLIFE website which supports community based suicide prevention approaches.

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 the Lifeline Information Service on **1300 13 11 14.**

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.

Mental Illness (MI) Fact Sheets
http://www.schizophrenia.org.au/papers_the_fact_sheets.htm or http://www.mifellowship.org/
The Mental Illness Fellowship (MIF) has produced a series of 35 Fact Sheets, covering topics such as:
- *Signs of mental illness and what to do*
- *What can friends and family do to help a person experiencing mental illness?*
- *Understanding suicide and mental illness*
- *Collaborating with professionals for the best outcomes*
- *The mental health legal framework in South Australia*
- *The mental health service delivery framework in South Australia*

For copies phone 08 8221 5160 or go to the MIF website.

Toughin' it out
http://www.kirinaran.com/index.php?option=com_content&task=view&id=40&Itemid=156
A pamphlet designed to be handed to the consumer or to be placed with other health promotion material.
'Toughin' It Out' is based on years of counselling and personal experience. The pamphlet exposes the way that suicidal thoughts work. This gives the consumer strategies to control the thoughts and to arrange their environment to diminish the likelihood of self-harm.

for further information
www.square.org.au

square

Australian Government
Department of Health and Ageing

Government of South Australia
Department of Health

Relationships Australia
SOUTH AUSTRALIA

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