SUICIDE: AN OVERVIEW

1. CONTEXT

1.1 INTRODUCTION

All Australians are affected by suicide. It is a major public health issue with significant human, social and economic costs. Yet suicide is still surrounded by a great deal of stigma. People are reluctant to talk about it, both with those who are at risk and also with family members, friends and others affected by it. While there has been significant change since the days when attempted suicide could be prosecuted as a crime and people who suicided were buried in separate parts of cemeteries, it is still a topic which is often shrouded in secrecy and associated with feelings of guilt and shame.

Statistically suicide is a relatively rare event. Nonetheless, the World Health Organization estimates that in the year 2020, based on current trends, approximately 1.53 million people worldwide will die from suicide and ten to twenty times this number will attempt suicide (Howell *et al.*, 2005, p.3)

In 2003, 1.7% of all registered deaths in Australia were attributed to suicide. This was 2213 deaths (ABS, 2004), an average of six suicides every day, and more than the number of deaths from road accidents, industrial accidents and homicides put together. The actual number of suicides is likely to be greater than this, because of under-reporting due to enduring moral disapproval and stigma.

When you add to this picture the many more Australians who harm themselves or attempt suicide, often with serious impediments as a consequence (e.g. brain injury due to overdose), and the psychological distress experienced by grieving friends and family members, it is evident why the prevention of suicide, suicidal behaviours and self harming is an important focus for public health interventions, both in Australia and internationally.

Long-term, population-based prevention campaigns, alongside programmes aimed at specific populations of at risk people, have been developed in response to recognition of the ongoing social impact of suicide (Howell *et al.*, 2005). This has necessitated a broadening of the ways in which we define suicide, understand its causes and formulate prevention strategies.

One of the main outcomes of recent state and federal suicide prevention programs within Australia has been the growing recognition of the importance of primary health care services in early intervention and prevention. While many would concur that there are wider systemic health care issues to be addressed, there is still an immediate imperative to address suicide prevention within the existing system.

Howell *et al.* (2005) suggest that:

Primary health care services are well placed to play a role in all levels of prevention whether it be assisting with social supports, services at the time of crisis or post-vention activities. Goldney has described primary care practitioners as having a 'window of opportunity' for preventing suicide. It is common for people who ... suicide to have contact with health care services in the year before they suicide. Rates of contact were found to be much higher for primary health care providers (75%), relative to mental health services (33%). On average 45% of suicide victims had contact with primary health care providers within a month of suicide....if these trends in health care contact continue, suicide prevention efforts involving primary care may be the most effective means of preventing suicide (p.48).

It is recognised that health practitioners working at the coal face may have little time to engage in training around suicide prevention. It is also recognised that they face inevitable pressures of time in consulting with many clients in a day. Nonetheless, their potential role in suicide prevention is absolutely vital (see Pfaff *et al.*, 2001).

Such recognition has inspired the development of **square**. The information contained within this overview paper and the accompanying suggested readings and annotated bibliography will provide general practitioners and other primary health care workers, specialists, community workers and any people in the community concerned about suicide prevention, with an overview of current information and thinking about suicide in Australia. Other papers and articles will address specific issues of risk management, self care, referral pathways and cultural, moral and legal issues and available resources.

1.2. UNDERSTANDING SUICIDE

Understanding suicidal behaviours and thoughts requires us to reflect on the society in which we live and to accept that suicide is everyone's responsibility. This means adopting a broad approach which takes into account social and cultural as well as biological and medical factors, and acknowledging that individual behaviours are determined in a complex interaction between 'the person, their mental state, their support network, their culture and their society' (LIFE Framework, 2000. p.3).

The ability to cope with life, or not, is shaped by the social contexts in which individuals exist and social inequities such as unequal access to education, health care and community support have an effect on suicide rates. Hassan (1995) explains that in countries such as Australia:

> *…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 [sic] (p. 3).*

Reconnecting people to one another and challenging ways in which social systems may fail individual people are thus an integral part of an ethical framework for suicide prevention.

Prevention initiatives will be most effective when they take into account the diversity of cultural attitudes and beliefs. Cultural factors must therefore also be added to a bio-psychosocial model. Recognition of the role of culture suggests that we must pay attention to the ways in which dominant cultural norms may shape our biology, our psyche and our social relations. For example, disadvantage may lead to poor nutrition and long term illness; discrimination may lead to feelings of inadequacy or futility; a lack of social cohesiveness and support may result in people having nowhere to turn in times of crisis.

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 historically derived, social and economic disadvantage which may heighten their risk of suicide.

1.3. DEFINING SUICIDE AND SUICIDAL BEHAVIOUR

When defining suicide and suicidal behaviour it is important to consider both the role of the individual person and also the ways in which the behaviour may be a response to particular social and cultural contexts. The following definitions are useful.

Suicide is defined as the deliberate taking of one's own life. Suicidal behaviour refers to the whole spectrum of suicide attempts from:

1. Highly lethal (in which survival is due to good fortune)

2. Low-lethality attempts in the context of a social crisis (often containing a strong element of an appeal for help), and

3. Death by suicide.

Suicidal ideation is thinking about suicide without action, and is more common than suicidal behaviour.

Deliberate self harm is defined as 'the intentional injuring of one's own body without apparent suicidal intent'. Other words sometimes used are parasuicide and self mutilation. Not all people who self-harm are suicidal, but a significant proportion do die by suicide [Adapted from Howell *et al.*, 2005 p.13].

It is important to acknowledge that self harm may not necessarily be a suicide attempt. It is usually a response to distress of some sort, and is often associated with mental illness. It can sometimes be a form of control – ie. a strategy for 'managing' the risk of suicide. Or it may be a way of coping with psychological distress – a form of release to temporarily avoid pain. However, self harming behaviour can become a dangerous and compulsive activity and may precede suicidal attempts.

These definitions draw attention to the role of the individual person in suicidal behaviour, while also acknowledging how that behaviour may be a response to particular social and cultural contexts of crisis. While it recognises that some 'low lethality' suicidal behaviour may be an 'appeal for help', this does not imply that such appeals are necessarily individualistic or psychological. Suicidal attempts are all too readily dismissed as 'appeals for help' or 'acting out', yet there is ample evidence that people who have previously attempted suicide are at high risk of ultimately suiciding.

1.4. DIMENSIONS OF THE PROBLEM

Statistics on suicide demonstrate that it is a major concern for those involved in public health. Whilst reports of suicide rates are unreliable due to issues of definition and stigmatisation (see Hassan, 1995), it is nonetheless the case that death by suicide constantly ranks among the highest causes of death, both nationally and internationally.

While men and women and 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, older men, Indigenous young men and rural residents. One disturbing trend is that the suicide rate for young males aged 25-34 years has more than tripled over the past 40 years. For example, since 1990, suicide has been a more common cause of death for men in Australia than motor vehicle accidents (Hassan, 1996).

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.

Stewart (2005) summarises the research on women and self harm as follows:

Consistent with global trends, the documented rate of attempted suicide among women in Australia is substantially higher than among men (ABS 2002). While hospitalised self-harm should not be seen as equivalent to 'attempted suicide', it is significant to note that rates for women in this category are markedly higher than among men for all age groups, with an overall ratio of male to female of 0:74 (Steenkamp & Harrison 2000). In NSW in 1996-97, the ratio of 'attempted suicide' that resulted in hospitalisation to suicide death was 23.5:1 in females as compared to 4.4:1 in males. The rate of non-fatal suicide resulting in hospitalisation is even higher among young women, with approximately 40 attempts for every 'completed suicide', as compared to approximately 6 attempts for every death among young men. (Stewart, 2005 p.8)

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. The community impact of suicide should therefore not go unmentioned. Those who are bereaved by suicide, or those who may survive a suicide attempt, are often not considered when we examine suicide statistics. Yet these people constitute a large number of those presenting in primary health care and community health setting for help in relation to suicide. Understanding the wide and long ranging impact of suicide behaviour will greatly assist in assessing suicide risk.

NATIONAL STATISTICS

- In 2005, 1.6% of all registered deaths were attributed to suicide (2101 deaths by suicide)

- In the period 1995 – 2005 the male age-standardised suicide death rate was nearly four times higher than the corresponding female rate. More young women than men attempt suicide, but women have fewer fatal outcomes.

- In age-standardised suicide death rates, most occurred in males aged between 15 and 45 years.

- The highest age-specific suicide death rate for both males and females in 2005 was observed in the 30-34 years age group.

- Many more people attempt than complete suicide. Admissions to hospital for intentional self injury are about 10 times as common as deaths due to suicide.

- While suicide remains a major public health issue, there has been a reduction in suicide rates since 1997, when the highest rates ever were recorded in Australia. In particular, the number of suicide deaths of young people aged 15-24 years, an age group that has been the focus of many of the Australian Government's suicide prevention initiatives, has decreased.

- National data, published by the Australian Bureau of Statistics for the ten years 1995- 2005, show that since 1997 there has been a continuing downward trend in the overall number of people dying as a result of suicide, but with the overall male suicide rate remaining at about four times that for females.

STATE AND GEOGRAPHIC STATISTICS

In the period 2001-2005, the Northern Territory had more than double the national rate of suicides. Tasmania was 39% above the national rate with Queensland and South Australia 14% above the national rate. New South Wales, Victoria and the ACT all had rates lower than the national rate.

When the statistics are alternatively split by geographic location, moving away from major urban centres means higher rates of suicide per capita for men (Caldwell, Jorm, & Dear, 2004). While the increase in suicide rates away from major urban centres is seen for all age groups of men, it is particularly notable for men aged 20-29. There is a very slight but insignificant decrease for women.

SUICIDE RATES (PER 100,000) BY GEOGRAPHIC AREA, 1997-2000

	Metro (>100,000 in urban centre)	Rural (99,999 - 10,000)	Other rural/remote (<10,000)
Men > 20 yrs	20.2	24.0	25.7
	5.6	5.7	5.1

1.5 FACTORS CONTRIBUTING TO SUICIDE

Different contributing factors are found across suicides, though there are also individual characteristics. The Table below sets out the 11 factors which were identified in one study as contributing to 411 suicides in South Australia between the 1st January 2000 and the 31st December 2001 (Miller, 2004):

TABLE 1: FACTORS CONSIDERED AS CONTRIBUTING TO SUICIDES IN 2000 AND 2001.

	Cases	Percent
Mental Health Issues	235	61.8
Other Factors	234	61.3
Interpersonal Problems	195	51.3
Employment Status	194	48.1
Relationship Breakdown	159	39.7
Physical Health Issues	104	27.4
Residential Mobility	104	27.4
Financial Problems	100	26.2
Attempted Suicide	87	22.9
Migrant/Refugee	38	10.0
Educational Achievement	23	6.0

These factors were not mutually exclusive and multiple factors were identified in each case as having contributed to the suicide. The Table indicates the number of cases for which each of the eleven factors were considered as contributing to the suicide and the percentage that these cases comprised of the total. Significantly, interpersonal problems and mental health issues were the two most frequently identified contributing factors.

This Table does not indicate which factors were more crucial in leading a person to making the final decision, nor the time period over which the confluence of factors occurred, nor the order in which the factors took place, though often they occurred concurrently. But it does show clearly the complexity of factors that often contributed to the suicides. This indicates that it is often not particular factors that lead to suicide, but rather the overwhelming sense that life is just too much. People are seeking a way out from all the negative 'stuff' that has consumed their lives, often for many years.

It was found that for two-thirds of victims, precipitating events occur in the six months prior to the suicide that are directly related to the suicide, and often these events occur within a day, a few days, or few weeks.

2. RISK AND PROTECTIVE FACTORS

2.1 RISK FACTORS

Being informed about risk factors assists in the identification of individuals who may be at risk of suicide. These factors cannot be viewed as causal – rather, they indicate patterns and trends that could serve as useful background material to factor into situations where risk may be present.

ATTEMPTED SUICIDES/SELF HARM

Data on attempted suicide is difficult to obtain because of definitional difficulty and because people who attempt suicide, or self harm, are not necessarily admitted to hospital or recorded anywhere. The studies that do exist indicate that rates are much higher for females than males. In Australia there is a striking difference in terms of the methods used. In attempted suicides the most common method is drug overdose. More lethal methods of suicide such as hanging or shooting are linked with higher rates of death by suicide, however.

SELF HARM

Self harm encompasses a wide variety of behaviours and acts. Terms such as attempted suicide, parasuicide, and deliberate self harm (DSH) are also sometimes used to describe it. They all describe non-fatal acts of self harm with varying degrees of risk to life and suicidal intent. All indicate intense emotional distress. People who have self-harmed are at greatly increased risk of suicide and should have access to assessment and support (from Samaritans Website, 'Self Harm & Suicide Information sheet', 2005).

MARITAL STATUS

The suicide rate among married people tends to be lower than for others in the community.

ECONOMIC CYCLES

During the 20th century there was a strong correlation between unemployment and the suicide rate, particularly at peak times e.g. during the Depression and the stock market crash of 1987.

OCCUPATION

There appears to be some link between job characteristics and suicide rates. These characteristics are:

1. Unskilled and semi skilled work

2. Low job autonomy

3. High supervision

4. Low on-job training

5. Poor promotional opportunity

6. Low wages

7. High sensitivity to market trends

In addition, these characteristics are likely to have higher impact on people as they age. Conversely, high status occupations with the reverse characteristics of those listed above tend to have low suicide rates, except where there is downward mobility with associated loss of esteem.

MIGRATION AND ETHNICITY

There is a significantly higher suicide rate among people born overseas than for those born in Australia. There is also a high variation in suicide rates between different groups of immigrants. This is attributed to degrees of social disruption and levels of integration that have been possible. There seems, for example, to be a lower suicide rate among people who have good English language skills.

Indigenous Australians have a suicide rate that is up to 40% higher than the general population. The rates of suicide are not distributed evenly throughout Indigenous communities, however. Most studies attribute high rates of suicide in Indigenous communities to the effects of colonisation and ongoing disadvantage that has produced dislocation, despair and a range of risk behaviours.

PUBLIC WELFARE

There is an indication that the provision of a comprehensive social welfare system has a bearing on suicide rates. This is because it helps to counter the vulnerability of high risk groups.

AGE AND GENDER

Males aged between 15 and 34 are a high risk group in almost every country in the world and suicide is one of the three leading causes of death in this age category. (De Leo et al.,2001). In Australia, the highest risk group is males between 25 and 44 years of age. There is also a high rate of suicide among men of 65 years and over. More young women than men harm themselves or attempt suicide, but women have fewer fatal outcomes.

MENTAL ILLNESS.

Nearly all mental disorders bring an increased risk of suicide. Personality disorders or schizophrenia have been encountered in young suicidal people, while mood disorders peak in older life. It has been reported that 40 to 50% of elderly depressed people may not mention feeling depressed in a clinical consultation (Shulman,1999, in De Leo, 2001). The 'presenting problem' may be something like tiredness or insomnia, for example, which may make the detection of the underlying problem difficult.

AT RISK MENTAL STATES

States such as hopelessness, shame, guilt, anger can become a personal risk factor.

SEXUAL IDENTITY CONFLICTS

If people are in conflict about their sexual identity, for example experiencing ongoing conflict between their sexual responses and the ways in which they want or need to be perceived, they can be at risk. Homosexual people can also carry the burden of people's responses towards them, i.e. homophobia.

HOMELESSNESS

Homeless people are a vulnerable risk group and likely to experience a convergence of risk factors, such as mental illness, isolation, and substance misuse.

HOSTILITY

There has been some suggestion that generalised hostility is a characteristic of suicide attempters, irrespective of age and associated depression (Weissman *et al.*, 1973), though no significant research work appears to have been undertaken since this date.

RECENT MAJOR LIFE EVENTS

Major life events involving loss, especially if they are accompanied by humiliation, can be risky situations.

Other risk factors include:

- Chronic pain or illness

- Impending legal prosecution

- Family breakdown, child custody issues

- Difficulty in accessing services

- Unwillingness to accept help

- Impulsivity.

2.2 PROTECTIVE FACTORS

These include strong perceived social supports

- Family cohesion

- Peer group affiliation

- Strong community connections

- Good coping and problem solving skills

- Positive problem solving skills

- Ability to seek and access help.

3. ISSUES

The factors involved in suicide behaviour and prevention are constantly changing, making it difficult for primary health care workers to stay abreast of the many competing factors that may require assessment. Whilst there are a number of factors (such as mental health problems, isolation and marginalisation) that are relatively constant in their impact upon suicide risk, there are other factors which are only now starting to make themselves known.

The changing face of the dominant Australian culture, specifically the increasingly multicultural composition of the population, is a major factor in shaping the context of suicide risk management. This is accompanied by global shifts in economics, technologies and politics. In addition, new forms of suicide risk are arising from the innovative types of relationships that people develop with one another (e.g. through the internet), or through the increasing availability of means to suicide that may not have formerly been available (e.g. new poisons, technologies etc.).

Understanding and engaging with these changes are a part of the worker's commitment to ongoing learning, and to providing current, informed, care to clients. It is likely that the vast majority of the issues presented here will continue to shape suicide risk in Australia for the foreseeable future, thus requiring health care workers to understand some of the reasons behind them and appropriate responses to them.

3.1 DIVERSITY

An awareness of diversity is relevant to suicide in a primary health care context for several reasons. These include:

- The fact that Australia is one of the most culturally diverse countries in the world

- Aspects of difference and diversity are often significant in understanding and relating to another person

- Aspects of identity and diversity can influence service access and delivery

- Aspects of identity and diversity can involve burdens of stigma and marginalisation that are relevant in risk assessment and case management.

A key concept in thinking usefully about diversity is to examine our own 'cultural location' and the ways in which this may influence our perceptions, ways of looking and assumptions about 'how things are'. This is an important concept for people delivering primary health care, because their judgements can have high impact on another person's wellbeing.

THE SOCIALLY CONSTRUCTED NATURE OF DIFFERENCE

Any individual's 'world views', values and assumptions are constructed by many complex influences, for example:

- Family/community values, behaviours, practices, stories

- Ethnic identities and rural, city, suburban location

- Religious and political influences

- Degree of privilege e.g. education, social economic

- Gender.

An example of the ways in which values and assumptions are socially constructed – and the potential effect of this -- is to look at the changes and differences in attitudes towards homosexuality. It was not until 1973 that homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM). This was due in part to changing social norms generally, and in particular to a politically active gay community in the United States. The decision, made by the Board of Directors of the DSM, was supported by a vote of the membership in 1974. Significantly however, the vote was by no means unanimous and still today there is debate, both about the moral acceptability of non-heterosexual responses and whether non-heterosexual behaviour constitutes a disorder. This example raises several issues about diversity, for instance:

- Do assumptions about 'normality' change in different historical times and in different places?

- What implications are there in the issue of a medical classification being made by a vote which was heavily informed by political and social perspectives?

- Is it ever possible to talk about any population e.g. homosexual people, as if they are homogenous?

DIVERSITY IN PRACTICE

Delivering services effectively to a diverse range of people requires the ability to be open to differences and the responses that might therefore be appropriate – without generalising about those differences. In practice this means not highlighting certain features of a person's identity in ways that become defining of who that person is. The following points may assist in achieving this balance.

- Examining diversity involves recognizing the complexity of intersecting and multiple aspects of identities, for example, gender, ethnicity, age, socio economic status, sexuality, physical and mental ability.

- Many people who experience marginalisation (e.g. someone with a mental health problem or a person living with a disability, or who is Indigenous) report that by far the most difficult thing to handle are the attitudes and responses of the general community.

Responding effectively to diversity requires an appreciation of the many overlaps that may exist in any one person's identity. It also requires an appreciation of 'positional' factors that can be in play in certain interactions (e.g. the unequal relationship between a young Aboriginal woman and a white male doctor).

SOME POINTS FOR PRACTICE

- Collecting 'snapshot' aspects of another culture or population is less likely to be helpful than being aware of the dynamics involved in diverse interactions

- Cultural self reflection may involve heightening awareness of issues such as:

  o The relationship between oppression and privilege

  o How some cultural values are privileged over others

  o The cultural specificity of knowledge (e.g. there are many different cultural understandings of what depression is, and where and how it is located in the body)

  o Language used to convey knowledge and information

  o The constructed nature of professional reality (e.g. consider the assumptions and meanings behind 'poor' patient attitude)

  o Learning how to deal respectfully with difference rather than 'forwarding on' as a first option can be important

  o Recognition of the social and political connections with health, e.g. most health issues for Indigenous people are produced by political and historical events and ongoing practices.

Having established the importance of not generalising about individuals within population groups, it is nonetheless important to identify populations who may be living with additional issues in relation to risk. These populations are identified below.

POPULATIONS

MALES AGED 15 TO 24 YEARS

In Australia, the suicide rate among this population is among the highest when compared with other western industrialised countries. In the period 1995-2005 the rate for this group was nearly four times higher than for the corresponding female rate. Reasons for this may be a higher level of risky behaviours, impulsiveness and drug and alcohol use. The rate for this group is particularly high in small rural towns.

INDIGENOUS AUSTRALIANS

The overall suicide rate in Indigenous communities is estimated to be up to 40% higher than in the general population. The rates are not distributed evenly across communities, however. Much research identifies the consequences of colonisation such as alienation, despair, loss and grief, combined with ongoing social disadvantage, as linked to high rates of suicide.

SEXUALITY ISSUES

People who do not identify as heterosexual are often at increased risk of stigmatisation and discrimination. Examples of this include:

- Harassment in the workplace

- 'Gay bashing' and abuse in public places

- Rejection by family and friends

- Stereotyped responses e.g. from health providers or educators

- Being pathologised and totalized (i.e. defined only by sexuality and defining anything other than heterosexuality as, by definition, problematic or an illness).

IMMIGRANTS

Some research (Burvill, 1998) has established that suicide rates tend to closely mirror those within their former country. It may therefore be important for workers to engage with the cultural meanings that a person brings with them. It is also important to recognise issues such as the discrepant cultural pressures that can be operating in someone's life when they are negotiating home country and host country values.

REMOTE AND RURAL COMMUNITIES

As well as access to service problems there are compounding issues in remote and rural communities, for example:

- Small community numbers may provide little buffer against social discrimination

- Changing and unpredictable socioeconomic circumstances can result in feelings of failure.

It is also well established that ongoing hardship and lack of support may lead some people in rural and remote communities to contemplate suicide. Their risk may therefore be higher and they may also:

- Use more violent means

- Engage in higher risk behaviour in general

- Be likely to complete suicide

- Display less obvious warning signs of suicide risk

- Have greater access to means e.g. guns.

WAR VETERANS

Research has established that the effects of being involved in war can increase an individual's risk of suicide. This is predominantly due to:

- Post traumatic stress disorder, amputation, spinal injury or other impediments resulting from fighting

- Being a prisoner of war

- Chronic pain and depression

Significantly, there also seems to be a particular risk for the children and families of war veterans who suicide. It has been suggested (O'Brien, 2004) that post traumatic stress disorder can be transferred as a learned behaviour, thus increasing suicide risk across generations. Such children have a three times greater risk of suicide than the general population (Australian Institute of Health and Welfare, 2000).

OLDER ADULTS

Some factors associated with suicide among older adults are:

- Loneliness

- Loss of partner

- Chronic illness, terminal illness, pain

- Loss of mobility and freedom

- Older men are at higher risk.

REFUGEES

Suicide rates in mandatory detention centres are 41 times higher than the national rate for men and 26 times higher than the national rate for women (Dudley, 2003). There are also detrimental implications for refugees post detention for example:

- Grief and loss

- Breakdown of community and recognition of rights

- Post traumatic stress disorder from experiencing and or witnessing abuse

- Disrespect of religious and cultural practices.

PRISONERS

Suicide is the leading cause of death in Australian prisons, and is estimated to be between 2.5 times and 15 times that of the general population (depending on calculation methods). In the period 1980-1998, a total of 787 people died in Australian prisons and 46.6 % of these deaths were as a result of suicide. While the national average prison population almost doubled during this period, the number of deaths and those resulting from suicide, increased at the alarming rate of 240% (Dalton, 1999; McArthur *et al.*, 1999). The incidence and rate of self harm is also extremely high.

> *It has been estimated that for every suicide there are 60 incidents of self-harming behaviour …. It is evident that inmate self-harm has become endemic in many correctional institutions. [McArthur et al., 1999 p.1]*

3.2 THE INTERNET AND THE MEDIA

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.

THE INTERNET

The numbers of people who are connected to the Internet at home, or who have access in some form, is rapidly growing. While there are a number of potential gains to be made in using the Internet as a support and resource tool for those at risk for suicide, it may also work against these ends by providing access to increased knowledge about suicide means. Research by Baume *et al.* (1998) has shown that the Internet may be used by those at risk for suicide to:

- Gain information about effective suicide means

- Access advice (on suicide) from online chat rooms

- Feel supported in their decision to suicide.

Factors such as these are also influenced by the relative anonymity of the Internet, which may encourage those contemplating suicide to explore thoughts and plans when they may not otherwise have had the opportunity. It has thus been suggested that whilst the Internet may be a valuable resource for those at low risk for suicide, it may only serve to promote suicide to those who are at high risk or in crisis (Becker & Schmidt, 2004).

It may be possible to intervene by providing information about alternate online sites that support suicide prevention (for examples of this see the weblinks in the Resources section of the **square** CD-ROM/Website). This may also involve encouraging people to seek offline counselling, or to reconsider the information and choices made available online. As the Internet continues to open up new possibilities for relating to one another and for promoting health, it is important that practitioners continue to develop an understanding of the implications of these ongoing changes, and to use them as required when assessing risk.

THE MEDIA

The way in which suicide is reported in the media can have an impact on both suicide rates and prevailing community attitudes to suicide and support for prevention programs. In an excellent report on suicide and the media, Pirkis and Blood (2001) outline some of the current problems regarding the ways in which suicide is reported within the media. These include:

- The methods used in suicide or self-harm are often explicitly described.

- The language used for describing suicide is often inappropriate, such as 'failed suicide attempt' or 'successful suicide bid'. We would also add to this the use of the term 'committed suicide', which implies the moral evaluation of suicide as a crime.

- Behaviour that is associated with mental health problems may be described in derogatory language (e.g. talk back radio hosts might refer to 'crackpots' or 'nutcases').

- Within media articles there is a lack of accompanying information about support services for those at risk of suicide.

While it is important to realise that people do not uncritically absorb all media messages, it is also likely that the reporting of suicide can have a number of negative outcomes. Pirkis and Blood (2001) identify some of these:

- Reports of suicide can lead to an actual increase in suicide rates

- The reporting of new or particularly violent suicide means can lead to awareness and increased use of such means

- Negative reports of suicide can lead to increased stigmatisation within the community of those at risk of suicide

- Media reports of suicide may increase the impact upon those bereaved by suicide, particularly if they are approached by the media.

However it is also possible that news stories or television programs can provide the catalyst for those at risk to seek support, and/or they can raise public awareness of the prevalence of suicide risk and the need for prevention strategies. With regard to the media people need to:

- Recognise the impact of their own comments if speaking to the media

- Be aware of the importance of non-stigmatising language

- Recognise the cultural contexts that may lead to suicide risk

- Advocate to promote appropriate reporting of suicide.

Further information can be accessed at Mindframe-media, a resource for media professionals. www.mindframe-media.info/

3.3 ALCOHOL/DRUG USE AND SUICIDE

The relationship between alcohol and drug use is not simple or straightforward. However the constant use or over use of alcohol and drugs may be the result of a complex set of life circumstances and may lead people to see suicide as a viable option. The research indicates that drugs and alcohol may:

- Destabilise a person's sense of hope or social value

- Promote mood swings leading to spur of the moment decisions, irrational thinking or unpredictable behaviour

- Exacerbate other problems such as mental illness or domestic violence

- Increase misuse of personal property or money

- Interact with each other and thus cause overdose.

There may be important gender differences in the risks and therapeutic interventions associated with alcohol and drug use. The research (e.g. Cottler *et al.*, 2005; Rivara *et al.*, 1996) suggests that suicide

ideation as a result of alcohol use may be higher among women than men. Cottler *et al.* propose that women may require interventions in relation to the use of alcohol and drugs that focus on depression, while men may require interventions that focus on both the use of alcohol and drugs as a response to poor coping skills, and in relation to the likelihood of the increased aggression which some men may exhibit due to drug and alcohol use.

The use of illicit drugs such as cannabis and amphetamines has been shown to be associated with mental illness and suicidality, especially among young people i.e. 15-24 years. A Western Australian study revealed that of the 571 young people who died by suicide in the period 1986-1998, 30% had illicit drugs detected in their toxicology analysis. Alcohol is often consumed just prior to suicide, and where blood alcohol levels reached the point of intoxication there was an increased likelihood that illicit drugs were also present. Where drugs were detected at post mortem they were usually found in combination (WA Ministerial Council for Suicide Prevention, no date).

It is clearly important that health workers include assessments for drug and alcohol use in their suicide risk assessment and that they have a high index of awareness of the possibility of suicide risk when they are responding to drug and alcohol related issues.

3.4 FAMILY AND DOMESTIC VIOLENCE, SEXUAL ABUSE AND SUICIDE

A substantial amount of research has explored the relationship between suicide and experiences of interpersonal violence. The prevalence of family and domestic violence, alongside the high rates of sexual abuse (both adult and child rape), suggest that the effects of such trauma are likely to impact on suicide risk. It is becoming increasingly apparent that childhood sexual abuse, physical abuse and neglect are all strong independent suicide risk factors.

It is important to emphasise that domestic violence (which may be physical, emotional, social or economic abuse) and sexual abuse are highly gendered – the great majority of perpetrators are men and the vast majority of those who experience abuse are women. Domestic violence occurs most commonly within heterosexual relationships, although there is increasing recognition of it in same sex relationships. Women who are, or have been, in violent relationships may have feelings of despair or hopelessness, and therefore may be at increased risk of suicide or self-harm.

> *A solid research base also exists correlating histories of sexual assault with suicidal behaviour….A number of studies have demonstrated that abused women are significantly more likely to be suicidal than non-abused women ….Almost a decade ago, Stark & Flitcraft (1995) identified domestic violence as possibly the single most important precipitant of female suicide, a finding that has subsequently been confirmed by a number of other studies, both overseas and in Australia …[Stewart, 2004, p.11].*

Violent abusive men may also be at risk of suicide as a response to their own violence, or after a relationship ends – for example if they lose custody of children as a result of their violent behaviours. Talk of suicide may be also used as a tool for further threatening violence against women, or may play a role in justifying or perpetuating abuse against partners. Abusive men may also contemplate murder-suicide. Men at risk of murder-suicide may manifest signs of premeditation such as stalking, obsessive thoughts, or plans for revenge.

IMPLICATIONS FOR PRIMARY HEALTH CARE WORKERS

When assessing risk, practitioners need to acknowledge 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.

Signs of premeditation of violence from abusive men – such as stalking, threatening or planning revenge – necessitate risk assessment both for the client and other family members or friends who may be at risk of further violence.

There are complex imbalances of power in abusive relationships. Consulting with women in these situations requires awareness of these complexities – e.g. rebuking someone for not leaving, or challenging their sanity when faced with repeated abuse, are not helpful responses.

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.

3.5 RISKY BEHAVIOURS

High risk behaviours such as binge drinking, problem gambling, dangerous driving, drink driving, unprotected intercourse or 'playing chicken' with cars or trains do not necessarily signify suicide behaviour, but they may precipitate later suicide behaviour.

While many of these behaviours have been typically engaged in by young men, there is growing evidence of adults 25 years and over, and women, engaging in risky behaviours, especially binge drinking (which may then be associated with other risky behaviours).

Together, these forms of risky behaviour demonstrate the changing nature of suicide behaviour within Western societies. While all risky behaviour may not be informed by suicide intent, it is important that such behaviours are taken into consideration when conducting risk assessment.

Engagement in risky behaviours may constitute an early warning sign for suicide risk. Such behaviours are therefore an important site for intervention.

3.6 MORAL AND LEGAL ISSUES

Suicide was once considered a crime in Australia (as in Britain) and attempted suicide was punishable by law. While this is no longer the case, suicide is viewed by most people in Western societies as being an unacceptable choice, although a contested one as indicated by the often impassioned debate surrounding euthanasia. This topic is discussed at more length in the Current Issues discussion paper.

It is important to examine and challenge the many moral judgements, stereotypes and taboos surrounding suicide and to examine our own moral positions and the negative impact that they may have upon patients and community members. Promotion of a view of suicide as always being morally bad may reinforce social stereotypes and heighten the feelings of worthlessness or despair experienced by those people considering suicide as an option. Important questions for a reflective practitioner to ask might include:

- How may moral judgements around the cause of death lead to suicide statistics and rates being misreported?

- How may the focus on morality serve to marginalise the important social and institutional factors (such as poverty, mental health issues and lack of community support) that often underpin suicide?

The colonial history of Australia has powerfully shaped social disadvantage, especially for Indigenous people, while privileging non Indigenous people in many ways. Despite a prevailing belief that Australia is an egalitarian society, there is unequal access to education, health care, employment and community support and marked structural divisions in terms of class, gender, sexuality, ability, race, ethnicity and socioeconomic status. These inequities have an effect on rates of suicide as a response to individual and social hardship and despair.

An ethical suicide prevention strategy must, therefore, take heed of the specific histories of suicide in Australia, in order to effectively engage with the range of moral positions adopted and the subjective experiences of individuals and groups.

LEGAL ISSUES

In an increasingly litigious climate, there are some important legal issues that practitioners must be aware of in relation to suicide prevention and risk assessment. Understanding some of these complex legal issues will assist practitioners in negotiating safe practice with clients at risk of suicide.

LIABILITY

Packman *et al.* (2004) suggest 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 predict or diagnose suicide

- Failure to control, supervise or constrain

- Failure to take proper tests and evaluations of the patient to establish suicidal intent

- Failure to treat properly.

These potential causes of litigation can be summarised under the headings of foreseeability and causation. In regards to the former, the practitioner must ensure that an appropriate risk assessment is undertaken, and that such assessments are regularly updated and monitored (Simon, 2000). It is important that practitioners not only foresee potential suicide risk, but that this risk is adequately addressed and that a treatment or intervention programme is implemented.

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

If a practitioner 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 practitioner 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.

Legal action over causation may occur when a practitioner fails to intervene when suicide means and plans are known, or when a practitioner's own comments, opinions or actions lead a client to suicide. These may include inappropriate or abusive actions or comments. This demonstrates the importance of practitioners examining their own beliefs and behaviours around suicide, which may be imposed upon clients within the clinical setting.

DUTY OF CARE

Practitioners owe 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. Australian case law emphasises the need for a medical practitioner to be up to date with current medical knowledge, though this is still governed by the standard of reasonableness. Australian court decisions place greater emphasis on 'reasonable care' as opposed to standards of professional practice and custom.

RISK ASSESSMENT AND DOCUMENTATION

Risk assessment also requires an assessment of potential risks that the client may not be aware of. Therefore, while it is important to value client's subjective experiences of suicide risk, it is also important that practitioners adequately document their own assessment of risk. Documentation enables the practitioner to demonstrate 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

- 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 others who are important.

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

CONTRACTS

There is some disagreement about the usefulness of suicide prevention contracts. For example, Petrakis (2004) warns:

Though these may be helpful in some cases, it is worth a therapist considering whose needs are being served by such contracts. It may be that they in fact hope to alleviate their own fear of somehow failing in their duty of care or that they are uncomfortable working with uncertainty.....In contracting therapists should reflect on whether a very distressed client is able to make such a commitment over a longer period.

In the Risk Assessment discussion paper, Dr Randall Long cautions about the use of prevention contracts in this way:

Professionals should take care if they plan to use so called 'suicide prevention contracts'. It can be argued that suicide prevention contracts in themselves can be counterproductive as they may give the professional a false sense of security. Suicide prevention contracts do not work in themselves, but rather it is the intuitive therapy that a professional may deliver around the contract that can actively reduce suicide risk. It should be remembered that a contract is a technical and legal agreement with benefit for both parties. In general, a client may not enter into a contract if they lack autonomy in that specific area. A suicidal client, by definition, probably lacks autonomy in this area, or the professional would not be trying to intervene. Therefore, based on this ethical argument clients cannot credibly enter into suicide prevention contracts. Other disadvantages with suicide prevention contracts are that patients may feel ashamed if they believe they are 'breaking the contract', and will not contact the professional for fear of letting them down.

It is also important to point out here that the use of 'suicide prevention contracts' does not mitigate against legal action (Simon, 2000). Indeed, the irresponsible use of such contracts (e.g. where there is not a strong therapeutic bond as the basis, or where definite means and plans are known) may lead to litigation.

CONFIDENTIALITY

Information about a patient should not be given to anyone else without the patient's permission. A disclosure in the absence of a strong belief that the client presents an immediate risk to themselves potentially creates a situation in which the therapist could be sued by the client for breach of confidence. However, failure to disclose where there is a strong belief that the client presents an immediate risk to themselves, and if the client subsequently takes his/her own life, may lead to someone having to defend themselves against the accusation of failure in their duty of care. Asking permission is empowering; it shows the client that the practitioner is caring and validates the agency of the client in decisions.

CONSENT

While different states and territories may have particular understandings and legislation around key issues, in South Australia consent to treatment means informed consent (Mental Health Act 1993 (SA) s3). For consent to be informed the patient 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. The person must be given information as to the general nature of the treatment. Consent must also be effective – i.e. the person should be able to demonstrate in his or her words their understanding of the treatment.

A person at risk of suicide can consent to Voluntary Admission in an approved treatment centre (hospital, clinic or other premises or any particular part of such a place, declared under Part 2 of the Mental Health Act to be an approved treatment centre). While they can leave at any time, they can also be made subject to an order for detention if the criteria are satisfied ([Mental Health Act 1993 (SA) s11](#)).

DETENTION

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

- Person has a mental illness that requires immediate treatment

- Such treatment is available at an approved treatment centre

- 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 or for the protection of other persons. (Mental Health Act 1993 (SA) s12)

There are some situations when a person can 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.

Health workers are generally acutely aware of the issues facing chronically ill people. In an important article, Stevens and Hassan (1994) focus on the juxtaposition between the intentions of the Hippocratic Oath – among other things the commitment to do no harm – and the increasing demand from clients and users of public health for greater control over medical decision making and life options. Their discussion distinguishes between active euthanasia (where a practitioner actively assists in terminating life), and the withdrawal of treatment (where a person is no longer given treatment that has thus far kept him or her alive).

While the legality of euthanasia or physician-assisted suicide may vary in different states (for example, it is illegal in South Australia), Stevens and Hassan state that a considerable percentage of practitioners report enabling euthanasia, either through active or withdrawal methods. While a number of practitioners in their study refuted the rights of health care professionals to do this, there were others who either supported or who had practised euthanasia, demonstrating the changing and contested views in this area.

Much of the debate over euthanasia focuses on the conflict between sustaining life and relieving suffering. These are important issues for General Practitioners who may be confronted by clients who either implicitly or explicitly seek assistance in accessing medications that may assist in suicide. While this paper does not attempt to take a definitive position on this dilemma, it canvasses these issues so that workers can consider their views and how they may respond to patients seeking their assistance in this way. Their responses may well shape whether and how a person goes on to contemplate suicide, and how this may relate to the end of life decisions that they make.

Practitioners also need to be aware of related issues such as those surrounding do-not-resuscitate (DNR) (Eliot & Olver, 2003). Clients may approach practitioners for information or advice in these areas, and it is important that they are able to offer informed, non-judgmental information. This of course does not mean that practitioners must uncritically accept information presented to them within the clinical setting, but it is nonetheless important that clients are able to access available information in order to make appropriate decisions. Withholding information on the basis of moral or personal judgments about euthanasia or DNR orders will not enable people to make informed decisions.

It is useful to highlight the difference between those who may contemplate suicide as a result of personal, cultural or emotional hardship, and those who may consider suicide as a necessary choice when life quality is severely reduced by extreme pain or illness (a category that may include those doctors treating clients in such pain, as Stevens and Hassan (1994) suggest). While the legal issues involved in euthanasia are very much the same as those for any health worker working with clients at risk of suicide, the issue of euthanasia is part of a debate about morality, life and death that will continue to be contested within health care. The information provided here may assist practitioners to reflect on the possible decisions they can make when confronted with these issues, and when making risk assessments.

4. POLICIES AND PRINCIPLES

4.1 SUICIDE PREVENTION STRATEGIES

Suicide prevention aims to reduce the risk factors associated with suicide and increase the protective factors, such as promoting mental health and resilience within the community.

There is a range of both national and state prevention programs and initiatives which address suicide prevention, either directly or indirectly. Because suicide is a complex problem it requires a collaborative effort across sectors and across agencies. The health sector is a crucial player in suicide prevention, but so also are a number of other sectors including education, the law, community services and business. To be effective, suicide prevention initiatives require the building of partnerships between families, communities, and all levels of government and non government agencies. A comprehensive approach to suicide prevention will include broad mental health promotion as well as specific initiatives addressing suicide.

NATIONAL STRATEGIES

There are a number of key national strategies responding to suicide. These are described briefly below and links are provided to websites which provide more detailed information about them.

NATIONAL SUICIDE PREVENTION STRATEGY (NSPS)

The Australian Government's Department of Health and Ageing implements the National Suicide Prevention Strategy (NSPS). The NSPS commenced in 1999 and builds on the former National Youth Suicide Prevention Strategy (NYSPS). The key outcomes of the NSPS are:

- Development and implementation of a strategic framework (the LIFE Framework) for a whole of government and whole of community approach to suicide prevention across all levels of government, the community and business; and funding and support to a range of suicide prevention projects and activities in states and territories.

The focus of the NSPS includes people of all age groups and those identified as being at high risk such as: young men, rural residents, the elderly, people with substance use problems, prisoners, rural communities, people with mental illnesses, and Aboriginal and Torres Strait Islander communities. There is an emphasis on promoting initiatives that aim to address risk and protective factors for suicide. (see: www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-suicide-overview or http://www.livingisforeveryone.com.au/about_nsps.asp)

LIFE FRAMEWORK

The Living is for Everyone (LIFE) Framework, guides and informs the implementation of the NSPS. The LIFE Framework promotes 6 Action Areas for suicide prevention activity:

1. Promoting well-being, resilience and community capacity across Australia

2. Enhancing protective factors and reducing risk factors for suicide and self harm across the Australian Community

3. Services and support within the community for groups at increased risk

4. Services for individuals at high risk

5. Partnerships with Aboriginal and Torres Strait Islander peoples

6. Progressing the evidence base for suicide prevention and good practice.

The NSPS currently funds a number of major national initiatives, most of which address the high rates of suicidal behaviour among identified population groups and emphasise community capacity building in a range of settings. Some are jointly funded with the National Mental Health Strategy and seek to better integrate mental health promotion and prevention with suicide prevention.

See: www.livingisforeveryone.com.au/about_nsps.html

THE NATIONAL YOUTH SUICIDE PREVENTION STRATEGY

The National Youth Suicide Prevention Strategy (NYSPS) was an initiative of the Commonwealth Government implemented by the Department of Health and Aged Care to provide a comprehensive and coordinated public health approach to youth suicide prevention throughout Australia. Underpinning the NYSPS was the premise that suicide is a complex problem caused by a number of interacting factors both social and individual, which must be addressed using a range of approaches. A total of $31 million was allocated over 1995-99 for the Strategy with over 70 projects being funded. It was coordinated with several related initiatives such as the National Mental Health Strategy and certain programs administered by the Office for Aboriginal and Torres Strait Islander Health Services.

The goals of the Strategy were: a) to prevent premature death from suicide among young people; b) to reduce rates of injury and self-harm; c) to reduce the incidence and prevalence of suicidal ideation and behaviour; and (d) to enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

Its initiatives included: parenting skills programs; training programs for GPs, community health workers, students and a range of community members; suicide prevention internet sites and telecounselling services; and grants to states and territories for suicide prevention strategies.
See: www.nhmrc.gov.au/publications/synopses/mh12syn.htm

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

THE NATIONAL MENTAL HEALTH STRATEGY

Mental illness is the strongest and most consistent risk factor for suicide. This strategy was adopted by all Health Ministers in 1992. It aims to promote the mental health of the Australian community, to prevent the development of mental health problems, and to provide improved treatment and support for people affected by mental health problems. Its Action Plan has direct links to the LIFE Action Areas. Its initiatives include a National Action Plan for Depression.
www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-strategy

THE NATIONAL DRUG STRATEGY

The National Drug Strategy 2004–2009 provides a framework for a coordinated, integrated approach to drug issues in the Australian community. It aims to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society. Its strategies are aligned with the National Suicide Prevention Strategy.
www.nationaldrugstrategy.gov.au/

In addition to these national strategies, the LIFE Framework incorporates partnerships with a range of other national programs in the areas of public health, sexuality and sexual health, health and wellbeing of Aboriginal and Torres Strait Islander peoples, people in rural and remote areas, older Australians, culturally and linguistically diverse people, families and social wellbeing, homelessness, child abuse, young people and education, employment and Vietnam veterans. Its Framework document makes explicit the suicide issues involved in all of these areas.
See www.livingisforeveryone.com.au/nsps/natproj.html

BETTER OUTCOMES IN MENTAL HEALTH CARE PROGRAM

Introduced in 2001 and due for continued expansion from 2008, this program aimed to improve access to mental health resources and the ability to response effectively to mental health problems in the community. It includes funding for its different components such as GP training and Medicare funded referrals onto allied health professionals under the management of GPs using Mental Health Plans.
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-boimhc

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

In South Australia, there is a steering committee of the National Suicide Prevention Strategy (NSPS) with the responsibility to provide advice on federal government funding decisions and opportunities. It identifies, responds to and communicates suicide prevention issues in South Australia and nationally. Organisations that are represented on the SA committee include SA Divisions of General Practice, Aboriginal Health Council, SA Department of Health, UnitingCare Wesley and the Australian Rotary Health Fund.

The State Government's approach to suicide prevention clearly acknowledges the central role of GPs and other primary health care providers, working in collaboration with the community and specialists. This is illustrated in the 2005 state budget, which announced a $45 million funding increase for mental health services over the next four years. The bulk of this was earmarked for increasing the capacity of GPs and various community organisations dealing with mental illness on a daily basis. The funding allocation included increased funding for the Assessment and Crisis Intervention Service (ACIS); funding for GP partnership programs using the Divisions of General Practice, including money for shared care programs where care is co-ordinated between GPs and specialist services; and funding for the employment of allied mental health workers (nurses, social workers, occupational therapists) to work with GPs and Specialist Mental Health Services. Funding and resources were also provided to aid in the development of **square** and to support delivery to SA Department of Health staff.

In May 2005 the State Government announced a Suicide Prevention Initiative for Country regions, an initiative of the SA Social Inclusion Unit. This initiative explicitly acknowledges that 'rural and remote communities, young men and Aboriginal people have been identified nationally as high-risk groups'. The aim of the funding is to 'allow regional communities to access existing suicide prevention and postvention services and help them to develop their own local responses to the issue' (State Health Minister Lea Stevens, press release, 3/5/05).The initiative will target community members and primary health care providers, in particular General Practitioners.

4.2 PRINCIPLES OF EFFECTIVE SUICIDE PREVENTION

The LIFE framework identifies the following as principles of effective suicide prevention:

- It is a shared responsibility across the community, professional groups, government and non government agencies

- A diverse approach is needed targeting the whole population, specific population subgroups and people at risk

- Programs must be based on evidence, focus on achieving results and incorporate evaluation as an integral part

- It must incorporate input from the community, carers and experts

- It must be sustainable to ensure a continuous and consistent service.

It also emphasises that it is crucial that activities do no harm, pointing out that some activities that aim to prevent suicide can increase the risk of suicide among vulnerable groups, who may interpret well intended messages differently. In particular they advise caution with awareness raising campaigns, media coverage and with programs involving schools.

Communication, Collaboration and Co-ordination are integral elements of **square**. It emphasises that:

- Good communication, involving clear documentation and timely and effective transfer of information, is essential

- Collaborative practice is not only an effective strategy for the wellbeing of the client – it is also a cost effective use of community expertise and resources

- Successful collaboration requires sharing information; valuing and understanding other workers' roles and expertise; and including the client as part of the team

- Coordination requires clearly articulated pathways for referral; and establishing mechanisms for coordinated planning, review and feedback.

Your own service or agency may also have its own policies, procedures and protocols in relation to suicide risk management and prevention. It is important to follow these.

5. WORKING WITH SUICIDALITY

5.1 ENGAGEMENT

Engagement with a person who may be at risk of suicidality is vital. If the person experiences others as concerned, empathic, helpful and trustworthy, they are much more likely to be able to express their feelings and needs – thereby allowing a greater likelihood of effective intervention. Conversely, if a

person experiences other people as distant, judgemental, aloof or distracted, the less likely they are to disclose aspects of their inner and/or disturbing world.

Engaging respectfully and appropriately involves skills which are often subtle and intuitive. There is a great difference, for example, in the ways in which a worker might ask the question: Are you having suicidal thoughts?. Different people may use different wording, different tone, body language and different timing in terms of when the question is asked – not to mention how they respond to the answer given. These issues can make a significant difference in terms of whether a person feels invited to talk or whether they have negative responses, such as feeling judged, intimidated or generally as if they inhabit a world that the worker would have no understanding of.

Recognising that a person may be experiencing distress, being open to engaging with that aspect of their wellbeing and having the skills to do this effectively, can be learnt and practised. They are central to primary health care and especially to preventing and responding to suicidality. These skills involve knowing:

- How to listen well

- How to be 'psychologically present and available'

- How to encourage exploration of feeling states

- How to view the world through the lens of someone else, even if very different from your own view

- How to move through a consultation or conversation clearly and in stages

- How to convey that you have understood what someone has been saying.

Empathic engagement should always occur regardless of other procedures that are being undertaken.

5.2 RISK ASSESSMENT

It is important that there is awareness that anyone could be at risk of suicide and that suicidality can underlie other presenting issues and problems. There have been two main types of suicide prevention strategies: those targeted towards specific 'at risk populations' and those targeted towards a more general population. Risk assessment and screening can be seen as arising from these two approaches.

There is sometimes confusion, both within the research and in practice, on the differences between suicide risk screening and suicide risk assessment. While the differences are quite subtle, they are nonetheless important distinctions to understand. This is because each approach requires different types of assessment, and each aims to address different branches of suicide prevention.

DEFINITIONS

Risk assessment, which predominantly takes place when someone is already known to be at risk, is most commonly applied to people within specific known 'at risk' populations. Risk assessment is primarily applied during a crisis, or when a crisis may be imminent. Risk assessment is therefore typically a reactive response to attempted suicide or thoughts about suicide.

Risk screening, on the other hand, typically occurs with people who may have little or no known risk, but who may have a family history that suggests there is a possibility of suicide risk. Screening is thus a more general tool for identifying suicide risk in the wider population. Screening in many ways is a proactive approach, attempting to identify risk before a crisis occurs. It is therefore useful as a general suicide prevention strategy within the wider population.

The research literature on suicide risk prevention at times does not distinguish between assessment and screening, and the term 'assessment' is often used when what is actually being referred to is screening. This presents a number of issues for health care workers who need to provide risk assessment, or who are interested in contributing to suicide prevention within the general population through screening. The following approaches typify the available understandings of (predominantly) suicide risk assessment, and elaborate some of the ways in which risk is measured.

RISK AND PROTECTIVE FACTORS

A focus on factors that may increase risk, while necessary in order to assess risk and make decisions about appropriate treatment plans or interventions, is only part of the story. The other important aspect of risk assessment is a focus on those factors that may protect a person against risk. This second focus is important, because focusing only on risk can:

- Result in misdiagnosis of suicide risk

- Result in unnecessary hospitalisation or medication

- Deny the rights of the client in relation to their knowledge of risk

- Contribute to feelings of helplessness if protective factors are not emphasised

- Minimise the role that external factors may play in preventing risk.

The importance of focusing on protective factors is demonstrated in the need for a range of appropriate responses to risk assessment. Assessment may be useful in determining those people who are in crisis and require immediate intervention and the use of an assessment that focuses more broadly on the many different, and often conflicting factors that influence risk, may enable workers to determine appropriate outcomes for those with lower, but still considerable risk.

It is therefore important when working with all clients to include investigation of protective factors, and examine how such factors may be used to further mitigate suicide risk. This may also assist practitioners in making appropriate referrals for social support services and for engaging in ways of monitoring suicide risk. Attention to protective factors in suicide risk assessment is thus central to providing an accurate, productive measure of risk.

INDIVIDUALISATION

Much assessment is undertaken using an individualised approach. This can be a problem especially if it is exacerbated by a reliance upon singular, medical interpretations of risk, to the exclusion of psychosocial and cultural factors. When this occurs, the complex causes of suicide are reduced to individualistic risk factors.

Individualisation also occurs when the only people consulted about risk are the clients. Such an approach may pay little attention to the diverse ways in which community and family networks either prevent or promote suicide. It is important that workers understand the many differing ways in which people may understand themselves and their relationships with other people. These relationships extend beyond the individual who is the typical focus within the consultation setting, and require consideration when assessing risk.

A HOLISTIC APPROACH

Assessment should include not only measures of current suicidal ideation, but also awareness of clinical and social demographic risk factors for suicide. It is also important to explore subjective risk, which is most usually established during an empathic consultation. Subjective risk involves personal meanings and experiences of distress, and is a fluid rather than static condition. Assessment tools are one component of a broader process.

Factors that warrant consideration within risk assessment for suicide include:

- History of suicidal behaviour

- Means to suicide

- Plans for suicide

- Desire for suicide

- Mitigating circumstances (social, economic, personal)

- Levels of available support

- Emotional feelings of hopelessness and worthlessness.

Family members will often have a wealth of knowledge about contributing factors, family history and available levels of support. Working with family members within the context of risk assessment may encourage them to further support the client, or to elaborate other potential avenues for support.

Including family members in an assessment also gives the health worker the opportunity to assess how the client's suicide behaviour is impacting upon the family, and to determine if other family members may also be at risk.

Consulting with colleagues is also an important part of the assessment procedure. Other health care workers may be able to assist practitioners in examining their own biases around suicide, in determining appropriate referrals, and in cross checking risk assessment outcomes. This approach will also be useful when practitioners themselves find risk assessment stressful, as it provides an opportunity to debrief around key issues.

For those clients who rely on community or institutional support, there is also a great need to consult with family and other significant people who may be able to share information about suicide risk, and will be key to developing appropriate prevention strategies.

In summary, approaches to risk assessment and screening and the tools used in the clinical setting must represent a holistic and integrated approach to risk management. Recognition of the importance of the client's subjective world should be valued as a central factor in the whole process.

5.3 MANAGING SUICIDE RISK

Managing suicide risk requires a high degree of awareness that the potential for risk could exist among a range of people who a primary health care worker sees. The possibility of suicidality being an underlying factor should never be overlooked.

The issue of stigma and how it may impact in any given consultation or interaction is an important factor. People with a mental illness often report that coping with stigma is just as difficult as coping with the symptoms of the illness.

Some people who are at risk carry the burden of multiple aspects of their life and identity being stigmatised, e.g. poverty, homelessness, non heterosexual preference, drug use. It is crucial that clients do not experience stigma in the very settings that they access for assistance. A person can experience stigma in subtle, as well as in explicit ways. It can be apparent in how seriously a person is taken and in the respect they are shown during interactions.

Effective management of suicide risk involves both immediate and ongoing management. Management options will depend on issues such as the degree of assessed risk, the type of supports available and access to particular services.

Crisis intervention (immediate management) involves ensuring the safety of the suicidal person and any others at risk. For example, if the person at risk is a single parent or carer, it is important to establish the safety of his/her dependants as well. This necessarily involves 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.

If the individual is at high risk it is important to ensure that they have immediate access to specialist care and that access is facilitated when necessary.

Immediate management will be followed by a more comprehensive risk assessment process which may include a mental health assessment to diagnose/confirm underlying mental health problems and/or identify associated problems such as drug and alcohol misuse.

Management of suicide risk may involve the primary health care worker as case manager for the person and offering immediate treatment, e.g. medication. Whenever anti depressant medication is prescribed the possibility of suicidality should be checked within the context of an empathic discussion of the person's feelings. The worker may enter a shared care arrangement in collaboration with other people, e.g. supportive family and friends and other workers.

Specialist services are used when the person's risk is judged to be more safely managed in this context. This can be voluntary on the patient's part or can, in some circumstances, involve detaining them.

It is vital that communication between agencies involved in care is not only one way – everybody involved in a management plan should be informed and have the opportunity to contribute their insights and information. Management of risk should be ongoing and monitoring and review plans need to be clearly established and communicated.

A health worker should follow up on people who have been discharged from a specialist setting – there is an increased risk when people are transferring from care. Effective management of suicide risk includes contingency plans which anticipate and address any relevant issues. Contingency planning requires quite specific documentation of roles and responsibilities (e.g. by family/doctor/agency) in a range of potential scenarios.

MANAGEMENT PLANS TYPICALLY INVOLVE DECISIONS ABOUT:

- Whether the person should be hospitalised or not

- The degree of intervention required

- The most appropriate management options and interventions.

DEPENDING ON THE LEVEL OF SUICIDAL RISK, A MANAGEMENT PLAN MAY INVOLVE:

a) Ensuring safety (e.g. constant supervision, removal of lethal means)

b) Hospitalization

c) Management in the primary health care setting

d) Community support

e) Antidepressants or other medication

f) Therapeutic interventions

g) Aftercare/longer term care

h) Referral to a mental health specialist (e.g. mental health nurse, allied health worker or a psychiatrist).

KEY MANAGEMENT PRINCIPLES ARE:

- Effective engagement with the person at risk

- Establishment of a therapeutic and supportive relationship

- Safety

- Continuity of care

- Appropriate intervention strategies depending on changing needs and circumstances in negotiation with the person.

- Clients' own resourcefulness and social networks should be acknowledged and self management encouraged, where possible.

- Collaborative practice

- Clear, timely and effective transfer of information (that keeps pace with the person's care pathway).

5.4 REFERRAL AND FOLLOW UP

Referral typically occurs between health services, and to other agencies for more comprehensive assessment, management or support.

It is important for health workers to refer more widely in the community if this is appropriate. There are networks of care and support outside the medical paradigm that can share support and management arrangements. These may include agencies that can offer practical assistance, support groups, significant people in a person's life and religious agencies.

The referrer needs to be 'kept in the loop' with follow-up information and suggestions from the agency accepting the referral communicated back to the referrer. It is common for people across agencies or services to discuss the issues that are impacting on the health of the client. They must also involve the client in these discussions.

The worker should enquire on an ongoing basis about the progress of previous plans to address problems. In addition, and with permission of the client, the carer may be consulted about the implications of other recommendations. The same sorts of 'circular' and multiple processes should apply in the management of suicide risk and self harm.

It is important that referral is not simply a mechanism for moving someone into another context, but rather a way of collaborating in care. This requires all stakeholders to be informed about the progress and planning to address a client's issues and for everyone to have the opportunity to add relevant information as it occurs. Documentation needs to be comprehensive, clear, current and in the appropriate hands for effective outcomes for the client.

RE ENTRY PATHWAYS

It is not only desirable that a person has planned access to a continuum of care, but crucial, given the changeability involved in suicidal mental states. A person who has been at risk may never experience such feelings again – but that is not an assumption that it is safe to make. People are particularly vulnerable during transfers of care, e.g. after discharge from specialist care. Some people who are, or have been, at risk of suicide are particularly vulnerable because they do not have a GP, network of support, or other protective factors. Such individuals often have multiple issues and are in particular need of support

5.5 PSYCHOTHERAPEUTIC INTERVENTIONS

There are many psychotherapeutic approaches which are useful for the treatment of depression and suicidal thinking. Some of the main therapeutic interventions which are widely available in South Australia are described below. Many therapists use a combination of these approaches.

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 is directed at the negative and distorted thinking patterns that depressed or anxious individuals may have. These 'cognitive distortions' (for example, seeing the world in black and white terms as 'all good or all bad', over generalisations which lead them to see themselves as total failures, or automatically assuming personal responsibility for any negative event) can impede people's perceptions of the life choices they may have and lead to feelings of uselessness and pessimism about the future.

CBT assists people to redefine their world view more positively and optimistically. It is based on the premise that if you can turn around negative patterns of thinking, then you can change how people feel and help lift their depression.

INTERPERSONAL PSYCHOTHERAPY (IPT)

IPT aims to help people to learn to manage interpersonal relationship difficulties that can lead to depressive symptoms. It focuses on the interpersonal context, especially the four key social functioning areas of interpersonal disputes, grief, role transitions (e.g. moving house, retirement), and interpersonal deficits (such as loneliness or boredom). One of the founders of IPT, Myrna Weissman explained its methodology in this way on ABC Radio's Health Report (July 11th 2005).

The first thing you do is make a diagnosis. You educate the person about the depression and then you do an interpersonal inventory which is find out who's important in their life and how has that been going. And during that dialogue you're usually able to figure out what the patient thought was going on their life that led to their symptoms. That doesn't mean that's the ultimate cause, it just means it's the trigger. You know… it's a marital dispute, a child dispute, problems at work, you know the practical problems of living. So you try to have them identified in a very here and now practical way. It's not about their mother, or their past, or their dreams, it's about what's going on right now. And figure out strategies. But everything is changeable but at least people feel a sense of mastery if they know what's going on.

Interpersonal psychotherapy utilizes a number of techniques, many of which are borrowed from other therapies such as cognitive behaviour therapy and brief crisis intervention.

PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic psychotherapy recognises that problems in the present may have their roots in past experience, and that current behaviour may be motivated by feelings derived from that experience. Psychodynamic therapists work on the assumption that such problems will emerge in the relationship with the therapist as well as in other relationships (with family, partners, children, work colleagues, etc.), and the therapeutic relationship is therefore the central focus of therapy. The treatment consists of developing a therapeutic conversation focusing 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. Psychodynamic psychotherapy is used both in brief therapy where there is a defined area of difficulty (a 'focus'), and over the longer term, aimed at helping to change how people function in relationships in all areas of their lives.
(See for example www.geocities.com/~nwidp)

MOTIVATIONAL INTERVIEWING

Motivational interviewing is a client-centred counselling method which focuses on enhancing motivation for change by exploring and resolving ambivalence. It is based on the principle that many people feel ambivalence about making changes in their lives and that they can be assisted to think through this ambivalence themselves. It is frequently used in counselling for drug and alcohol problems.

Miller & Rollnick (1991) identify five strategies which are at the heart of motivational interviewing:

- Express empathy: Reflecting back to the client his/her feelings and thoughts not only helps build rapport, but in this process, helps mirror the client's experience in a way which allows him/her to fully experience their dilemma.

- Develop discrepancy: The discrepancy is not so much between the positives and non positives of the behaviour but between the present behaviour and significant goals which will motivate change.

- Avoid argumentation: Arguments are counter-productive and result in defensiveness.

- Roll with resistance: Otherwise know as verbal judo. The use of reframe or simply changing tack may help maintain momentum towards change.

- Support self-efficacy: Motivation is partly made up of two main factors - importance and confidence. While it may be important to change, it won't happen if the client feels unable to do it. Every opportunity is taken to support the client's abilities to aid motivation to change.

NARRATIVE THERAPY

Narrative therapy is an approach to counselling and community work. It centres people as the experts in their own lives and views problems as separate from people. Narrative therapy assumes that people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives. The word 'narrative' refers to the emphasis that is placed upon the stories of people's lives and the differences that can be made through particular tellings and retellings of these stories…. in collaboration between the therapist/community worker and the people whose lives are being discussed (Adapted from the Dulwich Centre website).

For…people struggling with the idea of suicide and plagued by hopeless and worthless thinking, a story of self destruction or giving away one's life, narrative therapy can help reconnect them with their experiences of competence, survival and hope. These reconnections can invite them into an alternative story of self worth, courage and purpose…. (Martin et al., 1997)

FAMILY THERAPY

Family therapy targets the improvement of communication between family members. The family therapy field considers problems people face in the wider context of life and the identities they construct through family relations and through history and culture. It addresses people's problems through an interactional or participatory approach – that is to say by meeting with families and other communities of people.

Within family therapy there are a number of different approaches – narrative therapy, structural family therapy, systemic family therapy, constructivist family therapy, brief therapy, solution-focused therapy, linguistic systems approach and various others. (Adapted from the [Dulwich Centre website](#))

SOLUTION FOCUSSED BRIEF THERAPY

Solution focussed therapy is a short-term, goal-oriented, therapeutic approach which works with people's strengths by making the best use of their resources. It aims to bring about lasting change by building long term solutions rather than dwelling on problems. It can be used to treat stress, depression, anxiety, sleep-problems, drug and alcohol problems, relationship difficulties with both children and partners, histories of abuse and oppression, pain, mental health problems and work-related concerns.

Understanding the details and 'cause' of the problem is often not necessary to finding a solution. The important issues are how does the client want things to be different and what will it take to make it happen. Envisioning a clear and detailed picture of how things will be when things are better creates hope and expectation and makes solution possible. (Brief Therapy Institute of Sydney website)

PROBLEM SOLVING THERAPY

Problem-solving skills 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. The action most likely to solve the problem is planned in detail and implemented. Its outcome is then evaluated. If not successful another course of action is selected, implemented and evaluated (ADGP, 2003).

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 Distress. The particular therapeutic emphasis of such groups will depend on the background and training of the facilitator. Group Therapy could involve one or more of the interventions described above or have another focus such as Transactional Analysis, which examines the 'life scripts' that people learnt in their formative years and the ways in which these influence patterns of relationships in later life. It is important to be aware of the particular background and credentials of anyone who is offering group therapy.

5.6 POSTVENTION FOR BEREAVED FAMILIES AND FRIENDS

(See also the Postvention Booklet for more information or watch Jill Chapman talking about the importance of postvention.)

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

Shneidman 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 & Clark, 2003, p.77)*

Wilson & Clark (2003, p.77-8) suggest that postvention is a neglected and under-serviced area the world over and that the needs of the service providers who serve the bereaved are also neglected. The research literature suggests a number of reasons for paying attention to postvention. People bereaved through suicide may:

1. Grieve differently and possibly more intensely, and have different needs from those bereaved through other modes of death

2. Experience stigma, social rejection and alienation

3. Feel unsupported by friends who may be fearful and uncertain how to respond

4. Experience a high level of grief for a number of years, and this is often associated with depression, suicidal ideation and behaviour, substance abuse and family breakdown

5. Experience anger and guilt in addition to pain and shock

6. Regret not having had the opportunity to say goodbye

7. Experience loss of faith and trust in themselves and others.

Postvention activities are high on the priority action list of the NSPS and are identified as crucial in the LIFE framework. 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).

Postvention activities around Australia broadly focus on:

- Enhancing and coordinating access to mainstream services and support mechanisms

- Building the capacity of health, welfare and education workers and communities to initiate and facilitate suicide postvention interventions, and

- Providing a range of direct interventions and resources for those bereaved by suicide. [National Advisory Council on Suicide Prevention, 2004].

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.

5.7 INVOLVING THE 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 – even if this connection is as informal as using a particular hotel regularly.

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 stigmatized as they are). Sometimes an appropriate intervention could be as simple as another 'regular' at the local hotel noticing that one of the group hasn't been in 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 settings need to convey a culture and ethos that invites people to feel comfortable in disclosing their feelings and fears if they need to.

STRATEGIES

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

1. Reviewing to what extent the primary health care environment is inviting. For example, what messages appear in leaflets and posters about discussing mental health concerns?

2. 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?

3. Reviewing suicide awareness training needs for other staff working with clients in any capacity

4. Having an understanding of who are significant people in a person's life

5. Knowing of, and having information for clients, about available community services – for example, support groups, advocacy groups, community education and relationship skills, church and other organisations offering counselling and other support

6. Having contact networks for information sharing, for example, with people involved in:

7. Financial planning assistance

8. Counselling and relationship building

9. Drug and alcohol services

10. Gambling programs

11. Employment services

12. Community participation organisations (e.g. Rotary, Lions clubs).

Connecting people with communities can be 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 health care services 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 LifeForce, www.wesleymission.org.au/centres/lifeforce/about.asp.

BROADER COMMUNITY ISSUES

So far the discussion has focussed on what could occur in a particular primary health care setting and this is appropriate because it is often in such settings that suicidality is detected and managed. However, it is important to recognise that the issue of suicide could be more successfully addressed if it were regarded as a public health issue having broad based community support for suicide prevention. This might involve, for example:

- Developing a professional group or structure with the brief of ensuring that national policy is implemented

- Establishing appropriate community and industry partnerships to progress and advance specific components of policy and practice

- Increasing the number of professional groups and agencies which have policies and activities directed at the prevention of suicide

- Establishing effective ways in which to de-stigmatise mental health in the community so that people are more inclined to access services when they are needed

- Involving a range of partnerships with relevant people and organisations with a view to coordinated care and response to suicidality, e.g. educators, police, community groups, faith-based groups, survivor groups, health care workers, industry health and safety agencies

- Using these connections to coordinate responses to State and National Governments about the adequacy of response options, and to prioritise the issue on relevant agendas.

COMMUNITY DEVELOPMENT

Community development is 'a process of empowering communities to improve their health and wellbeing' (McMurray, 1999). Its objective is to foster community competence, to build the capacity of the community to negotiate effectively to get the services they need. It avoids the power imbalance of consumer-provider models of service delivery through actively promoting partnership arrangements between the public and relevant government, business and community agencies. By definition, community development is developmental – when health workers collaborate with people in communities their skills, knowledge and confidence are developed. Community development aims to transform unequal power structures and social systems.

In her book Community health and wellness: A socioecological approach, Anne McMurray identifies five principles which guide community development. The five principles are:

1. Integration – community development must be accomplished with integration of social, political, cultural, environmental, personal and spiritual elements. By adopting a holistic approach, issues of class, gender, race/ethnicity, age, disability or sexuality can be considered for their contribution to health.

2. Community ownership – the community, rather than health workers, must own the structures and processes of change. This ensures independence of strategies and action, which empowers the community for decision-making and the pace of development. It also circumvents any need for coercion or oppression from outsiders.

3. Recognition of the political nature of community change – the links between individual and public issues are crucial and mutually dependent; for example, political processes give rise to unemployment, which in turn has an effect on health and family functioning. Community development must not be oppressive or grounded in conflict.

4. Advocacy and partnership – the role of the health professional is to preserve the human rights of community members, ensure integrity of the processes of change, and strengthen social interactions by bringing community members together and helping them communicate with genuine dialogue, understanding and social action. Such an approach must be inclusive, so all community members are encouraged to participate. In addition, the health professional must help the community recognise and define need, by bringing together residents, service providers and researchers.

5. Vision – community development must be undertaken with a view toward sustainability and a holistic approach.

Involving the community in suicide prevention needs to be a multi layered and coherent strategy – from impacting on Government policy and its implementation, through to creating responsive communities at the local level. Within local communities it is desirable that different types and levels of support are widely available. This requires both informing and utilising different groups within the community. If suicide prevention is to be effective in these ways, everyone has a vital role to play, not only within the health framework but also in wider community settings.

6. SELF CARE

Self care is typically not given much emphasis in health training. Yet there are proactive ways in which practitioners may engage in self care which may prevent burnout or other long term negative effects or potentially, practitioners' suicide.

6.1 BURNOUT

Health care workers are at high risk of burnout which may be caused by: 1) emotional exhaustion, 2) lack of professional efficacy, 3) cynicism, or 4) lack of adequate social support (Barnett *et al.*1999; Fox & Cooper, 1998).

STRESSORS
Common stressors within health, which may lead to burnout, are:

- Understaffing/high client load

- Constantly having to make critical decisions

- The litigious context within which health care operates

- High levels of emotionality with clients

- Sleep deprivation

- Teaching and research demands (Gundersen, 2001).

VICARIOUS TRAUMATISATION

These stressors, particularly when associated with the loss of a client through suicide, may result in health workers feeling overwhelmed by their work. Working constantly with clients in crisis can also result in vicarious traumatisation, where the practitioner personally experiences the client's psychological traumas.

This is most likely to occur if a practitioner does not have suitable opportunities to debrief after a critical incident or when they feel personally accountable for the incident itself.

IMPLICATIONS FOR PRACTICE

It is important for practitioners to remember that while they can assess the risk of suicide, they cannot always prevent it. They should not feel guilt or shame if they have not been able to 'save' a client. Working with clients, and empowering them to develop the necessary skills to maintain a positive focus on life may be a more productive means to suicide prevention than attempting to 'rescue' clients who are at risk.

EFFECTS

Effects of burnout may include:

- Negative work-related attitudes, including cynicism

- High levels of alcohol and drug use

- Relationship problems

- Mental health problems.

Negative or cynical attitudes may lead to practitioners making unethical decisions, or failing to adequately address issues of suicide risk (eg. by minimising their time with clients).

Health workers who themselves do not take seriously their own health care, may have problems in promoting the importance of health care (and in particular preventative care) to their clients (Gross, *et al.*, 2000; Gundersen, 2001).

6.2 PRACTITIONER SUICIDE

The prevalence of practitioner suicide is a cause for concern and therefore an important aspect of any suicide prevention project.

The impact of practitioner suicide is obviously enormous. Besides the impact that is experienced by the family of the practitioner who suicides, there is also an impact on:

- Colleagues

- Clients

- Employers

- Service provision within place of employment

- Reputation of health care system more broadly.

In particular, it may result in: disillusionment from colleagues; despair, or feelings of resentment from clients; the inadequacy of the caseload to be filled in the short term; and the potential for litigation for the place of employment. It may negatively impact upon clients already at risk for suicide.

THE CULTURE OF MEDICAL TRAINING AND PRACTICE

It is important to understand the cultural context in which Australian health care workers practice. Because the dominant (male) 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. Reflective thinking is integral to self care.

Medical training may create a culture that mitigates against self care, by teaching 'dysfunctional beliefs', such as:

1. Altruism, even to the point of self-denial, is good

2. Professionalism means keeping feelings, emotions, and uncertainty to oneself

3. Ultimate responsibility for the patient is the physician's alone

4. Lack of knowledge is a personal failure.

These types of beliefs may result in practitioners taking on unreasonable burdens, making decisions that may not be theirs to make, ignoring their own needs and wants, blaming themselves for mistakes based on poor knowledge, 'playing God', and failing to examine their own beliefs and roles. These may all obviously have very serious consequences, both for the client and practitioner.

IMPLICATIONS FOR PRACTICE

If medical practice is to be fulfilling and sustaining for both clients and practitioners, we need a system of primary health care that is both community building and individually supportive. It is important that workers, just like those at risk of suicide, focus on the protective, as well as the causative factors. This may involve paying more attention to matters such as:

- Setting life priorities

- Understanding one's own needs

- Learning to say 'I don't know' or 'No'

- Joining peer support groups for debriefing, trauma support and ongoing support.

7. REFERENCES

7.1 WEBSITES CITED

Brief Therapy Institute of Sydney website. www.brieftherapysydney.com.au/

Dulwich Centre www.dulwichcentre.com.au/

LifeForce www.wesleymission.org.au/centres/lifeforce/about.asp

LIFE Framework (2000), Living is for Everyone, National Suicide Prevention Strategy, Commonwealth of Australia www.livingisforeveryone.com.au

Mindframe-media. A resource for media professionals. www.mindframe-media.info/

National Advisory Council for Suicide Prevention www.livingisforeveryone.com.au/about_nac.html

National Drug Strategy www.nationaldrugstrategy.gov.au/

National Mental Health Strategy www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-strategy

National Programs link www.livingisforeveryone.com.au/nsps/natproj.html

National Suicide Prevention Strategy (NSPS) www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-suicide-overview

National Youth Suicide Prevention Strategy: http://www.nhmrc.gov.au/publications/synopses/mh12syn.htm

North West Institute of Dynamic Psychotherapy website: www.geocities.com/~nwidp/

Samaritans 'Self harm and Suicide Information Sheet', March 2005. www.samaritans.org.uk/know/information/informationsheets/selfharm/selfharm_sheet.shtm

WA Ministerial Council for Suicide Prevention www.mcsp.org.au/prevention/prevention_plan

7.2 REFERENCES CITED

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

Australian Divisions of General Practice (ADGP) (2003). Familiarisation Training GP and Practice Manual, June 2003.

Australian Institute of Health and Welfare (2000). Morbidity of Vietnam veterans: A study of the health of Australia's Vietnam veteran community. Suicide in Vietnam veterans' children: Supplementary Report no. 1. AIHW cat. no. PHE 25. Canberra: AIHW.

Barnett, R.C., Brennan, R.T. & Gareis, K.C. (1999). A closer look at the measurement of burnout. Journal of Applied Biobehavioral Research, 4, pp. 65-78.

Baume, P., Rolfe, A. & Clinton, M. (1998). 'Suicide on the internet: A focus for nursing intervention?' Australian and New Zealand Journal of Mental Health Nursing, 7, pp. 134-141.

Becker, K. & Schmidt, M.H. (2004). Internet chat rooms and suicide. Journal of the American Academy of Child and Adolescent Psychiatry, 43, pp. 246-247.

Burvill, P.W. (1995). Suicide in the multiethnic elderly population in Australia, 1979-1990. International Psychogeriatrics, 7, pp. 319-333.

Caldwell, T.M., Jorm, A.F. & Dear, K.B.G. (2004). Suicide and mental health in rural, remote and metropolitan areas in Australia. Medical Journal of Australia, 181 (7 Suppl): S10-S14. http://www.mja.com.au/public/issues/181_07_041004/cal10801_fm.html

Cottler, L. B., Campbell, W., Krishna, V.A.S., Cunningham-Williams, R.M. & Abdallah, A.B. (2005). Predictors of high rates of suicidal ideation among drug users. Journal of Nervous and Mental Disorders, 193, pp. 431-437.

Dalton, V. (1999). Suicide in Prison 1980 to 1998: National Overview. Australian Institute of Criminology, Trends & Issues in Crime and Criminal Justice, August 1999.

De Leo, Diego, Hickey, Portia A., Neulinger, Kerryn & Cantor, Christopher H. (2001). Ageing and Suicide. Australian Institute for Suicide Research and Prevention, Commonwealth Dept. of Health and Aged Care.

Dudley, M. (2003). Contradictory Australian national policies on self-harm and suicide: The case of refugees in mandatory detention. Australasian Psychiatry, 11, pp. 103-108.

Eliott, J., & Olver, I. (2003). Legitimating do-not-resuscitate orders: a discursive study of cancer patients' speech. Journal of Palliative Care 6, pp. 59-68.

Fox, R. & Cooper, M. (1998). The effects of suicide on the private practitioner: A professional and personal perspective. Clinical Social Work Journal, 26, pp. 143-157.

Gross, C.P., Mead, L.A., Ford, D.E. & Klag, M.J. (2000). Physician, heal thyself? Regular source of care and use of preventive health services among physicians. Archives of Internal Medicine, 160, pp. 3209-3214.

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

Hassan, R. (1995). Suicide Explained: The Australian Experience. Carlton South: Melbourne University Press,

Hassan, R. (1996). Social Factors in Suicide. Trends and Issues in Crime and Criminal Justice, Paper 52. Canberra: Australian Institute of Criminology.

Hassan, R. (2000). Suicide in Australia. In A. Kellehear, Death and dying in Australia. Melbourne: Oxford University Press.

Howell, C., Wolinski, K., Newbury, W. & Black, C. (2005) Resource Kit. NSPS: Pathways to Care Project.

Martin, G., Clark, S., Beckinsale, P., Stacey, K. & Skene, C. (1997). Keep yourself alive: Prevention of suicide in young people – A manual for health professionals. Adelaide: Foundation Studios.

McArthur M., Camilleri, P. & Webb, H. (1999). Strategies for managing suicide and self harm in prisons. Australian Institute of Criminology, Trends & Issues in Crime and Criminal Justice, August 1999.

McMurray, Anne. (1999). Community health and wellness: A socioecological approach. Sydney: Mosby

Miller, Keith (2004). Presentation on Suicides to Registrars at Mannum, SA 19th November 2004 (unpublished paper and PowerPoint presentation).

Miller, W. & Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behaviour. New York: Guilford Press.

National Advisory Council on Suicide Prevention (2004). National Planning Forum. Theme Paper: People bereaved by suicide.

O'Brien, K. (2004). The intergenerational transference of Post-Traumatic Stress Disorder amongst children and grandchildren of Vietnam veterans in Australia: An argument for a genetic origin: Review of current literature. Paper presented to the Social Change in the 21st Century Conference, Centre for Social Change Research, Queensland University of Technology, 29 October.

Packman, W.L., O'Connor Pennuto, J.D., Bongar, B. & Orthwein, J. (2004). Legal issues of professional negligence in suicide cases. Behavioral Sciences and the Law, 22, pp. 697-713.

Petrakis, M. (2004). Keeping the client safe: Complexities and clinician risk in working with the suicidal client. antiTHESIS forum Volume Two. /www.antithesis.unimelb.edu.au/main.html

Pfaff, J.J., Acres, J.G. & McKelvey, R.S. (2001). Training general practitioners to recognise and respond to psychological distress and suicidal ideation in young people. Medical Journal of Australia, 174, pp. 222-226.

Pirkis, J. & Blood, R.W. (2001). Suicide and the media: A critical review. Canberra: Commonwealth Department of Health and Aged Care.

Rivara, F.P., Mueller, B.A., Somes, G., Mendoza, C.T., Rushforth, N. & Kellerman, A.L. (1996). Alcohol and illicit drug abuse and the risk of violence death in the home. Journal of the American Medical Association, 278, pp. 569-575.

Simon, R.I. (2000). Taking the 'sue' out of suicide: A forensic psychiatrist's perspective. Psychiatric Annals, 30, pp. 399-407.

Stevens, C.A. & Hassan, R. (1994). Management of death, dying and euthanasia: Attitudes and practices of medical practitioners in South Australia. Journal of Medical Ethics, 20, pp. 41-46.

Stewart, S. (2004)Interpersonal violence, suicide & cultural diversity– what are the links? Australian Domestic and Family Violence Clearinghouse Newsletter, 20, December 2004. www.austdvclearinghouse.unsw.edu.au/PDF%20files/Newsletter_20.pdf

Stewart, S. (2005). Suicidality, interpersonal trauma and cultural diversity: A review of the literature. Australian E-Journal for the Advancement of Mental Health. Volume 4, Issue 2,

WA Ministerial Council for Suicide Prevention (no date). Youth suicide in Western Australia involving cannabis and other drugs, Research sheet from the MCSP website, www.mcsp.org.au/files/user2/illicit_drugs_suicide.pdf

Weissman, M. (2005). interviewed on ABC Radio's Health Report, July 11th 2005.

Weissman, M., Fox, K. ahd Klerman, G.L. (1973). Hostility and depression associated with suicide attempts. American Journal of Psychiatry, 130, 4, pp. 450-5.

Wilson A., Clark, S. (2003). Desperate to tell: towards improving the care of people bereaved through suicide- a report of work in progress. *Published in RED Snapshots, March 2004, Issue 2: PHCRED-SA State Conference 2003 Proceedings.*