Early detection of risk – Suicide and the relationship with mental disorders

Early intervention for mental health issues is important in maximising the wellbeing of patients.[6] On average, GPs see more than 80% of the population each year.[5] Therefore, the primary care setting is the ideal place for mental health issues to be detected and responded to, the risk to be assessed, and for people to seek help as early as possible to prevent mental health issues and disorders leading to suicide.

It is important that GPs have the knowledge and skills to recognise when a patient might be experiencing mental health issues and to investigate whether they might be at risk of suicide. Undertaking regular mental health education and training is vital to ensuring your skills and knowledge are up to date. Access the GPMHSC website at www.gpmhsc.org.au for accredited education and training.

Below you will find useful information and further reading about the specific risk factors for suicide, one of which is mental disorders. Also included are some specific warning signs that might indicate someone is thinking about suicide.

Suicide

People who are contemplating suicide will often give some clues or signs to those around them, including friends, family, colleagues, their GP or other mental health professionals.[7] Preventing suicide starts with recognising and acting on warning signs, which usually occur in combination, and being aware of the specific risk factors involved. It should be noted, however, that in some cases there might not be any warning signs.

Did you know …

In 2013, 65,000 people attempted suicide in Australia, and in 2014, 2864 lives were lost by suicide.[4] That is almost eight people every day.

Risk factors

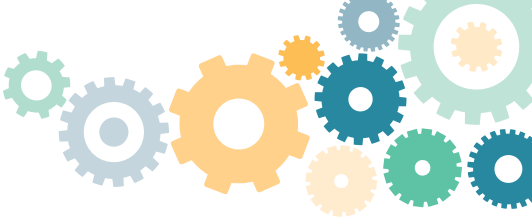
Risk factors for suicide include:

- previous suicide attempt(s)
- substance abuse
- low/limited social support
- male gender
- a feeling of hopelessness/absolute despair
- having lost a family member to suicide
- mental disorders.

Protective factors

Personal protective factors include:

- adaptive coping skills
- effective problem solving skills
- self-understanding
- sense of competence
- spirituality.



Work protective factors include:

- supportive work environment
- positive relationships with colleagues
- professional development opportunities
- access to employee assistance programs.

Family and community protective factors include:

- relationship to family
- sense of responsibility
- involvement in social/community activities/support group
- access to support within their means.

Suicide warning signs

Does your patient describe any of the following?

- Quitting activities that were once important
- Withdrawing from family/friends
- Writing a suicide note or goodbye letter to people
- A sense of hopelessness or no hope for the future
- Isolation or feeling alone – 'No one understands me'
- Aggressiveness and irritability – 'Leave me alone'
- Possessing lethal means – medication, weapons
- Negative view of self – 'I am worthless'
- Drastic changes in mood and behaviour
- Frequently talking about death – 'If I died would you miss me?'
- Self-harming behaviours (eg cutting)
- Engaging in 'risky' behaviours – 'I'll try anything, I'm not afraid to die'
- Making funeral arrangements
- Giving things away (clothes, expensive gifts) – 'When I am gone, I want you to have this'
- Substance abuse
- Feeling like a burden to others – 'You would be better off without me'
- Making suicide threats – 'Sometimes I feel like I just want to die'

The videos below present some common warning signs of suicide and thoughts and feelings experienced by people who were at risk of suicide.

beyondblue – Suicide warning signs, www.beyondblue.org.au/the-facts/suicide/worried-about-suicide/what-are-the-warning-signs

beyondblue – Suicidal thoughts, www.beyondblue.org.au/the-facts/suicide/worried-about-suicide/what-are-the-warning-signs/common-warning-signs

Risk factor – Mental disorders

Literature suggests that there is a significant correlation between suicide and diagnosed mood disorders; notably mood, substance-related, anxiety and psychotic disorders with comorbidity being common.[3] It is important that GPs be able to detect the key warning signs and assess for mental disorders.

Depression

Did you know …

The mortality risk for suicide associated with depression is many times the general population risk.[3]

Research indicates that somatic symptoms are the commonest presenting features of depression in high-income countries[8] and that patients with mental health problems usually present to GPs with physical health problems.[9] Look out for headache, nausea, muscular and skeletal pain, and insomnia.[10] It is also worth noting that these physical symptoms are often overlooked in older patients where such complaints might not seem out of the ordinary.

Depression warning signs

Does your patient describe any of the following?

- Not going out as much/withdrawing from family
- Difficulty sleeping
- Over sleeping
- Feeling tired all the time
- Feeling sick and run down
- Loss or change of appetite
- Significant weight loss/gain
- Difficulty concentrating
- Reliance on substances
- Feeling overwhelmed, guilty, unhappy, sad, frustrated, irritable etc
- Thoughts of failure

Further reading and resources

Australian Psychological Society (APS) – Depression tip sheet, www.psychology.org.au/publications/tip_sheets/depression

Black Dog Institute – Patient resource,
www.blackdoginstitute.org.au/clinical-resources/depression/types-of-depression

headspace – Youth mental health information,
www.headspace.org.au/young-people/understanding-and-dealing-with-depression-for-young-people/

headspace – Youth mental health video, www.youtube.com/watch?v=GjK6yfpxaew

Reynolds J, Griffiths K, Christensen H. Anxiety and depression: Online resources and managements tools. Aust Fam Physician 2011;40(6):382–86, www.racgp.org.au/afp/2011/june/anxiety-and-depression

Anxiety

Did you know …

Anxiety disorders are the most common mental health disorders in Australia, affecting 14.4% of the population.[11]

Anxiety has been shown to be an independent risk factor for suicide.[12]

Physical illness can trigger anxiety or complicate the treatment of either the anxiety or the physical illness itself. Examples might be hormonal problems, diabetes, asthma or heart disease/conditions.[13]

Anxiety warning signs

Does your patient describe any of the following?

- Hot and cold flushes
- Racing heart
- Tightening of the chest
- Snowballing worries
- Difficulty sleeping
- Dizziness
- Shortness of breath
- Difficulty concentrating
- Feeling irritable

Further reading and resources

Australian Psychological Society (APS) – Anxiety tip sheet, www.psychology.org.au/publications/tip_sheets/anxiety

beyondblue – Symptoms of anxiety, www.beyondblue.org.au/the-facts/anxiety/signs-and-symptoms

headspace – Youth mental health resource library, Anxiety factsheet, www.headspace.org.au/assets/Uploads/Mental-Illness-Fact-Sheets-mg.pdf

Kyrios M, Moulding R, Nedeljkovic M, Anxiety disorders: Assessment and management in general practice, Aust Fam Physician 2011;40(6):370–74, www.racgp.org.au/afp/2011/june/anxiety-disorders

mindhealthconnect – Anxiety: Symptoms, treatment and causes, www.mindhealthconnect.org.au/anxiety

Bipolar disorder

Bipolar disorder

Research indicates that the symptoms of bipolar disorder are often mistaken for, and result in a diagnosis of, unipolar depression.[14] This is because patients with bipolar disorder usually experience or present more commonly with depressive symptoms, and might not recognise and/or report hypomanic or manic episodes.[15]

Manic episodes may involve changes in mood, behaviour, energy, sleep, and cognition, and might be characterised by a positive mood, irritability, inappropriate behaviour and heightened creativity.[16]

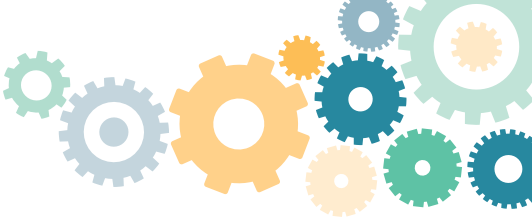
Did you know …

People with bipolar disorder have a much higher risk of suicide (about eight times) than the general population.[15]

Treating misdiagnosed bipolar disorder with antidepressant medication can worsen manic and hypomanic symptoms, so keep this in mind if a patient presents with depressive symptoms.[17]

Further reading and resources

Black Dog Institute – Bipolar disorder symptoms fact sheet,
www.blackdoginstitute.org.au/docs/Symptomsofbipolardisorder.pdf



Talking about suicide and mental health issues

If you are concerned about a patient and have noticed some signals of risk, it is important to ask questions to make sure you identify and act on risk factors.

Beginning a conversation about suicide

Research shows that the relationship between the GP and the patient can often be one of the most important factors in reducing self-harm ideation – for example, the GP demonstrating empathy and a willingness to discuss emotional concerns.[18]

Make reassuring statements like:

'It's my job to make sure you're doing OK. I have some concerns that things might not be going so well for you at the moment. Is it OK if we have a bit of a chat about how you are?'

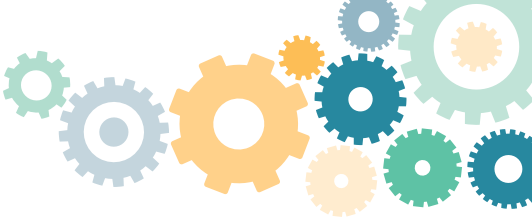
Sometimes it can be daunting asking difficult questions about suicide and mental illness for fear of prying, upsetting the person, stigmatising your patients[9] or putting ideas in their head. However, the first step to supporting people considering suicide is to begin a conversation about it. By being calm, non-judgemental and empathetic, a GP provides an opportunity for a client to discuss their suicidal thoughts. They can be encouraged to tell their story, outline their stresses, provide information about their history, and describe their current suicidal thoughts.

While everyone has their own personal communication style, being direct when asking about suicide is imperative. Information about the frequency and intensity of the suicidal thinking, history of suicidal behaviour, current plans, overall mental state, and level of support will inform the overall level of risk and the subsequent management plan required.

Some example questions are highlighted below.

What to ask

- Do you ever feel like giving up?
- How does your future seem to you?
- Does your life ever seem so bad that you wish to die?
- How often do you have these thoughts? How intense are they?
- Have you made any plans? If so, what have you been thinking about?
- How close have you come to doing something?
- What stops you from doing something?



Responding to patients who might be at risk of suicide

If patients disclose symptoms, thoughts or feelings that might indicate a mental illness, mental health issue or suicidality, some things that might help you work positively with your patients, are to:

- normalise your patient's feelings
- use people first language – talk about mental health issues, mental illness and mental disorders as being separate to the person, not as defining them
- give patients clear messages of recovery
- acknowledge how scary it must feel to have thoughts of suicide.

Normalising patients' feelings

A useful analogy …

'I have nothing to wear.'

'But you have a closet full of clothes.'

To the outsider, what may seem like an irrational feeling is very real and rational for the person experiencing it. It is the same for those suffering from anxiety. To the outsider, it might seem like the person has everything (ie a great job, family and social life). However, a crippling fear of one thing renders all others as inconsequential. While anxiety might be seen as an irrational feeling by an outsider, it might be completely rational to the person.[19]

Part of the problem with the way services and the community respond to mental health issues is the stigma that is associated with mental illness.

You can help to reduce the problems caused by stigma by normalising mental health issues and by talking about mental illness/conditions/disorders the same way you would about physical illness/conditions/disorders.

The information below includes mental health analogies and strategies that might assist you to normalise mental health issues and reduce stigma for your patients.

Using 'people first' language

When talking to patients about mental health issues, the language that you use can really impact how the person thinks and feels about themselves. It is important to talk to and about your patients (if you have consent to liaise with other professionals/family members) as individual people first and not as being defined by their condition, illness or issue.

Examples of replacing 'illness first' language with 'people first' language

Replace this:	With this:
'Being bipolar doesn't mean that you won't be able to get the job you want …'	'Jane, living with bipolar disorder shouldn't stop you from getting the job you want ...'
'Yes, he is undoubtedly depressed. I am recommending a combination of medication and some CBT [cognitive behavioural therapy] sessions.'	'Yes, David is undoubtedly experiencing depression. I have discussed with him trying some CBT sessions in combination with trialling some medication.'
'Well, she is highly suicidal and I will be arranging a referral to a psychiatrist.'	'It must feel so scary for Nicole, and for you and your husband, when she has thoughts about taking her own life. I'd like to discuss some options with you that might help you and Nicole feel more supported and less isolated.'

Give hope of recovery

Most people who receive treatment and ongoing support for a mental illness can learn to adapt their life to the illness (seen as recovery). It is important for mental health professionals to give patients hope of recovery, acknowledging that the term 'recovery' has different meanings for different people and is better conceptualised as a personal journey rather than as an having an end point.[20] In supporting people on their personal journey to recovery, the external environment (including services providing treatment and care) also has a role to play in assisting with the recovery journey. For example, GPs might focus on the individual by:

- acknowledging his/her strengths, talents, interests and limitations
- acknowledging his/her rights to full partnership in all aspects of their recovery
- promoting the rights of people to make choices regarding their own desired goals and outcomes
- projecting a belief in the inherent capacity of the individual to recover.[21]

While it can be the case for some people, recovery in a mental health context doesn't necessarily mean being rid of all symptoms or returning to function without the symptoms first presented (as it might be for a person recovering from influenza or a chest infection, for example). Rather, a person's sense of self might include the mental illness but is not determined by it. Their recovery process is fostered by components of hope, self-identity, meaning in life and responsibility.[21]

Is your patient struggling to see past their mental illness/issue/condition and thoughts of suicide?

'It is possible for you to get through this.'

'You managed to get through [insert previous life challenge], so I am confident you will be able to find a way through this.'

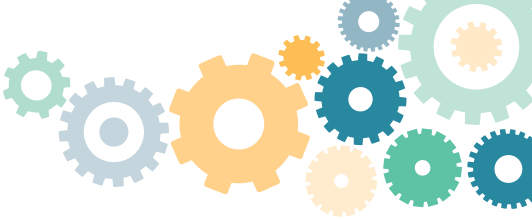
'I have worked with lots of other people who experienced similar feelings to you, and we have found a way through.'

'Living with a mental health issue is only one small part of you … don't forget to think about your strengths and other positive aspects about who you are.'

Did you know …

Recovery for individuals with mental illness can mean gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life, developing personal autonomy, developing a social identity, connecting meaning and purpose in life, and fostering a positive sense of self.[22]

View the video, visit racgp.cachefly.net/racgp/SuicidePrevention/Suicide-Risk-Assessment-1.m4v



Further reading and resources

The Analogy Bank – An analogy resource for mental health clinicians, www.theanalogybank.wordpress.com

Department of Health – Principles of recovery oriented mental health practice, www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-nongov-toc~mental-pubs-i-nongov-pri

Government of Western Australia, Office of Mental Health – Psychiatric rehabilitation policy and strategic framework, www.health.wa.gov.au/docreg/Education/Population/Health_Problems/Mental_Illness/A_recovery_vision_for_rehabilitation.pdf (Section 4.2)

Mental Health Coordinating Council (MHCC) – Recovery oriented language, www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

mindhealthconnect – Do's and don'ts of discussing mental health issues, www.mindhealthconnect.org.au/dos-and-donts-discussing-mental-health-issues

SANE Australia – Reducing stigma, www.sane.org/mental-health-and-illness/facts-and-guides/reducing-stigma

SANE Australia – Personal stories, www.sane.org/information-stories/people-like-us

Women's Web – Mental health analogies, www.womensweb.in/2015/07/analogies-help-one-understand-depression-mental-health-conditions

Suicide prevention – Risk assessment in general practice

Why complete a suicide risk assessment?

An effective treatment plan that supports and manages clients at risk of suicide should be informed by a thorough risk assessment.[23] A risk assessment is a direct conversation with a patient about their suicidal thoughts, plans and intent; it is a matter-of-fact empathetic conversation that allows patients to discuss suicide openly.

A suicide risk assessment brings together key information about a patient's current mental state, any current or previous risk and protective factors, any key stresses contributing to the risk, and a review of current supports. It is the combination of these factors and identified warning signs that contribute to a patient's overall level of risk for suicide.

GPs should consider completing a thorough risk assessment for any patients they are concerned may be at elevated risk due to their current mental state and/or significant life stresses. Some patients will outline their suicidal thinking quite openly, while others will need encouragement to share these thoughts with their GP. Often a starting point is to say, 'With all this going on, have you ever felt like life is not worth living – is this something that you have considered recently?'

There are a range of tools that can guide GPs through the completion of a risk assessment. Often the use of these tools helps to collate the information, formulate the assessment information and provide the documentation required for the medical file. One such tool is the www.griffith.edu.au/griffith-health/australian-institute-suicide-research-prevention/screening-tool-for-assessing-risk-of-suicide (STARS).[24]

It should also be noted that at present, a statistically strong and reliable method to usefully distinguish patients with a high risk of suicide has not been developed.[25]

There are several other general mental health assessment tools that might also assist with establishing your patients' levels of wellbeing:

Sphere-12

A self-rated, 12-item tool to screen for anxiety, depression and somatisation in primary care.

http://webcache.googleusercontent.com/search?q=cache:aCtzMj2HvYQJ:www.gpgc.com.au/getFileLibFile.aspx%3FFK%3D955+&cd=1&hl=en&ct=clnk&gl=au

K10 anxiety and depression checklist

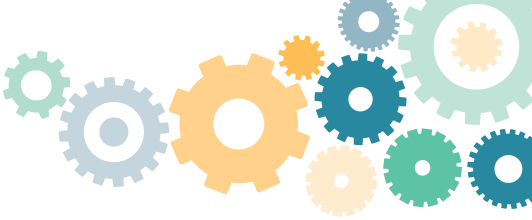
A simple self-report checklist aiming to measure whether patients have been affected by depression or anxiety in the past four weeks.

www.beyondblue.org.au/the-facts/anxiety-and-depression-checklist-k10

Depression Anxiety Stress Scales (DASS)

A 42-item self-report instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress.

www2.psy.unsw.edu.au/dass



Depression self-report questionnaire (DMI-10 and DMI-18)

Self-report measures for assessing depression in the medically ill.

www.blackdoginstitute.org.au/docs/default-source/psychological-toolkit/dmi-10.pdf?sfvrsn=2

Antenatal risk questionnaire

A clinician-administered questionnaire, designed to consider specific key risk factors thought to increase the risk of women developing perinatal mental health morbidity (eg postnatal depression or anxiety disorder) and sub-optimal mother infant attachment.

www.blackdoginstitute.org.au/docs/default-source/psychological-toolkit/anrqclinicians.pdf?sfvrsn=2

www.blackdoginstitute.org.au/docs/default-source/psychological-toolkit/postnatal-risk-questionnaire-(pnrq).pdf?sfvrsn=0

Edinburgh Postnatal Depression Scale (EPDS)

A 10-item self-report measure designed to screen women for symptoms of emotional distress during pregnancy and the postnatal period.

www.blackdoginstitute.org.au/docs/CliniciansdownloadableEdinburgh.pdf

The level of risk informs the treatment plan

It is generally agreed upon by experts in the field of suicide risk assessment, that it is the combination of warning signs, risk factors and protective factors that contributes to overall suicide risk.[24]

The outcome of a risk assessment will guide what treatment and support options are required immediately to maintain a patient's safety, and what additional treatment and/or support would be useful to put in place over the coming days and weeks. Options for consideration include an urgent mental health assessment, a non-urgent appointment with a health professional, ongoing support from the GP, increased community and peer support, or a combination of one or more of these initiatives. Where there is any doubt about the level of risk, GPs can contact their local crisis mental health service for consultation and follow up.

Risk assessments provide a forum for open conversation about suicidal thinking, and can help patients to establish hope and maintain a positive belief in their lives.

Further reading and resources

Sivasankaran B. Mental health risk assessment: A guide for GPs. Aust Fam Physician 2011;40(6):366–69, www.racgp.org.au/afp/2011/june/mental-health-risk-assessment

Hayes P. GP Communication: Suicide in general practice. *Good Practice*. August 2015, www.racgp.org.au/publications/goodpractice/archive/201508/suicide-in-general-practice

Suicide Questions Answers Resources (SQUARE) – Risk assessment questions, www.square.org.au/risk-assessment/risk-assessment-questions

Lifeline – Facts about suicide, www.lifeline.org.au/Get-Help/Facts-and-Information

Suicideline – Estimating the risk of suicide, www.suicideline.org.au/health-professionals/estimating-the-risk-of-suicide

Now what? Suicide safety planning in general practice

Introduction

Safety planning provides a structured approach that empowers people to manage psychological distress and suicidal thoughts, thus aiming to reduce their immediate risk of engaging in suicidal behaviour.[26] It involves the person – ideally with support from a health professional – identifying coping and help-seeking strategies that are tailored for their needs, situation and personal relationships. The resulting safety plan is then used during times of distress and crisis.

When to do a safety plan

A safety plan can be a useful therapeutic tool when someone is ambivalent about living or dying, whether these thoughts are vague or intense in nature, as it can help to contain distress and offer ideas for improving their mental health. Safety planning is most pertinent when a GP understands the risk of suicide to be serious in nature.

An appointment with a GP might be the first and only contact that the person has with a health professional and as such, offers a unique opportunity to influence a person's safety and begin to create a roadmap for improving their mental health.

Documenting a safety plan

A safety plan can be documented on a paper template or via e-resources such as websites or apps. The BeyondNow app provides a simple-to-use tool for people to refer to on their phones (download at the Apple App Store or Google Play), or to complete online and email to themselves.

BeyondNow gives people access to their safety plan whenever they feel their level of distress increasing. They can refer to their safety plan at any appointments with their health professionals and share it with their family and close friends.

Start by downloading the app from the Apple App Store or Google Play and familiarising yourself with it. You can also check out a quick introduction here, to the different features, including editing and sharing a plan.

Apps might not be for everyone, so first consider whether using an app for safety planning is appropriate for your individual patients. It is then important to consider how you are going to introduce it to your patients; including information about the strengths and limitation of the app, when they might use it, as well as a reminder that this is a confidential plan that they can choose to share with those they find supportive.

Key steps of safety planning

When you're supporting your patient to create their plan, asking questions can help them think about what might work for their situation and ensure the identified strategies meet their individual needs.

Below are a range of questions that seek to find the key information for a safety plan. The BeyondNow app, and some associated information on the beyondblue website, also provides these prompts to assist with the completion of the plan.

1. Recognising warning signs and personal triggering events

Being aware of changes in thoughts, moods and behaviour that may signal a developing crisis allows the person to act earlier, helping to reduce further risk.

Questions to ask might include:	Warning signs might include:
• How will you know when your safety plan should be used? • What are some of the difficult thoughts, feelings or behaviours that you experience leading up to a crisis?	• Moods such as sadness, anxiety or irritability. • Thoughts involving hopelessness, helplessness, or self-criticism. • Behaviours such as drinking more alcohol than usual, avoiding social situations, or arguing more often with friends or loved ones.

2. Creating a safe environment

Identifying ways of keeping the person's immediate environment safe can be achieved by reducing or eliminating their access to potentially lethal means. This can also include being aware of and avoiding stressful or upsetting situations.

Questions to ask might include:	Restricting access to lethal means might include:
• Are there any specific situations or people that you find stressful or triggering, or that contribute to your suicidal thoughts? • What things do you have access to that are likely to be used in a suicide attempt? • How can we develop a plan to limit your access to these means and avoid these situations?	• Asking someone else to manage access to medication. • Reducing access to firearms or improving safety procedures. This step should always involve having a support person remove any firearms. • Getting rid of glass or blades that might be used to cause harm.

3. Identifying reasons to live

Developing a list of positive things in life that bring joy and meaning or something to look forward to can help to change the client's focus.

Questions to ask might include:	Reasons to live might include:
• What's the best thing about living? • What's the most important thing in your life? • What things in your future do you look forward to?	• Family, friends or pets. • Spiritual or religious beliefs. • Everyday pleasures such as walking on the beach or enjoying nature. • Life experiences such as having children or travelling.

4. Things I can do by myself – Internal coping strategies

Identifying activities and internal coping strategies that an individual can do without contacting anyone else. These activities/strategies can help to regulate their emotions, reduce distress, change the focus of their thinking, and distract themselves from suicidal ideation, potentially preventing a further escalation into crisis.

Questions to ask might include:	Internal coping strategies might include:
• What can you do on your own if you have suicidal thoughts in the future, to avoid acting on those thoughts? • What can you do to help take your mind off your problems, even for a short amount of time?	• Breathing or relaxation exercises. • Going for a walk, doing yoga or other exercise. • Watching a favourite movie or listening to a favourite band. • Playing or cuddling with a pet.

5. Socialisations strategies for distraction and support – Connecting with people and places

Just being around other people can help provide distraction from suicidal thoughts – this can include spending time with family and friends, or going to a busy park or shopping centre.

Questions to ask might include:	Socialisation strategies might include:
• Who helps you to feel good when you socialise with them? • Where can you go and be around other people in a safe environment?	• Spending time with friends and family, remembering that socialising can also include activities that don't require much talking or engagement (eg watching TV). • A coffee shop, park, place of worship or meeting group.

6. Trusted contacts for assisting with a crisis – Friends and family to talk to

The person should think carefully about who would be helpful in a crisis, and avoid listing people who could possibly exacerbate the situation.

Questions to ask might include:
• Among your friends and family, who do you feel you could talk to when you're having suicidal thoughts? • Who do you feel you could contact to support you during a suicidal crisis?

7. Professional contacts for assisting with a crisis

Questions to ask might include:
• Which services could you turn to for support? • What health professionals can you involve in your treatment plan?

Some people may not wish to complete a particular step or steps in the safety plan. Their plan is unique to them and is all about keeping safe, so if certain steps aren't helpful or create an additional source of burden, stress or conflict, these can be left out.

Safety plans are designed to be followed step by step. However, it's important to reinforce with your client that if they feel at imminent risk and are unable to remain safe – even for a short period of time – they should phone or present to an emergency service.

Reviewing the safety plan

A safety plan should be modified over time to ensure its effectiveness. At a follow-up appointment GPs should ask their patient:

- How often they have needed to use the plan?
- What the most useful aspect of the safety plan was?
- Were there any barriers to its use?
- How they can continue to use the safety plan?

Safety planning is a practical and accessible strategy that can assist GPs to help patients to manage difficult emotions in a self-directed manner, while also guiding them as to when to seek out the support of other health professionals.

Safety planning resources

Patient safety plan template: Suicide Prevention Resource Center (USA), www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

beyondblue video – offers an insight into how individuals have used safety planning on their road to recovery, www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning

The below video is a documentary titled *Suicide and Me*. It includes personal reflections about experiences of suicidal thoughts and footage of what it's like to work at a suicide helpline service. Please note, some information in this video may be distressing. To view the video, visit www.youtube.com/watch?v=TFs9hjMzciY

Further reading and patient resources

Melvin GA, Gresham D, Beaton S. Safety first – Not last! Suicide Safety Planning Intervention (SPI). InPsych 2016; 38(1):14–15, www.psychology.org.au/inpsych/2016/feb/melvin

beyondblue – 'Finding our way back', a resource for Aboriginal and Torres Strait Islander peoples after a suicide attempt, www.beyondblue.org.au/the-facts/suicide-prevention/recovery-and-support-strategies/support-after-a-suicide-attempt/finding-our-way-back

beyondblue – 'Finding your way back', a resource for people who have attempted suicide, www.beyondblue.org.au/the-facts/suicide-prevention/recovery-and-support-strategies/support-after-a-suicide-attempt/finding-your-way-back

beyondblue – 'Guiding their way back', a resource for people who are supporting someone after a suicide attempt, www.beyondblue.org.au/the-facts/suicide-prevention/recovery-and-support-strategies/support-after-a-suicide-attempt/guiding-their-way-back

Conversations Matter – Resources for professionals and those working with communities, www.conversationsmatter.com.au/professional-resources

Lifeline – Tool kits, www.lifeline.org.au/get-help/get-help-home

Supporting staff to recognise and respond to risk/crises

If you work with other staff at your practice such as reception staff, a practice manager or a practice nurse, it is suggested that they are also trained and supported to be able to identify where patients might be at risk of suicide. Many organisations run training for employees in mental health first aid. See below for some resources.

Community Response to Eliminating Suicide (CORES), www.cores.org.au/contact

LivingWorks, www.livingworks.com.au/programs

Mental Health First Aid (MHFA) Australia, www.mhfa.com.au/cms/home

Wesley Mission – Suicide prevention, www.wesleymission.org.au/find-a-service/mental-health-and-hospitals/suicide-prevention/latest-suicide-prevention-news/

Suicide prevention – Ongoing care for patients and self-care for GPs

Ongoing care for your patients

Even if you're satisfied that your patient is not at immediate risk of harm, it is still important to initiate appropriate follow-up to prevent gaps in the mental healthcare of your patients. Some possible follow up actions might be:

- to make a plan for a follow-up appointment to develop a GP Mental Health Treatment Plan (GPMHTP)
- if you've already prepared a GPMHTP, you might make plans to refer the patient on to an allied health professional (ensure that you follow up with your patient if this is your plan of action)
- to introduce a follow-up text messaging service to remind patients about a scheduled appointment or to encourage them to make a follow-up appointment
- to set the patient some homework or refer them to an e-mental health resource to ensure a follow-up plan is in place
- to work on some activity scheduling with your patient over the period of time until you see them next/they have an appointment with an allied health practitioner
- to provide some psychoeducation to your patients (and their family/carer if applicable) explaining and normalising their mental health condition/issue
- if you are an eligible Focused Psychological Strategies (FPS) provider, you might schedule in some FPS sessions with your patient
- to give your patient hope – with the right treatment, most people will be able to manage their illness and live a normal life.

Further reading and resources

RACGP – *e-Mental health: A guide for GPs*, www.racgp.org.au/your-practice/guidelines/e-mental-health

GPMHTP templates,
www.gpmhsc.org.au/info/detail/8a218292-d2d3-47c0-b8a8-43ab7eddeb04/gp-mental-health-treatment

Black Dog Institute – Supporting you through anxiety and depression, Online tool kit
www.blackdoginstitute.org.au/docs/default-source/education-resources/bdi_cbh_toolkit_2019_final.pdf?sfvrsn=0

Psychoeducation

beyondblue – Depression guide, http://resources.beyondblue.org.au/prism/file?token=BL/0556

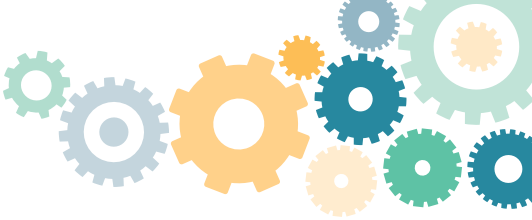
beyondblue – Anxiety guide, http://resources.beyondblue.org.au/prism/file?token=BL/0762

Black Dog Institute – Understanding your depressive episode,
www.blackdoginstitute.org.au/clinical-resources/depression/types-of-depression

Activity scheduling and other clinical interventions

Centre for Clinical Interventions – GP resources, www.cci.health.wa.gov.au/resources/doctors.cfm

Department of Health – Phase 5: Pleasant event and activity scheduling, www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-cogamph-toc~drugtreat-pubs-cogamph-3~drugtreat-pubs-cogamph-3-3~drugtreat-pubs-cogamph-3-3-5#act



Ongoing care for you

It is important for GPs who spend a lot of time working with patients with mental health issues/people at risk of suicide, to be mindful of their own mental health and their risk of burnout. Burnout is a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment that can occur among individuals who work with people in some capacity.[27]

Burnout might occur when GPs face repeated exposure to traumatic and distressing experiences of others[28] and highly stressful situations such as working with a patient who is at high risk of suicide. It has been suggested that GPs are less likely to suffer from burnout when they regularly engage in educational activities to maintain, develop or increase their knowledge and skills.[29] To reduce the risk of burnout, ensure you include some self-care strategies as part of your ongoing continuing professional development (CPD).

Reducing the risk of burnout

- Seek out supervision/consultation (individual or group)
- Make time for activities that are relaxing or de-stressing, such as exercise, spending time with friends, hobbies
- Engage in regular mental health CPD activities, such as small group learning sessions

Further reading and patient resources

Black Dog Institute – Self-care webinar for GPs, www.medcast.com.au/courses/10-online-self-care-for-doctors?utm_source=medcast&utm_medium=website&utm_campaign=online-self-care-for-doctors&utm_content=courses-pag

The National Rural Health Alliance – Case studies on rural GP self-care, www.ruralhealth.org.au/7thNRHC/Papers/general%20papers/roach.pdf

RACGP – *Abuse and violence: Working with our patients in general practice*, Chapter 14. The doctor and the importance of self-care, www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Whitebook/Abuse-and-violence-working-with-our-patients-in-general-practice.pdf

Psychiatric Times – Patient suicide: Impact on clinicians, www.psychiatrictimes.com/special-reports/patient-suicide-impact-clinicians/page/0/1#sthash.sOauzTfC.dpuf