Suicide remains a significant problem throughout Australia. According to the latest data from the Australian Bureau of Statistics (ABS), suicide accounted for more than 2500 deaths in 2013, an overall rate of 10.9 deaths per 100,000 population.1

As the first point of medical contact for the majority of Australians, GPs are at the frontline in working with people who have considered or attempted suicide.

Dr Vered Gordon, a GP facilitator with the Black Dog Institute, believes GPs’ ability to provide a safe place for people to discuss their feelings can make a significant difference in working with those who may be considering suicide.

‘Suicidal thoughts are very common in a variety of mental health conditions and we do know that it’s helpful for patients to be able to talk about their suicidal thoughts and share that with someone they trust and who can understand and won’t judge,’ she told Good Practice.

‘I think the big thing we want GPs to do is really feel confident and willing to have conversations about suicidal thoughts.’

Direct approach

The first step in treating people considering suicide in general practice is to have the conversation about it. While this may sound relatively straightforward, the sensitive nature of the topic can make raising the issue of suicide difficult for GPs and patients.

According to Dr Jill Gordon, a Sydney GP and Chair of the RACGP’s Psychological Medicine working group, a more direct approach is usually the best one.

‘It’s very important to ask the question, and that is probably the single biggest barrier,’ she told Good Practice. ‘Sometimes I think people worry that by bringing up the topic of suicide they may actually make it more real for the patient.

‘[But] the evidence tends to suggest that a matter-of-fact empathic approach is really important from the patient’s point of view because they may be feeling anxious about the prospect of disclosing and what that might mean.’

While a direct approach is definitely preferred, Dr Siva Bala, a community-based psychiatrist who works with GPs in the area of suicide prevention, recommends not making a suicide-related question too ‘clinical’.

‘What I advise against is checklist-type of questioning – “How have you been sleeping? How is your diet? How is your weight? Are you suicidal?” That comes out of the blue and is not therapeutic,’ he told Good Practice.

‘There are different ways of handling it. One is to talk about less strenuous subjects, such as eating, weight, those sorts of things,'
and establish if the person is distressed – “It sounds like you’ve got a lot of stress and haven’t been sleeping. With all of this going on have you ever felt like you can’t go on or life is not worth living?”

“It’s linking suicide and depression to what they have already told you, so it’s a more natural gateway to a conversation about suicidal ideation.”

Establish risk

Once the issue of suicide has been recognised in a consultation, a further step is to determine the likelihood of those ideas being acted upon.

“Once a suicidal thought is declared then the GP has to go through a process of identifying things such as the frequency of the thoughts, the intensity, the duration and the likelihood of the thoughts being carried out,” Bala said. “What are the promoting factors of the thought and what are the things that might protect the person from carrying out this thought?”

“Having worked that out, then the GP might come to an overall assessment of what needs to happen next. Can the person be managed in a local setting, with the GP providing more support? Can they be referred to a local service for a non-urgent assessment? Can they be admitted to hospital?”

“The GP is really a triaging person in this instance and they provide a deeper evaluation of the suicidal thoughts and the risks of acting them out.”

“We know it’s helpful for patients to be able to talk about their suicidal thoughts with someone they trust”

The often close doctor–patient relationships that exist within general practice can make GPs particularly well suited to help patients establish hope and maintain a positive sense of their own lives.

“Our relationship with our patients is part of what we can do to help keep them safe,” Vered Gordon said. “You may know their family, their children, their partner. You may have a fair understanding of the people who really care for them who very much want them to be here and stay in their lives.

“Support is really integral and family members have a really important role to play in helping to keep people safe and helping people be well. It’s important to work out who those people are in a person’s life, and work with the person you are looking after to engage those people in providing some of the support and care that is going to be required.’

However, according to Jill Gordon, GPs should be clear that including any family and friends in treatment will not come at the cost of the patient’s privacy.

“It’s really important for someone to feel that they have confidentiality in the consultation, but not confidentiality to a degree that puts them at a risk of harm,” she said.

“That is something that I would share with the patients, share my dilemma with them – “I am really worried about you and your wellbeing, I want to make sure that you are safe and I would like to know that there are other people around you who are also helping to care for you. Does anyone else know how bad you have been feeling?”

“You are trying to move them in the direction of actually being able to talk to others about how they are feeling.”

Beyond general practice

While GPs are well equipped to treat patients who have expressed suicidal thoughts, the serious nature of the presentation means they, and their patients, can benefit from a referral if they believe the situation cannot be best handled in general practice.

“I don’t think GPs should feel that they can do everything and I think they should share that concern with the patient and say, “I have someone who I know is very skilled in helping people and I would really like you to go and see them”,’ Jill Gordon said. ‘I don’t think you should take any risk if you really think someone might be likely to harm themselves.’

In addition to referral to specialists like a psychologist or psychiatrist, Vered Gordon suggests looking further afield.

“There is a variety of different support around and sometimes people may already belong to some support,’ she said. ‘For example, some of the people I look after might belong to a church or another religious institution where there is already a culture of a caring community that they can tap into.

‘Community mental health centres will often have various support groups and programs where there is also peer-to-peer support and that can be very useful.

“In acute times, you may involve an extended-hours mental health team that may provide calls or visits to the person at home with, for example, a newly-diagnosed depression. You are going to need an extra level of supervision and support for that person.”

Those acute cases may also require GPs to invoke their state or territory’s mental health act and compel a patient to enter care if they believe that patient is in danger.

“That is certainly something doctors need to understand: if they think that anyone is a danger to themselves or to others then they definitely need to act and not take the risk,” Jill Gordon said.

Specifics can vary depending on location, but, broadly speaking, invoking a mental health act involves contacting appropriate authorities, such as a crisis support team or even the police, in order to ensure a patient is taken for further evaluation. >>
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