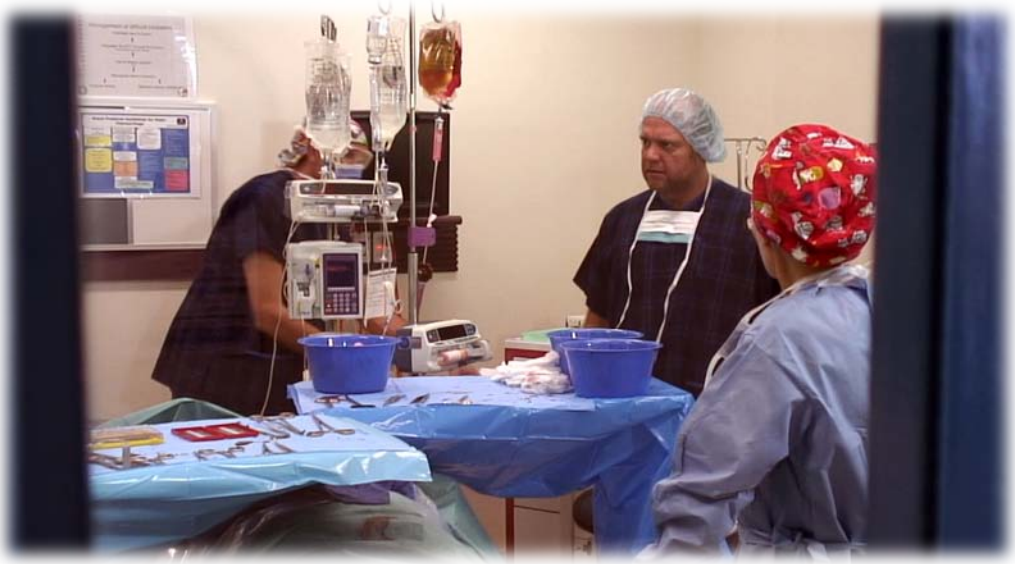
IpAC Unit
interprofessional ambulatory care unit

ECU AUSTRALIA EDITH COWAN UNIVERSITY

Interprofessional learning through simulation

Mental health in the workplace: *identifying and communicating with colleagues at risk of suicide*



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Health Simulation Centre

ECU AUSTRALIA EDITH COWAN UNIVERSITY

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Acknowledgements

This resource was developed by the Interprofessional Ambulatory Care Program (IpAC) at Edith Cowan University (ECU) in collaboration with the ECU Health Simulation Centre with funding provided by the Australian Government under the Increased Clinical Training Capacity (ICTC) Program.

Foreword

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Australia's health workforce is facing unprecedented challenges. Supply won't meet demand, and the safety and quality of care remain key issues. The national health workforce agency, Health Workforce Australia (HWA), an initiative of the Council of Australian Governments (COAG), has been established to address the challenges of providing a workforce that meets the needs of our community – now and in the future.

Accordingly, ECU has set a priority on meeting these challenges, with a focus on the national health workforce reform agenda set out in the 2008 National Partnership Agreement (NPA) on Hospital and Health Workforce Reform.

In June 2010, ECU was awarded $4.6M from the Australian Government through a nationally competitive process under the ICTC Program, an initiative which aims to develop interprofessional learning and practice capabilities in the Australian health workforce.

The IpAC Program aims to complement traditional clinical placement activities with high quality interprofessional learning competency development and assessment, so that at the earliest point students gain exposure to best work practices within multidisciplinary teams that have the patient's individual needs as the focus.

Additionally, the IpAC Program has developed interprofessional learning resources and interprofessional health simulation challenges in collaboration with the ECU Health Simulation Centre. The ECU Health Simulation Centre is recognised internationally as a

specialist centre in providing human factors based sequential simulation programs using professional actors. Most simulated learning interactions revolve around a single moment, such as a patient's admission to the emergency department. What we provide at the ECU Health Simulation Centre is a sequential simulated learning event that follows the patient and carer's journey through the healthcare system, for example, from the accident site following a motor vehicle accident, to the emergency department, to a hospital ward, to their home and into the community for GP and allied health follow-up.

Human factors in health care are the non-technical factors that impact on patient care, including communication, teamwork and leadership. Awareness of and attention to the negative aspects of clinical human factors improves patient care.

ECU's involvement in national health workforce reform is all about playing a role that enables the health workforce to better respond to the evolving care needs of the Australian community in accordance with the NPA's agenda. The IpAC Program is an example of how we can work across sectors, nationally and internationally, to determine better ways of addressing the pressing issue of how best to prepare students for the workplace and thus assuring that health systems have safe, high quality health services.

Interprofessional Ambulatory Care Program

ECU's IpAC Program was established with support from the Australian Federal Government through funding from the ICTC Program. The IpAC Program aims to deliver a world-class interprofessional learning environment and community clinic that develops collaborative practice among health professionals and optimises chronic disease self-management for clients.

This is achieved through the provision of clinical placements within the multidisciplinary team at the IpAC Unit, a community clinic that develops communication and collaboration among health professionals and optimises chronic disease self-management for clients. Additionally, a range of clinical placements are offered at existing health facilities, where trained IpAC Program clinical supervisors provide clinical support and ensure the integration of interprofessional learning into each clinical placement.

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The IpAC Unit, in collaboration with the ECU Health Simulation Centre, has developed a range of interprofessional learning through simulation resources. These learning resources are packages consisting of an audiovisual resource and a facilitator's manual, and aim to facilitate interprofessional learning and to support the participants in the development of interprofessional skills.

The interprofessional learning through simulation resources developed by the IpAC Program aim to provide health students and health professionals with the opportunity to learn with, from and about one another by engaging them in interactive live simulation events. These simulations encourage students and professionals to challenge themselves and each other in a safe learning environment.

ECU Health Simulation Centre

ECU houses the only fully functioning Health Simulation Centre of its kind in Western Australia, specifically designed and equipped to address the interprofessional learning needs of the health workforce and implementation of both state and national safety and quality frameworks.

The ECU Health Simulation Centre offers health workforce training and development specialising in clinical skills, human factors, and patient safety training for multidisciplinary health teams. Using a variety of educational techniques, including a broad range of simulation mannequins, professional actors and task trainers, ECU specialises in immersive simulation and observational learning. Supporting the ECU Health Simulation Centre are nursing, medical, paramedic and psychology academic and technical staff whose aim is to cultivate the development of competent and confident health professionals centred on enhancing patient safety.

Interprofessional learning

Interprofessional education occurs when two or more professions learn with, from and about each other in order to improve collaboration and quality of care (Centre for the Advancement of Interprofessional Education, 2002).

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Interprofessional learning is the learning arising from interaction between students or members of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings (Freeth, Hammick, Reeves, Barr, & Koppel, 2005). It has been found that interprofessional education can improve collaborative practice, enhance delivery of services and have a positive impact on patient care (Canadian Interprofessional Health Collaborative, 2008).

The World Health Organization (WHO) has recognised the importance of interprofessional education and collaborative practice in developing a health workforce that is able to meet the complex health challenges facing the world and assist in the achievement of the health-related Millennium Development Goals (World Health Organization, 2010a). In developing its framework for action, the WHO have recognised that models of interprofessional collaboration are most effective when they consider the regional issues and priority areas (including areas of unmet need) in the local population (World Health Organization, 2010a). In doing so, interprofessional education and collaborative practice can best maximise local health resources, reduce service duplication, advance coordinated and integrated patient care, ensure patient safety and increase health professional's job satisfaction (World Health Organization, 2010a).

The end goal of interprofessional education is to create a health workforce with improved levels of teamwork, collaboration, knowledge-sharing and problem-solving, eventually leading to better patient and client outcomes in health settings (Braithwaite et al., 2007).

Interprofessional learning through simulation

Simulation in education refers to the re-creation of an event that is as closely linked to reality as possible. Gaba (2004) defined simulation as a technique, rather than a technology, to replace or amplify real life experiences with guided experiences often immersive in nature to evoke or replicate aspects of the real world, in a fully interactive pattern. Simulation provides a safe learning environment for students to practice, where they are free to make mistakes, correct them and improve the processes of care (Kenaszchuk, MacMillan, van Soeren, & Reeves, 2011). Simulation is the bridge between classroom learning and the real life clinical experience, allowing students to put theory into practice.

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Interprofessional learning through simulation combines the principles of interprofessional learning and the use of simulation as an educational methodology. Interprofessional learning through simulation provides students with the opportunity to practice working with other health professionals and allows participants to explore collaborative ways of improving communication aspects of clinical care (Kenaszchuk, et al., 2011).

Many of the interdisciplinary team core competencies, such as problem solving, respect, communication, shared knowledge and skills, patient-centred practice, and the ability to work collaboratively (Canadian Interprofessional Health Collaborative, 2010) can all be developed by interprofessional learning through simulation.

Teamwork and interprofessional practice and learning are being recognised as central to improving client care and outcomes and enhancing client safety (Sargent, 2008). Promoting patient safety through team efforts is one of the five core competencies identified by the Institute of Medicine (2003).

In today's healthcare setting, no one health professional can meet all of the client's needs and therefore a healthcare team approach is required. Interprofessional learning through simulation provides learning opportunities to prepare future healthcare professionals for the collaborative models of healthcare being developed internationally (Baker et al., 2008).

How to use this resource package

This interprofessional learning through simulation resource package has been designed to support the facilitation of interprofessional learning among students and practitioners with an interest in developing their skills and knowledge of interprofessional practice and suicide prevention.

The package consists of two components: an audiovisual resource and a supporting manual. In order to optimise the learning opportunities from this package it is recommended that participants are firstly introduced to the concepts of interprofessional learning and human factors in health care.

The audiovisual resource consists of two scenarios, the first demonstrating sub-optimal performance of the healthcare team, with the second demonstrating more effective

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performance, thus improving the final outcome. The package has been created in a format to enable flexibility in its application depending of the educational setting. We recommend the following format:

1. Facilitator guided discussion around the concepts of interprofessional learning and human factors in health care
2. View scenario 1 of the audiovisual resource
3. Facilitator guided discussion around the scenario specific learning competency areas (samples given within manual)
4. View scenario 2 of audiovisual resource
5. Facilitator guided discussion, identifying and discussing the changes witnessed and how this resulted in an alternative outcome. In particular discussion relating the causes of these changes to personal (future) practice is essential in improving interprofessional practice.

Opportunities for further reading and exploration of the scenario are provided in the *Further Information* and *References* sections of this resource manual.

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Scenario brief

In the operating theatre, a patient has haemorrhaged to death following removal of a pancreatic cyst. The anaesthetist and surgeon are faced with telling his wife and family. The anaesthetist is emotionally affected by the death of this patient. Colleagues have noticed a change in the anaesthetist's appearance and demeanour over recent months. Unbeknown to his colleagues he is suffering from depression and he has experienced a number of significant negative life events recently. He has feelings of hopelessness, helplessness and powerlessness. This patient's death has further contributed to these negative feelings.

List of characters

- Anaesthetist
- Anaesthetic technician
- Orderly
- Scout Nurse
- Scrub Nurse
- Surgeon

Key learning competencies

The key learning competencies for this scenario are based on the IpAC Program learning objectives, the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework (Canadian Interprofessional Health Collaborative, 2010) and the suicide prevention gatekeeper training manual (Telethon Institute for Child Health Research, 2008). The specific competency areas for this scenario are:

- Suicide prevention: recognising the indicators and taking appropriate action
- Interprofessional communication
- Perceptions and attitudes influencing practice

Suicide prevention: recognising the indicators and taking appropriate action

Many people with suicidal intent provide someone they know with indicators that they are intending to commit suicide. It is important for individuals to be able to notice the indicators of suicide and ask the difficult questions. Individuals should therefore be able to:

- Identify indicators of suicidal ideation and/or behavior.

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- Develop strategies for coping with work related stress, when working in the health care field.
- Provide support strategies for a colleague in psychological distress.
- Conduct a risk assessment and construct a safety plan, when a person shows signs of risk of suicide.

Interprofessional communication

The health care team consists of health professionals, the client and the family. The interaction within the health care team demonstrates:

- Communication is authentic, consistent and demonstrates trust.
- Team members demonstrate active listening skills.
- Communication ensures a common understanding of decisions made.
- Trusting relationships with team members.

Perceptions and attitudes influencing practice

Reflective practice is crucial in continuous development and re-assessment of skills when working in health care. A reflective practitioner:

- Reflects on feedback and integrates changes into practice.
- Reflects on how own perceptions, attitudes and beliefs impact on practice.
- Identifies knowledge deficits and seeks clarification.

Key discussion points

Scenario 1

- Identify and talk about some of the cultural, religious, environmental and social factors that might influence an individual's perception and attitude towards suicide.
- Individually, or discuss in groups of 2-3:
  - What are your personal views on suicide?
  - Have you known anyone who has attempted or completed suicide?
  - How do you think your personal views and experiences shape you?
- What are the indicators for someone at risk of a suicide attempt? How might these manifest themselves in behaviours or actions that someone else might be able to recognise?

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- What risk factors and indicators did the anaesthetist reveal in his conversation with the surgeon?
- How do you think the anaesthetist felt after his discussion with the surgeon?
- How could the surgeon have handled her discussion with the anaesthetist differently?
- What advice do you have for the other colleagues (Anaesthetic technician, Orderly, Scrub Nurse, Scout Nurse)?

Key discussion points

Scenario 2

- What did you notice had changed from Part 1 of the scenario? How did these changes impact on the final outcome?
- How do you think the anaesthetist felt in the revised scenario? Why?
- How did the surgeon's body language differ from the first scenario? How did this affect the interaction?
- What were some of the specific improvements made in regards to communication?
- What were the key behaviours and actions taken which improved the outcome for this version of the scenario?
- What do you think would have been the next steps if the scenario was to continue?

Encourage participants to reflect on their own practice:

- How can you ensure the interprofessional learning objectives are addressed in your interprofessional and client-centred practice?

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Literature review

Suicide is the act of deliberately killing oneself (World Health Organization, 2010b). Suicide rates have increased worldwide by approximately 60% over the last 50 years, with 1.5% of all deaths being self-inflicted (Hawton & van Heeringen, 2009; World Health Organization, 2009). The global incidence of suicide is estimated at one million deaths per annum making it the tenth leading cause of death worldwide (Hawton & van Heeringen, 2009). It is estimated that there is one suicide attempt every 3 seconds, one death from suicide every minute and close to 3,000 deaths from suicide daily (World Health Organization, 2009).

Australian statistics reported approximately 2,200 suicide deaths annually over the decade 1993 to 2003 (range 1,800–2,500) (ABS 2004). In 2010, 2,361 intentional self-harm (suicide) deaths were reported (refer to the *Medical Glossary* for further details how this statistic is determined) (Australian Bureau of Statistics, 2012). This relates to one Australian life being taken by suicide every 4 or so hours or nearly 6 lives every day (Mendoza & Rosenberg, 2010) and accounts for more deaths than from homicide, motor vehicle accidents or skin cancer (Mendoza & Rosenberg, 2010).

Alternative research has estimated that the true figure for annual suicide deaths may be even higher at 2,700–3000 deaths due to open coroners' cases not being included in Australian Bureau of Statistics data (Bradley, Harrison, & Elnour, 2010). The process of classifying and recording a cause of death as suicide can be complex and challenging (Bradley, et al., 2010). Research has found that up to 20% of coroners' cases which may have been suicidal intent are not included in official statistics (Large & Nielssen, 2010).

The underreporting of suicides is not isolated to Australian data. Whilst the global annual mortality rate is estimated at 14.5 deaths per 100,000 people, the actual figure is assumed to be higher (World Health Organization, 2002, 2006b). Cultural and social variations in attitudes to suicide as well as procedural differences in the recording of deaths as suicides lead to inconsistencies in the global recording of suicide rates (Hawton & van Heeringen, 2009). The process of certification for the cause of an unexpected death differs by country, for example, it is the role of the police in Finland, physicians in China, and coroners in England and the United States of America (Hawton & van Heeringen, 2009).

The necessary requirements for a death to be recorded as a suicide also differ by country. In England, if the death was self-inflicted only a judgement of intent is required, however in

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Luxemburg external evidence such as a suicide note is required for a ruling of suicide to be made (Hawton & van Heeringen, 2009). In countries where suicide is illegal such as India and some Islamic countries, independent investigations have revealed significant underestimation of suicide rates with one study in India suggesting that the actual rate is 9-to-10 times the official suicide rate (Hawton & van Heeringen, 2009).

There is also important variation in rates of suicide by age. Whilst suicide accounts for only 1.5% of deaths in many countries, it is one of the top three causes of death among adolescents and young adults between the ages of 15 and 24 years (World Health Organization, 2009). Suicide is a leading cause of death for males under the age of 44 years, in women under the age of 34 years and in males over the age of 75 years (Mendoza & Rosenberg, 2010). Rates of suicide are generally higher in older people, however when demographic distributions are considered the absolute numbers recorded are higher in individuals under the age of 45 years in a number of countries including Australia, Bahrain, Canada, Columbia, Ecuador, Guyana, Kuwait, Mauritius, New Zealand, Sri Lanka and the United Kingdom (World Health Organization, 2002).

Method of suicide

Worldwide the most common means of suicide are hanging, self-inflicted gun-shot wound(s), jumping from a height, and drowning (World Health Organization, 2002). In the United States of America two-thirds of all suicides are the result of gun use whilst in China the leading method of suicide is intoxication of pesticides (World Health Organization, 2002). In Australia, hanging accounts for approximately half of all suicide deaths, followed by poisoning, including alcohol and drug overdoses or motor vehicle exhaust inhalation, which account for nearly another quarter of all suicide deaths. The remaining deaths are attributable to firearms at just under 10%, jumping, drowning and cutting (Mendoza & Rosenberg, 2010). Generally, women use less lethal and/or fatal methods to attempt suicide such as drug overdoses whilst more elderly individuals use methods requiring less physical strength such as drowning (World Health Organization, 2002).

An effective population level intervention to reduce suicide rates has been to decrease access to lethal means of suicide, such as the addition of safety barriers at places where people frequently attempt suicide (Hawton & van Heeringen, 2009). Similarly, the introduction of catalytic converters in motor vehicles in the 1970s has proved effective

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worldwide in reducing suicide rates from carbon monoxide poisoning (World Health Organization, 2002). Likewise, following a peak in suicides by gas in the 1960s, changes to the gas supply in England resulted in a reduction in suicide rates from this means (Hawton & van Heeringen, 2009). Similar reductions occurred in Japan, The Netherlands, Switzerland and the United States of America following changes to their domestic gas supplies (World Health Organization, 2002). Restrictions in access to firearms resulted in substantial reductions in their use for suicide in Australia (World Health Organization, 2002).

It has been suggested that restrictions in rural areas of developing countries to the access of pesticides through safer storage and tighter controls on the sale of toxic chemicals may help to tackle suicides by these means (Hawton & van Heeringen, 2009). However, the increasingly common method of hanging provides unique challenges globally because of the relatively easy access to means to carry out a suicide plan (Hawton & van Heeringen, 2009).

Suicide prevention: risk factors for suicide

Suicide risk is a complex interaction of biological, psychological, social and cultural factors (Telethon Institute for Child Health Research, 2008). There is no easy explanation as to why some people make the decision to commit suicide while others who may be in a similar or even worse situation do not (World Health Organization, 2000). However, it is generally recognised that most suicides can be prevented (World Health Organization, 2000).

A report by Mendoza and Rosenberg (2010) provides a useful framework for understanding the transition points for an individual who may possess suicidal risk factors and may reach the point of imminent risk of suicide (Mendoza & Rosenberg, 2010). Figure 1 replicates Mendoza & Rosenberg's framework and assists in directing the focus of this paper.

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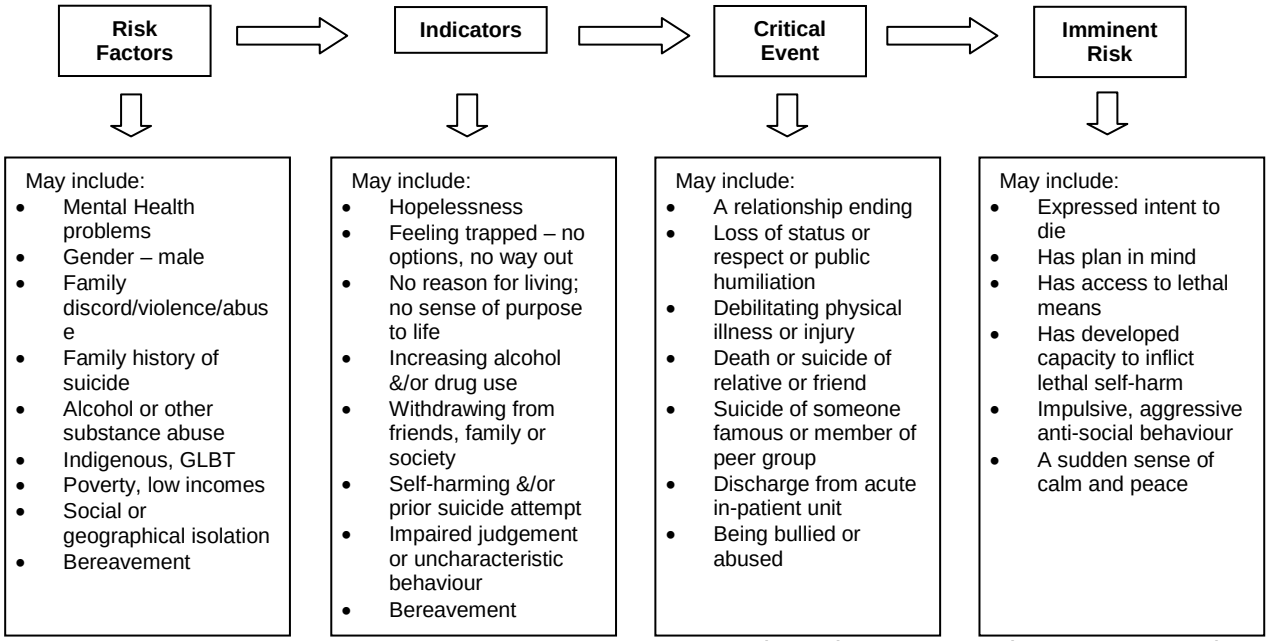
Figure 1: The transition from risk factors to the point of imminent risk.



Source: (Mendoza & Rosenberg, 2010, p. 5).

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Research has identified a range of risks that can increase the likelihood of someone considering or undertaking suicide (Martin & Page, 2009). The risk factors for suicide are numerous and interact with one another (World Health Organization, 2002). Whilst they may not necessarily contribute to a suicide when considered in isolation, they have been found to be an important indicator of suicide risk in vulnerable individuals (Telethon Institute for Child Health Research, 2008). Commonly accepted risk factors for suicide include:

A history of mental illness

Individuals who suffer from a mental illness, particularly affective disorders (e.g. depression), schizophrenia, substance abuse, and personality disorders (e.g. borderline or antisocial personality disorder) have a suicide risk 15 times higher than the general population (World Health Organization, 2009). Australian research has shown that individuals with a mental disorder experience suicidal thoughts at a higher rate compared to other people (8.3% as compared to less than 1%) (Mendoza & Rosenberg, 2010). It has been suggested that up to 95% of individuals who commit suicide may have a mental disorder with approximately 65% exhibiting symptoms consistent with major depression at the time of their death (Mendoza & Rosenberg, 2010; World Health Organization, 2009). Also, approximately one-in-ten people with schizophrenia commit suicide making it the most common cause of death for individuals experiencing psychosis (Telethon Institute for Child Health Research, 2008; World Health Organization, 2006b).

Suicide risk appears to peak with acute episodes of illness, recent hospital discharge, or recent contact with a mental health service (World Health Organization, 2009). Western Australian research on suicide deaths found that over 30% of males and 60% of females had been diagnosed with a psychiatric disorder in the 12 months prior to their death (Telethon Institute for Child Health Research, 2008). It has also been suggested that in the year prior to their death approximately 25% of people who complete suicide were in contact with a mental health service (World Health Organization, 2009).

Alcohol and substance use

The World Health Organization reports that alcohol dependency is found in approximately one-third of suicides and that up to 10% of people who are dependent on alcohol end their life by suicide (World Health Organization, 2000).

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The abuse of alcohol is a strong risk factor for suicide with more than 80% of suicides identifying alcohol in the blood stream of the victim, and in 25% of cases the level of alcohol in the blood stream are at levels associated with drunkenness (Martin & Page, 2009). The concern is that when facing periods of stress and uncertainty, alcohol use can distort an individual's view of reality and increase the potential for self-harm (World Health Organization, 2006b). Alcohol and substance use can lead to a loss of self-control and the undertaking of risky and impulsive suicidal behaviours (Mendoza & Rosenberg, 2010).

Sex

Women report marginally higher rates of suicidal ideation and are two- to three-times more likely to make a suicide attempt. However, suicide deaths are four-times more common in men than in women (World Health Organization, 2000, 2009). According to Australian statistics, nearly 80% of annual suicide deaths are in males making sex a significant risk factor (Mendoza & Rosenberg, 2010). This has been attributed to men often using more violent and irreversible methods, therefore resulting in a more successful suicide attempt (World Health Organization, 2009).

Rurality

In some countries, such as Australia, variations in rates of suicides are also often evident between rural and urban areas (World Health Organization, 2002). A number of reasons have been put forward to explain this variation and include social isolation, limited access to health and support services, lower levels of education and more ready access to lethal means, such as firearms and pesticides (World Health Organization, 2002).

Indigenous populations

High suicide rates compared with the general population are also evident in several Indigenous populations. These include Aboriginal people from Australia, Maori from New Zealand, Metis and Inuit from Canada and Native American people from the United States of America (Hawton & van Heeringen, 2009). All these groups have higher than average suicide rates for their country, with this being attributed to social and cultural marginalisation; previous government policies and practices that have weakened traditional social and cultural networks; poor educational, health and socioeconomic status; and high rates of substance abuse (Hawton & van Heeringen, 2009).

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Severe family difficulties

Problems with family functioning, social relationships, and support systems including relationship breakdown, divorce, reduced access to children and domestic violence are all associated with an increased risk of suicide (Telethon Institute for Child Health Research, 2008). It has been found that suicidal ideation is two- to three-times more likely in those who are divorced or separated (World Health Organization, 2009). Likewise, suicide attempts are also three- to five-times higher in this group (World Health Organization, 2009). Those who live alone also have a higher vulnerability to suicide (World Health Organization, 2000).

History of abuse

A family history of childhood adversity including sexual, physical and emotional abuse can increase the risk of suicide in adolescence and adulthood (Mendoza & Rosenberg, 2010).

Conflict over sexual identity or other sexual issues

Suicide rates among gay and lesbian youth have been reported at between 2.5% and 30% (World Health Organization, 2002). Bullying, marginalisation and discrimination, stress in interpersonal relations, drugs and alcohol, anxiety about HIV/AIDS and limited sources of support have all be identified as factors that may contribute to suicide in this cohort (World Health Organization, 2002).

Previous attempts

A previous suicide attempt significantly increases the risk of suicide (World Health Organization, 2006b) with research indicating half of all suicides have made a previous attempt including a quarter who have made an attempt in the previous 12 months (World Health Organization, 2009).

Losses, including death and decline in physical health

The loss of a loved one, especially if they were close to the person, may result in depressive symptoms which places the individual at increased suicidal risk (World Health Organization, 2002). Individuals experiencing physical illness and chronic pain have also been found to be at increased suicide risk (World Health Organization, 2006b). A range of terminal and chronic illnesses including cancer, HIV, multiple sclerosis, renal disease, epilepsy and stroke have been associated with increased suicide risk (Hawton & van Heeringen, 2009; World Health Organization, 2000).

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The availability of lethal methods of suicide

Access to guns, rifles and pesticides by individual who have expressed suicidal thoughts or made previous attempts is of particular concern as they pose an immediate threat (World Health Organization, 2009). Certain occupation groups including doctors, veterinarians, anaesthetists , dentists, pharmacists, nurses and farmers also have been found to have higher than average rates of suicide and this has been attributed, in part, to their relatively easy access to means for suicide such as lethal doses of drugs and firearms (Hawton & van Heeringen, 2009; World Health Organization, 2000).

Socio-economic disadvantage

Suicidal behaviours are more prevalent in individuals of lower socioeconomic means including those with low levels of education, the unemployed, and those under financial stress or experiencing sudden economic change (World Health Organization, 2002). Unemployment can lead to poverty and feelings of social isolation increasing suicidal risk (World Health Organization, 2002).

Financial problems

Research has identified an increase in suicide rates during periods of economic recession and high unemployment (World Health Organization, 2002).

Work-related stress

The World Health Organization defines job stress as occurring when '*there is a mismatch between the demands of the job or work environment, and the capabilities, resources, and needs of the worker'* (World Health Organization, 2006a, p. 4). Work-related stress may be associated with a traumatic event such as job transitions (e.g. retirements, dismissals) or disciplinary actions, and will often act as an additional psychosocial burden on someone who is already vulnerable to suicide (World Health Organization, 2006a). Workers who are experiencing mental health problems can be at particular risk from the negative influence of stress due to reduced psychological resilience, limited social support, and poor coping strategies (World Health Organization, 2006a).

Poor communication and social isolation

Individuals who display poor patterns of communication with others, especially with their family and/or friends, have a higher risk of suicide (Telethon Institute for Child Health Research, 2008). An Australian study analysed suicides in one town over a two-year period

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and noted that over one-third of the suicides were associated with social and personal difficulties (World Health Organization, 2002).

A family history of suicide or suicidal behaviour

Individuals who are left behind after a suicide are themselves at increased risk of suicide (Hawton & van Heeringen, 2009).

Legal problems, imprisonment and illegal or anti-social behaviour

Rates of suicide are found to be high compared to the general population in prisoners, particularly in those with a mental illness, a history of substance abuse, the occurrence of previous suicide attempts or those who are in confinement (Hawton & van Heeringen, 2009).

Exposure to environmental stressors

A relationship has been identified between suicide and extreme environmental stressors including floods, bushfires, earthquakes, civil war, political violence and global financial instability (Mendoza & Rosenberg, 2010; World Health Organization, 2002).

Suicide prevention: protective factors

In addition to risk factors for suicide, research has identified a number of protective factors that may shield a person from suicide risk (World Health Organization, 2006b). The Telethon Institute for Child Health Research list the following protective factors against suicide:

- Connectedness to family
- Responsibility for children
- The presence of a significant other, such as a spouse of partner, or an adult for a young person
- Personal resilience and problem-solving skills
- Good physical and mental health
- Economic security in older age
- Strong spiritual or religious faith, or a sense of meaning and purpose to life
- Community and social integration
- Early identification and appropriate treatment of psychiatric illness
- Belief that suicide is wrong
- Lack of access to guns in the house

Source:(Telethon Institute for Child Health Research, 2008, p. Handout 4).

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Protective factors can buffer the individual from the stress of life events (World Health Organization, 2006b). When an individual possesses a sufficient suite of protective factors suicidal ideation or behaviour may not occur despite the presence of risk factors (World Health Organization, 2002).

Suicide prevention: indicators for suicide

Evidence indicates that the intention behind suicide is a desire to end intolerable and uncontrollable emotional or psychological pain that exceeds any physical pain relating to self-harm or death (Mendoza & Rosenberg, 2010). Most people who commit suicide do not want to die but they may not be able to see any other option except death to stop their pain (Mendoza & Rosenberg, 2010).

Most people who have attempted or completed suicide have given some prior indication of their intention (Telethon Institute for Child Health Research, 2008). Suicide indicators should be taken seriously as a cry for help and an opportunity to save a life (Mendoza & Rosenberg, 2010). There are some behaviours which are recognised as common indicators for suicide risk and these are provided in Table 1.

Whilst it is not unexpected that these behaviours may be demonstrated by individuals during a particularly stressful period, it should be of particular concern if a number of these behaviours become evident within a short period of time as they may indicate suicidal risk (Mendoza & Rosenberg, 2010). In addition, certain life events sometimes referred to as 'critical events' may become the impetus for someone to consider suicide (Mendoza & Rosenberg, 2010). Some of these precipitating events, whilst upsetting, are relatively minor for a mentally healthy individual, yet for someone considering suicide it may be all that is needed to reach the point of imminent risk (Mendoza & Rosenberg, 2010). Some of the more common events include:

- An argument with family, friends or significant other (e.g. parent, partner, teacher)
- Loss or breakdown of a relationship
- Suicide of a family member, friend or public role model
- Media report or story about suicide
- Onset or recurrence of a mental or physical health problem
- Unexpected change in life circumstances (e.g. change in health status, work circumstances)

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- Transition phase or change from one life stage into another
- Experiencing a traumatic life event, such as abuse, bullying or violence

Source: (Mendoza & Rosenberg, 2010).

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Table 1: Indicators for suicide risk

INDICATOR	EXAMPLE
Sudden changes in usual pattern of relating to others	- Withdrawing from family/friends, or not wanting to be left alone - Not wanting to be touched - Loss of interest in usual social activities - Developing violent, argumentative or disruptive behaviour - Loss of humour, or unusual change to acting the 'clown'
Marked personal changes	- Decline in school or work, disinterest in the future - Apathy about dress and appearance - Changes that suggest depression or other mental health problems e.g. marked weight increase or decrease, lack of concentration, changes in sleeping pattern, delusions or hallucinations - Sudden happiness after a lengthy period of depression - Talk of being worthless, useless or hopeless
Impulsive and/or risk-taking behaviour	- Running away from home, truanting - Careless, accident-prone behaviours, taking personal risks, e.g. not looking after oneself when sick or playing 'chicken' on the road - Increased or heavy use of alcohol or other drugs
Making final arrangements	- Making a will - Giving away prized possessions - Organising own funeral - Saying goodbye
Self-harm and suicide attempts	- Self-mutilation, e.g. cigarette burns, cutting oneself - Having made previous suicide attempt(s) is one of the most important and reliable indicators of risk
Verbal expressions – direct or indirect	- "I wish I were dead" - "You won't have to bother with me anymore" - "I think dead people must be happier than when they were alive" - "I'd like to go to sleep and never wake up"

Source: (Telethon Institute for Child Health Research, 2008)

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The point of greatest danger for an individual considering suicide is called the point of "imminent risk" in which a suicidal individual may:

- threaten to hurt or kill themselves
- express an intention to die
- search for a means to attempt suicide
- discuss a suicide plan
- seek access to lethal means (e.g. guns, drugs)
- exhibit impulsive, aggressive or anti-social behaviour (especially if out of character)
- display a sense of urgency or crisis
- present with a sudden mood change, particular if the individual suddenly becomes calm (Mendoza & Rosenberg, 2010).

At this point it is imperative that the individual is questioned regarding any intentions or plans of suicide and appropriate action taken immediately (World Health Organization, 2009).

Suicide prevention: assessment of imminent risk

If someone is suspected of suicide intentions, further enquiries should be made to identify the immediate risk (Hawton & van Heeringen, 2009). It is recommended to ask the person directly (World Health Organization, 2000). Despite the common misconception, talking or asking about suicide does not put the idea into someone's head (World Health Organization, 2000). Conversely, the person is likely to welcome the opportunity to openly discuss their concerns and emotional turmoil and vent negative feelings (World Health Organization, 2006b). Demonstrations of care may prevent a suicide attempt.

Whilst not always easy, it is important to ask about suicidal intent if someone is believed to be at risk and help them to get the help they need. The World Health Organization suggests raising the topic sensitively and some useful starting questions can include:

- Do you feel sad?
- Do you feel that no one cares about you?
- Do you feel that life is not worth living?
- Do you feel like committing suicide? (World Health Organization, 2000).

In considering an individual's responses it is important to determine the immediate risk of suicide (Telethon Institute for Child Health Research, 2008). The Telethon Institute for Child

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Health Research suggests that the following six areas are explored with the person at risk of suicide:

1. Present feelings and thoughts about suicide
2. Thoughts, feelings and beliefs that oppose suicide
3. Seriousness of any plan and of any past attempts
4. Openness to other solutions or explanations to resolve problems
5. Available social supports and how involved they can be
6. Any events that might put the person at greater risk

Source: (Telethon Institute for Child Health Research, 2008).

Assessment

Those at high risk have a clear INTENT, a specific suicide PLAN, the MEANS to carry it out and a set TIMEFRAME for action (World Health Organization, 2009). It is important to recognise that regular monitoring of risk is essential as suicidal intent can fluctuate within a short time period (e.g. several hours or within a day) (World Health Organization, 2009). Risk can also be heightened by the consumption of alcohol or ready access to lethal means (Hawton & van Heeringen, 2009).

If the person has made multiple attempts with two or more risk factors then immediate action is also necessary (World Health Organization, 2006b). It is imperative not to:

- Ignore the situation
- Be shocked or embarrassed and panic
- Say that everything will be all right
- Challenge the person to go ahead
- Make the problem appear trivial
- Give false assurances
- Swear to secrecy
- Leave the person alone (World Health Organization, 2000, p. 17).

Intervention

The first step is to find a suitable private place to talk, ideally without being interrupted for as long as is necessary (World Health Organization, 2000). Time pressures and distractions should be minimised to allow the suicidal person to freely discuss the emotional weight they have been experiencing (Telethon Institute for Child Health Research, 2008).

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Effective listening is essential. It is important not to interrupt or offer advice too soon and ensure you complete your assessment in full before planning care pathways (Telethon Institute for Child Health Research, 2008). Use reflective listening (repeating back in your own words what has been said) and open questions (ones that require more than a 'yes' or 'no' response) to build rapport and demonstrate you are hearing what they are saying (Telethon Institute for Child Health Research, 2008).

Using effective body language can be particularly useful in fostering open communication and demonstrating you are interested in being an active participant (Henden, 2008). The Telethon Institute for Child Health Research (2008) suggest the acronym SOLAR for effective body language:

S – maintain a square facing body position
O – 'open' posture
L – lean slightly forward
E – eye contact softly maintained
R – relax and reflect calm confidence

Source: (Telethon Institute for Child Health Research, 2008).

During the course of the conversation it is important to be empathetic, calm, patient, non-judgemental, accepting and sincere (Henden, 2008; Telethon Institute for Child Health Research, 2008). It is important to validate and normalise the suicidal person's experiences and feelings as understandable (Henden, 2008). At this same time it should be made clear that suicide is not the solution (Telethon Institute for Child Health Research, 2008). Offer hope that the feelings being experienced are temporary and change for the better is possible (World Health Organization, 2000).

It is imperative that a person at imminent risk of suicide receives professional help immediately (World Health Organization, 2009). Suicidal people should never be left alone even if they promise they will get the help they need (World Health Organization, 2009). Escorting them to their general practitioner, a hospital or leaving them in the care of a responsible family member or friend is crucial (World Health Organization, 2010b). A local crisis telephone support agency can assist with the most appropriate course of action if there is uncertainty (World Health Organization, 2010b). Individuals must rally the support of family, friends and concerned others to monitor and support the suicidal person during the period of imminent risk (World Health Organization, 2010b). Ensure the removal of any

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potential means of self-harm; this may include medications, knives and guns (World Health Organization, 2010b). This should be reiterated if care and responsibility for the suicidal person is transferred from one individual to another (World Health Organization, 2009). Support should be continued beyond the immediate risk period, with the maintenance of regular contact via a telephone call, letter or visit (World Health Organization, 2010b).

Conclusion

The psychological, social and economic impact of suicide on family, friends and the community is considerable (World Health Organization, 2000). It is estimated that each completed suicide affects at least six other people (World Health Organization, 2000). Completed suicide has a multiplier effect impacting on a range of people from family and friends to health staff, first responders, coronial staff and suicide support agencies (Mendoza & Rosenberg, 2010). However, in the majority of cases suicide can be prevented (World Health Organization, 2000). Most people at imminent risk of suicide have revealed their intention to commit suicide to at least one other person prior to their attempt (World Health Organization, 2006b). Therefore, it is important that people within the wider community are aware of the indicators for suicide and can ask the necessary questions and take the necessary steps to prevent someone from unnecessarily taking their own life.

SUPPORT IS AVAILABLE FOR ANYONE WHO MAY BE DISTRESSED BY CALLING:

Mental Health Emergency Response Line (MHERL) 1300 555 788 (Western Australia)

Lifeline 131 114.

(For support outside of Australia please refer to the "Resources" section of this manual)

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Medical glossary and acronyms

Anaesthetist	A person who administers anaesthetics, usually a specially trained doctor or nurse.
Body language	A form of non-verbal communication, which consists of body posture, gestures, facial expressions, and eye movements.
Coroner	A public officer whose primary function is to investigate by inquest any death thought to be of other than natural causes.
Depression	A common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities.
Imminent risk	Indicators of pending or mounting suicide risk that indicate the need for intervention by a medical/mental health provider.
Incidence	Number of suicides in a given population in a given time span.
Intentional self-harm (suicide)	*For a death to be determined a suicide, it must be established by coronial enquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life* (Australian Bureau of Statistics, 2012, p. 1).
Interdisciplinary teams	A team that is collaboration-oriented. The team meets regularly to discuss and collaboratively set treatment goals and carry out treatment plans. There is a high level of communication and cooperation among team members (Korner, 2008, p. 2).
Mental illness	Also known as a **mental disorder**. Includes a range of psychiatric disorders characterised by impairment of an individual's normal cognitive, emotional, or behavioural

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	functioning.
Multidisciplinary teams	A team that is discipline-oriented. Each professional works in parallel, with clear role definitions, specified asks and hierarchical lines of authority (Korner, 2008, p. 2).
Protective factors	Factors that buffer the individual from the stress of life events.
Risk factors	Refer to an individual's characteristics, circumstances, history and experiences that raise the statistical risk for suicide.
Scout Nurse	Also known as **Circulating Nurse.** A Scout Nurse is an operating room nurse who provides support to the surgical team through preparation of surgical equipment, preparation of patients for surgery, documentation and monitoring of patient care post-surgery.
Scrub Nurse	Also known as **Instrument Nurse.** The Scrub Nurse is an operating room nurse whose primary responsibility is providing assistance to the surgical team by pre-empting the use of surgical instruments and equipment. They are also responsible for patient care during surgery, monitoring the patient's condition and responding accordingly.
Suicide	The act of deliberately killing oneself.
Suicide plan	An individual strategy inclusive of time frame and means to complete suicide.
Suicide prevention	Structured effort to reduce suicide risk factors and promote protective factors at the individual, community, or population-wide levels
Surgeon	A medical doctor who specialises in surgery.

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Warning sign	Overt indicator of high suicidal risk of an individual that indicates the need for immediate emergency intervention.

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Further information

Australia

Aboriginal Medical Services (Vibe Australia) www.vibe.com.au

Allows you to search for services by location.

Beyond Blue www.beyondblue.org.au
or 1300 22 4636

Australia info line providing information on depression and related disorders, as well as treatments and referrals.

Headspace http://www.headspace.org.au/

headspace is the National Youth Mental Health Foundation, helping young people aged 12 to 25 with centres located throughout Australia.

Kids Helpline www.kidshelponline.com.au
or 1800 55 1800

A 24-hour free counselling service for children and young people aged 5 to 25 years.

Lifeline www.lifeline.org.au
or 13 11 14

A 24-hour telephone counselling and referral service across Australia.

Mental Health Emergency Response Line (WA) 1300 555 788 (Metropolitan)
or 1800 676 822 (Peel)
or 1800 552 002 (Rural)

A 24 hour a day service provided to residents of Western Australia by the Government of Western Australia, Mental Health Commission. When clinicians at MHERL receive a call, they can provide assessment and support and, if required, referral to other services.

Multicultural Mental Health Australia www.mmha.org.au/find/services

National leadership in mental health and suicide prevention for Australians from culturally and linguistically diverse backgrounds. Allows you to search for services by location and language.

Salvo Care Line www.salvos.org.au

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or 1300 651 251

A crisis counselling service available throughout Australia.

SANE Helpline helpline@sane.org

or 1800 18 SANE (7263)

Mental illness information, support and referral throughout Australia and free helpline open weekdays 9am-5pm.

New Zealand

Lifeline http://www.lifeline.co.nz

or 0800 543 354

Free, confidential support service available 24 hours a day, 365 days a year.

Youthline http://www.youthline.co.nz

or 0800 376 633

Youthline offers access to a wide range of youth development and support services including a helpline and counseling.

United States

National Hopeline Network http://www.hopeline.com/

or 1-800-SUICIDE (784-2433)

Toll-free telephone number offering 24-hour suicide crisis support.

National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org

or 1-800-273-TALK (8255)

Suicide prevention telephone hotline funded by the U.S. government which provides free, 24-hour assistance.

Canada

Crisis Centers in Canada http://suicideinfo.ca/

Locate suicide crisis centers in Canada by province (Centre For Suicide Prevention).

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United Kingdom

Samaritans http://www.samaritans.org/
or 08457 90 90 90 (UK)
or 1850 60 90 90 (Ireland)

24-hour suicide support for people in the UK and Republic of Ireland.

International

Befrienders Worldwide http://www.befrienders.org/

International suicide prevention organisation that connects people to crisis hotlines in their country.

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