
# Australian General Practice Network submission to the Senate Community Affairs References Committee inquiry into suicide in Australia

## December 2009

Delivering local health solutions through general practice

AGPN represents a network of 110 general practice networks as well as eight state based entities. More that 90 percent of general practitioners (GPs) and an increasing number of practice nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an accessible, high quality health system by delivering local health solutions through general practice.

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# Introduction

The Australian General Practice Network (AGPN) is pleased to have this opportunity to make this submission to the Senate Community Affairs Reference Committee inquiry into suicide in Australia.

Across Australia there are 110 general practice networks (GPNs), supported and represented by eight State Based Organisations (SBOs) and the Australian General Practice Network (AGPN) at the national level. Collectively these organisations are known as the Network.

Approximately 90 percent of GPs and an increasing number of practice nurses and allied health professionals are members of their local GPN. All Network members (AGPN, SBOs and GPNs) are independently governed by individual boards of directors and are not-for-profit small businesses whose core activities are the delivery and organisation of primary care through general practice and broader primary health care teams. Locally, Network members deliver a range of services to their communities including health promotion, early intervention, general practice, after hours and allied health services. Education and training, practice support and service linkage are also central roles for general practice networks.

AGPN's submission focuses on the terms of reference of most relevance to the role and function of the Network:

c) the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide

e) the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk

f) the role of targeted programs and services that address the particular circumstances of high-risk groups

g) the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

Suicide constantly ranks among the highest causes of death, causing 8.7 per 100,000 people. Suicide accounted for 1,799 deaths in 2006. Since 1997 there has been a continuing downward trend in the overall number of people dying as a result of suicide.

Suicide is about four times higher among males than females. Males accounted for around 78% of suicide deaths in 2006. However, women are more likely than men to attempt suicide and harm themselves. Groups most likely to complete a suicide attempt are young males (including Indigenous young men), older men and rural Australians.

Key risk factors for suicide include mental health problems, being male, family discord, violence or abuse, family history of suicide, alcohol or other substance abuse, social or geographical isolation, financial stress, bereavement, prior suicide attempt.

Although warning signs can be detected, suicide can occur without warning or may be missed by skilled professionals. Most attempts occur outside of business hours. Less than 30% of people will go to a hospital after their suicidal behaviour.

Approaches to suicide prevention can be grouped into universal, selective and indicated prevention, and should take into account the spectrum of interventions (prevention, treatment, maintenance, recovery).

Allocation of resources to suicide prevention should reflect its prevalence in the community, its impacts when it does occur, the most at-risk groups and current available evidence about effective interventions.

Although it is acknowledged that suicide can occur in the absence of mental health problems or disorders, mental illness has been shown to have a strong relationship with suicide-related behaviours. Estimates of the percentage of people whose suicide is related to mental illness vary considerably, ranging from 30 percent to 90 percent of all suicides[1].

Nationally, the Network is involved in a range of primary mental health care activities, covering education and training of care providers, provision of support to general practices to improve their practice systems, delivery of primary mental health care services to the community, community engagement and resilience building, and provision of suicide prevention services. As a cohesive grouping with national coverage and a local presence, the Network is well placed to connect with both providers and community members, building community resilience and offering intervention services where risk factors for suicide exist.

Some Network mental health programs on which suicide prevention activities can be built include:

- headspace, the National Youth Mental Health Foundation
- *Access to Allied Psychological Services* (ATAPS) initiative
- *Specialist Services for Consumers at Risk of Suicide*, an extension of the ATAPS initiative
- *Mental Health Support for Drought Affected Communities Initiative*

These programs are discussed in further detail in this submission.

[1] Living Is For Everyone (LIFE) Framework. Research and evidence in suicide prevention. Commonwealth of Australia; Canberra: 2007.

## Responding to the Committee's Terms of Reference

### c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide

As identified in the Government's suicide prevention strategy, the *Living Is For Everyone Framework*, efforts to increase suicide prevention capacity across Australia must be addressed by a range of agencies across different sectors.

Primary health care is a sector that has a key role in suicide prevention. Primary health care, and in particular general practice, is an important place for identifying and supporting people who are at risk of suicide and for the provision of post-vention support to people who have attempted suicide and for their families. Approximately 85 per cent of the Australian population visit a general practitioner (GP) at least once in any year, and studies indicate the high proportion of people who have attempted suicide have seen a GP prior to that attempt. Howell *et al.* wrote in 2005[2] that:

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

**Role of general practice and primary health care providers**

While mental illness is not the sole predictor of suicide or self harm attempts, it has been shown to have a strong relationship with suicide-related behaviours[3], and up to 90 percent of people who die by suicide suffer from a diagnosable mental health condition[4]. Therefore, primary health care is the best place to manage the majority of high prevalence mental health problems and disorders. Primary health care stands at the centre of our care systems. It is the key entry point for most people, the place for receiving care for prevention, early intervention, and treatment and management of mental health problems. Primary health care is also the setting where a person's holistic health needs are best supported. Mental health problems regularly present with physical health problems. GPs are the ideal health professionals to take responsibility for holistic health needs, coordinating the efforts of a multidisciplinary team that may include specialist mental health professionals (e.g. psychiatrists, psychologists, social workers, occupational therapists, mental health nurses), community support workers (e.g. drug and alcohol workers, service coordinators, personal helpers and mentors) and social support services (e.g. housing, social engagement, employment services).

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[2] Howell C, Wolinski K, Newbury W & Black C. *Resource Kit*. NSPS: Pathways to Care Project. 2005.

[3] Australian Government Department of Health and Ageing, 2007, op cit.

[4] square. *suicide questions answers resources: desk guide*. Commonwealth of Australia: 2006.

It is important for GPs to have skills that assist them to identify and respond to people at risk of suicide or self harm. It is also important that the system supports access by those at risk of suicide to specialised suicide prevention services such as psychologists, psychiatrists and social workers. For those people with more complex needs, there is a need to ensure that primary health care is integrated with mental health services that include community mental health, acute care services and community supports.

Priorities for building suicide prevention capacity in the primary health sector include:

- provision of education and training on the identification, treatment and support for people at risk of suicide or self harm and on post-ventative care following a suicide attempt
- increased early intervention programs such as headspace youth mental health centres
- increased community development programs, modelled on the Mental Health Support for Drought Affected Communities Initiative
- specific programs and services that provide referral options for people at risk of suicide or self harm
- post-vention program access for care and community supports following a suicide attempt.

Suicide preventative care should be available both before and after an attempt. GPs and other primary mental health care providers require training and resources to enable preventative and post-ventative care. There should also be greater efforts to link people who have attempted suicide to community-based primary mental health care following discharge from tertiary services, to avoid 'falling into the gap' between services[5].

Two key programs that have improved access to community based mental health care are the *Better Outcomes in Mental Health Care* initiative ('Better Outcomes') and the *Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule (MBS)* program ('Better Access'). These programs have increased the capacity of primary health care professionals to more effectively respond to and treat mental health problems by driving uptake of mental health education and training, providing additional referral channels from general practice to mental health specialists, and access to psychiatrist advice.

**Role of general practice networks**

Local general practice networks play an invaluable role in supporting general practice and primary health care providers in mental health care and suicide prevention. General practice networks:

- provide mental health education and training for primary health care providers[6]
- deliver mental health programs and services directly to the community (e.g. ATAPS)

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[5] The *Specialist Services for Consumers at Risk of Suicide*, discussed in detail in section f), is trialling a post-vention referral option from general practice to an experienced psychologist for people who are at risk of or who have attempted suicide or self harm.

[6] The Network delivers a wide variety of mental health education and training in support of continuing professional development needs. The majority of this training is accredited as 'mental health skill training' and covers topics such as suicide prevention, youth mental health, developing mental health plans, comorbid mental and drug and alcohol problems, and comorbid mental health and physical health problems.

- deliver mental health programs and services specific to suicide prevention directly to the community[5]

- participate in or lead youth-friendly services established under the headspace and similar initiatives

- increasingly, provide community outreach services such as service coordination to enable at-risk individuals to connect with the necessary services and avoid falling through the gap

- build links and help integrate relevant services in the community, including between general practices, allied health professionals, specialist care, suicide prevention services, and community and tertiary mental health services

- deliver emergency services during times of community crisis, such as responding to drought/climate change, bushfires or flood

- deliver programs or services to vulnerable groups such as Aboriginal and/or Torres Strait Islander peoples, refugees, people with a culturally and linguistically diverse (CALD) background, youth and the aged.

Further discussion of some specific programs and services provided by GPNs is provided in section f) of this submission.

**Recommendations**

AGPN recommends that:

- Given the strong connection between suicide and mental illness, prevention efforts must include significant resources for mental health promotion, illness prevention and management when mental health problems or disorders occur. General practices and allied health professionals provide essential frontline, community based mental health care. They are supported in their role by GPNs, at the local level as well as the collective Network, which combines a national framework with a local presence that covers the entire country

- Suicide prevention resources should be directed towards primary health care provider education and training, service delivery, high-risk groups (such as Indigenous peoples, rural and remote areas, youth and males in each of these groups), and mental health plus suicide prevention specific services

- Voluntary registration by patients with a chronic disease with a general practice of their choice would strengthen general practices' capacity to support people with mental illness who are at risk of suicide. Building a relationship with a single doctor or practice over time provides a critical foundation for primary health care[7] and encourages GPs and patients to take a long-term approach to care[8]. It assures Australians that a specific general practice will be responsible for coordinating their chronic health needs, undertaking proactive preventative health care including monitoring their health, administrating registers, recalls and reminder systems, and coordinating their access to additional health services

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[7] Schoen C et al., op cit.

[8] *Towards A National Primary Health Care Strategy - Key themes from the 3rd National Health Reform Conference 2008*. 17th November 2008.

- General practice networks should be considered as important agencies (as local leaders as well as partners for other agencies) for the implementation of relevant mental health and suicide prevention programs, initiatives and services. The potential for GPNs and the Network to engage in community resilience building should also be recognised. GPNs routinely work with a wide variety of population groups and agencies, monitoring community need and building appropriate responses.

## e) The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk

AGPN supports the use of evidence based training packages to upskill and better equip frontline health and community workers in assisting people at risk of suicide.

AGPN recommends the *square* education and support package (see discussion below in section f for more information)[9] as a useful resource for general practice and other frontline workers providing services to people at risk.

The Network delivers a significant amount of mental health training accredited for continuing professional development points by General Practice Mental Health Standards Collaboration (GPMHSC) in support of the Better Access and Better Outcomes initiatives. Topics include suicide prevention, mental health skills training, focussed psychological strategies, comorbid mental health and physical health problems, comorbid mental health and drug and alcohol problems. The GPMHSC operates under the auspices of the Royal Australian College of General Practitioners or the Australian Psychological Society.

## f) The role of targeted programs and services that address the particular circumstances of high-risk groups

A number of targeted programs and services undertaken by the Network play an essential role in providing both direct support for high-risk groups and for the service providers and community workers who assist them. Examples of general practice network activities that have a role in suicide prevention, as first discussed in section c), are discussed below.

### Education and training for primary health care providers

*square* - Suicide, QUestions, Answers and REsources - is an integrated suicide prevention resource developed by General Practice SA and Relationships Australia (SA) in conjunction with the Federal and State Governments. It is part of the National Suicide Prevention Strategy and was jointly funded by the Australian Government and the Government of South Australia. It is both a standalone educational resource and a support package for training and systems change in suicide risk assessment, intervention and follow up. It supports a suicide and self harm primary health care model that promotes assessment and management of suicide risk and a pathway for referral through primary health care depending on the level of risk. square provides resources tailored for different settings – community, primary care and general practice, in-patient, emergency department, community mental health, forensic and mental health in-patient.

GPNs also routinely provide mental health education and training across a broad spectrum of topics. There is a need to build and maintain the mental health skills of GPs and other PHC providers so that they may provide prevention, early intervention and

[9] AGPN notes that no formal evaluation of this package is available at this time, and recommends further investigation may be warranted.

mental illness management, as well as suicide-specific training around prevention and post-vention care.

### Primary mental health programs and services

The *Access to Allied Psychological Services* (ATAPS) initiative allows engagement (through contracting or direct employment) of allied mental health professionals for provision of allied mental health services that would otherwise be unavailable or inaccessible in that community. ATAPS is a key component of the Australian Government's Better Outcomes in Mental Health Care initiative. A further advantage of this program is that it provides a free or low-cost service that can be targeted to low-income patients. ATAPS has been important initiatives for promoting access to specialised primary mental health services in rural, remote and urban communities.

The *Mental Health Support for Drought Affected Communities Initiative* is building the capacity of rural and remote drought affected communities to respond to the psychological impact of drought. The initiative provides community outreach and crisis counselling for distressed individuals and communities in drought affected rural and remote areas, raises community awareness about mental health and provides education and training to enable health workers and community leaders to recognise and respond to the early warnings of emotional stress. The initiative is led by local health workers referred to as Community Support Worker's (CSWs).

### Mental health programs and services specific to suicide prevention

A pilot extension of ATAPS called *Specialist Services for Consumers at Risk of Suicide* is allowing provision of intensive, prioritised services for people at risk of suicide delivered in 19 GPNs. It includes treatment for people discharged from hospital to GP care, people who have presented to a GP after an incident of self harm, and people who have expressed strong suicidal ideation to their GP. The GP is then able to refer the person to an experienced psychologist for immediate, intensive counselling (within 24-72 hours, for up to 2 months). The GP maintains responsibility for ongoing clinical case management, ensuring continuity of care. The person receives priority access to care, is followed up actively by the psychologist and receives care through a flexible model of face to face and telephone consultations.

The Interim Evaluation Report for this program indicates the services have been positively received, are attracting increasing numbers of referrals and are providing services to a different group of consumers to those normally seen by ATAPS services, hence complementing the general ATAPS program.

As part of the pilot, participating allied mental health professionals were required to complete a suicide prevention training course developed by the Australian Psychological Society (APS) and delivered through participating GPNs.

### headspace

*headspace* is Australia's National Youth Mental Health Foundation and is funded by the Australian Government. Under headspace, 30 youth-friendly hubs or one stop shops that have at their core a private practice comprised of medical, allied health and psychiatric practitioners have been established. The hubs deliver primary health care, mental health, alcohol and other drug, and social and vocational services for young people who may be experiencing mental health and related issues such as drug and alcohol misuse. Young people can also receive information on keeping healthy, general check-ups, sexual health information (including advice and check ups, contraception and pregnancy support), diet and exercise information and advice, and advice about any other physical concern.

The headspace model delivers more than collocated services, with provision of youth-specific education and training to headspace providers, and development of local referral pathways so that care providers are linked and the youth people presenting do not fall between the cracks. The headspace model provides young people with a comprehensive health service that provides integrated care located in the community setting. It is designed to provide prevention, early intervention and treatment for existing health problems. It is also an ideal model for building community resilience by engaging with young people – a group that often feels isolated – in their space and linking them with information, support and services.

**Stepped care**

There is growing evidence that a stepped care approach to mental health service delivery improves mental health outcomes, reduce costs and increases access to care[10]. Stepped care models are those in which there are interventions of different levels of intensity, and consumers are assigned to the level of intervention that matches their needs. Care ranges from low to high intensity interventions.

Entry to care occurs through different settings, most often occurring via general practice but also via settings such as Aboriginal medical services, schools, allied health, homelessness shelters, supported accommodation and acute services. Depending on needs, consumers can be stepped down to less intensive interventions such as tele or online supports or community connectedness programs, or stepped up to more intensive interventions such as specialist care (e.g. psychiatrist, psychologist), community mental health teams, service coordination, supported accommodation, subacute facilities or employment support. Regular monitoring of patient outcomes at all levels of intervention and clear referral pathways between the different levels of intervention are required.

Stepped care can better tailor care to meet patients' needs and minimise unnecessarily intensive or invasive treatment. Models of stepped care have been trialled in New Zealand and the United Kingdom (e.g. the 'Doncaster' model) with promising results[11,12]. For primary care and the broader health system, less intensive interventions offer a mechanism to help better manage demand for specialist psychological services and to more effectively use non-clinical staff in the management of mild cases of mental illness. They have the potential to help build the capacity of primary care to more effectively manage less severe cases of mental illness and to intervene early.

**Recommendations**

AGPN recommends:

- systematic rollout of evidence based multidisciplinary education and training on suicide prevention for primary health care professionals; e.g. use of the *square* resources

[10] Andrews G & Tolkien-Team: *TOLKIEN II: A needs-based, costed, stepped-care model for Mental Health Services*. World Health Organization Collaborating Centre for Classification in Mental Health; Sydney: 2007.

[11] Richards D & Suckling R. Improving access to psychological therapy: The Doncaster demonstration site organisational model. *Clinical Psychology Forum* 181: 9-16: 2008.

[12] Richards D & Suckling R. Improving access to psychological therapies: Phase IV prospective cohort study. *British Journal of Clinical Psychology*, in press: 2009.

- continued investment in the *Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule (MBS)* program and the *Better Outcomes in Mental Health Care* initiative

- extension of the Access to Allied Psychological Services (ATAPS) component of Better Outcomes, including:

    - incentives to promote collocation of, or sessional visits by, ATAPS workers in service settings such as homelessness shelters, supported accommodation, Aboriginal Medical Services (AMSs), schools, TAFE, university and **headspace** settings

    - extension beyond the '6+6' treatment structure for high need, 'hard to reach' groups such as Aboriginal and/or Torres Strait Islander people, youth and homeless people to enable a multidisciplinary care approach

    - broadening of referral pathways into ATAPS to include via other providers such as paediatricians, psychiatrists and medical officers in Non-Government Organisations. However, it will be important to ensure the consumer's GP is engaged through referral or consultation to avoid fragmentation of care and ensure general health needs are met

    - delivery of telephone Cognitive Behavioural Therapy (CBT) via ATAPS, which has the potential to broaden its reach, improve cost-effectiveness, and address barriers to access such as distance, transport and workforce availability. This could be enabled through revised ATAPS guidelines and funding formulae that provide for flexible delivery of 'hybrid' services; e.g. a combination of face-to-face focused psychological strategies with back up and reinforcement via groups or telephone counselling

- national rollout of the ATAPS extension program, *Specialist Services for Consumers at Risk of Suicide*

- extension of the **headspace** model to additional Australia communities, consistent the recommendations of the National Health and Hospital Reform Commission's final report[13] which recommended

    *a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians*

- introducing stepped models of mental health care, including the 'Doncaster' model, in the Australian primary care context.

## h) The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress

AGPN supports the National Suicide Prevention Strategy. Suicide prevention is a national responsibility, and it is important to have a national strategy in place to guide the efforts of individuals, groups, agencies and communities. AGPN also supports the broad domains of the LIFE Framework and offers these comments:

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[13] National Health and Hospital Reform Commission. *A healthier future for all Australians. Final Report of the National Health and Hospital Reform Commission.* NHHRC; Canberra: 2009.

- Universal interventions domain: Initiatives at this level must include messages about and integrate with primary care to ensure the target audience can/knows how to reach care. Mindmatters - a national mental health initiative for secondary schools – is an example of one program that has lacked integration with general practice and primary mental health care services. GPNs, with local footprint and experience at community engagement and resilience building, are well placed to deliver universal programs in partnership with other relevant agencies.

- Selected interventions domain: At-risk groups and communities can be better targeted through outreach service models that take care to the groups that need it most; e.g. homeless, CALD, Indigenous peoples, etc.

- Indicated interventions domain: Primary health care can offer significant value at this level, where interventions and care can be tailored to the needs of the individual. PHC providers require supports, including education and training to deliver individualised care as well as referral options to specialised mental health providers, to assist their work at this level.

## Conclusion

General practice-led primary health care has an essential role to play in suicide prevention – primarily at the indicated intervention level. Initiatives to increase capacity at the service provider level must address both the broad mental health agenda as well as suicide prevention-specific needs. Priorities at the service provider level include evidence based education/training and referral to specific services.

Primary health care is an essential space for the provision of suicide prevention care. Primary health care providers have frequent contact with the majority of the population and are therefore the key workforce for the early identification of people at risk of suicide and the provision of early intervention care. Primary health care providers are also ideally placed to provide post-vention care for people who attempt suicide and for their families, assisting in achieving and maintaining recovery in the community.

The Network combines a national framework with local presence. General practice networks are active in mental health care and suicide prevention, and are experienced in community engagement and capacity building. An outcome of GPN programs is increasing availability of primary health care services and support in the community, and improving overall access to care. The Network is an ideal vehicle for delivery, in partnership with other agencies, of community-level primary health care programs and initiatives. A number of programs already available, such as *ATAPS*, *Specialist Services for Consumers at Risk of Suicide*, and *headspace* should be expanded to increase their effectiveness and reach for people at risk of suicide or self harm.