



Suicide prevention

A resource for GPs

Suicide prevention and first aid: A resource for GPs

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Aboriginal and Torres Strait Islander readers are advised this resource may contain references to distressing topics. Some linked resources may include images, names or voices of people who have passed.

Introduction

General practice plays a central role in suicide prevention.¹ GPs are often the first, most frequent and most trusted point of contact for people experiencing psychological distress,² mental health difficulties, and periods of increased suicide risk. Many people who die by suicide have had contact with primary care in the months or weeks before their death,³ highlighting the opportunity for timely and compassionate intervention.

Australia's [National Suicide Prevention Strategy 2025–2035](#) (the Strategy) not only highlights the importance of this role, but also:

- positions suicide prevention as a whole-of-government and whole-of-community responsibility
- encourages a shift towards preventing suicidal distress before it arises – evidence indicates that early identification of distress, along with compassionate and relationship-based interventions are critical components of effective suicide prevention⁴
- emphasises the need for trauma-informed care and lived-experience leadership
- emphasises the need for coordinated responses across health, social, economic and community service systems.

Sitting alongside the [National Aboriginal and Torres Strait Islander Suicide Prevention Strategy](#), the Strategy stresses that, for Aboriginal and Torres Strait Islander consumers, the suicide prevention role of GPs must be grounded in Social and Emotional Wellbeing (SEWB). SEWB is a holistic understanding of health that includes connection to body, mind and emotions, as well as family, kinship, community, culture, Country, spirit and Ancestors.

The Strategy calls for the embedding of the principles of the Gayaa Dhuwi (Proud Spirit) Declaration into all aspects of mental health services, including:

- genuine collaboration with Aboriginal and Torres Strait Islander leaders and communities, including in the development of mental health policy and the co-design of suicide prevention systems
- provision of care that is culturally safe, responsive and self-determined
- provision of care that acknowledges the impacts of colonisation, racism and intergenerational trauma on the wellbeing of First Nations peoples.

Multiple risk factors

While mental disorders are an important risk factor for suicide, they cannot be considered in isolation: Suicide risk is dynamic and shaped by the interaction of multiple factors that include poor mental health, physical illness, psychosocial stressors, trauma, substance use, limited social connection and limited access to care.⁵

For Aboriginal and Torres Strait Islander peoples, these risk factors are further influenced by historical and ongoing impacts of colonisation, systemic racism and intergenerational trauma. It is important to also consider strengths-based protective factors such as cultural identity, community connection and cultural practices.

Therefore, this resource promotes a person-centred and trauma-informed approach, recognising that risk can change over time and that protective relationships and continuity of care are powerful interventions.

Purpose of this guide

This guide is intended as a practical support tool, and is not a replacement for clinical judgement, formal training or comprehensive guidelines. It does not constitute a standalone practice guide, therefore you are encouraged to continue engaging in ongoing professional development (including [GPMHSC-accredited mental health education](#)) and to draw on local pathways, specialist advice and community resources as needed.

The GPMHSC has also developed a companion resource, [After suicide: A resource for GPs](#), available via the GPMHSC website. This resource:

- supports GPs who are responding to suicide in their communities
- includes the care of bereaved consumers, colleagues and practice teams
- is particularly relevant for GPs working in rural and remote settings.

Suicide in Australia

Australian Bureau of Statistics data⁶ indicates that in 2024:

- 3,307 lives were lost by suicide
- suicide was the 16th leading cause of death overall in Australia in that year
- between 54,000 – 65,000 suicide attempts were made.

Suicide prevention is a key government and community initiative and GPs have an important role in working to identify people at risk of suicide and ensuring they get the right help at the right time.

Early detection of suicide risk

Early detection and response to suicide risk are central to effective, person-centred care in general practice.⁷ As GPs have ongoing, trusted relationships with a large proportion of the population, they are uniquely positioned to notice changes in a consumer's mental health, functioning and circumstances.

Many people who experience suicidal distress present first – and sometimes only – to primary care,⁸ often for reasons that are not explicitly related to their mental health (eg somatic symptoms, sleep disturbance, substance use, frequent attendance or changes in engagement or affect). GPs therefore have a critical role in recognising distress and gently exploring suicidal thoughts, including when presentations are indirect. A 'tough love' approach is not recommended, as this opposes the person-centred and trauma informed approach encouraged by suicide prevention guidelines.

Unfortunately, suicide risk is dynamic and cannot be predicted, so early identification relies on awareness of risk and protective factors, combined with compassionate enquiry and a willingness to revisit conversations when a consumer's circumstances change, especially during periods of stress, illness, loss or transition.

Ongoing training and education is essential

Maintaining your skills and confidence in suicide prevention is essential, as ongoing education supports effective, stigma-free, evidence-informed responses and the use of local pathways, specialist advice and community resources.

Risk factors, protective factors and social determinants of suicide

The following sections outline key risk factors and warning signs to remain alert for, so that you can exercise clinical judgement, guide conversations and

initiate timely follow-up. Please note that they are not to be used as predictive tools.

By focusing on risk factors, responding early to warning signs, and supporting connection, GPs can contribute to reducing suicidal distress and improving safety over time.

Population as a factor

Suicide does not discriminate, which means that what matters more than population or demographics is risk factors that contribute to suicidal distress. While it's important to be aware that some populations are more at risk than others, labelling or ranking populations only serves to incorrectly minimise the risk of others who do not fall into those categories.

Preventing suicide therefore requires GPs to be aware of risk factors, and to treat each person individually and without judgement.

Warning signs of suicidal distress

Suicidal distress often arises when a person comes to believe there is no other way to relieve overwhelming pain or to resolve an intolerable sense of distress.⁹

People considering suicide may communicate their distress in various ways, including:

- changes in behaviour
- expressions of hopelessness
- withdrawal
- indirect references to death.

These warning signs often occur together, though it is important to recognise that some people may show few or no outward signs.

Personal risk factors

Personal risk factors can increase a person's vulnerability, particularly when interacting over time. These include:

- cumulative stress
- types of loss, including death, employment, relationship etc
- isolation
- shame
- self-doubt
- lack of support
- barriers to accessing care.¹⁰

Protective factors

Preventing suicide is therefore not solely about averting an individual attempt, but about addressing the conditions that allow distress to escalate. This includes:

- reducing emotional pain and shame
- strengthening connection and belonging
- creating environments where people feel safe to seek help.

The following tables outline the risk factors that can contribute to suicide, and the protective factors that can contribute to prevention, as well as the clinical relevance and considerations of each one.

Table 1. Common suicide risk factors

Risk factor	Clinical relevance and considerations
Previous suicide attempt(s)	One of the strongest predictors of future suicide risk. Warrants careful exploration, particularly during periods of transition, stress or reduced support.
Substance abuse	Alcohol and other drugs can worsen mood, increase impulsivity, and lower inhibition, particularly during intoxication, withdrawal or escalation of use.
Low/limited social support	Fewer protective connections can reduce buffering against stress and decrease opportunities for help-seeking or early intervention.
Feelings of hopelessness or despair	This is a strong indicator of suicide risk, reflecting a perceived lack of future options or relief from distress.
Having lost a family member to suicide	This increases risk through grief, trauma, identification and social transmission, particularly in the absence of culturally or socially appropriate postvention support.
Feelings of shame and self-doubt	These undermine self-worth and belonging, increase self-criticism and perceived burdensomeness, and can inhibit help-seeking, leaving people feeling trapped and isolated during periods of distress.
Mental disorders	Depression, anxiety, trauma-related distress, psychosis and neurodevelopmental conditions can increase risk, especially when symptoms are acute or co-occurring.
Cultural shame and stigma	Fear of judgement, exclusion or community consequences can delay disclosure and reduce engagement with care.
Isolation and loneliness	Social disconnection can intensify distress and amplify feelings of burdensomeness or invisibility.
Financial instability	Debt, financial stress, or sudden loss of income can contribute to feelings of entrapment, shame, or loss of control.
Family instability	Ongoing conflict, relationship breakdown, or unsafe home environments can increase distress and the consumer's perception that they have little or no support.
Unemployment and cost-of-living pressures	Loss of work or financial pressure can affect identity, purpose, and self-worth, particularly when compounded by other stressors.
Housing instability or homelessness	This can lead to chronic stress, marginalisation, reduced access to care, and increased exposure to trauma.
Illness and disability	Chronic illness, pain, or disability can increase vulnerability through distress, functional loss, or perceived burden on others.
Impulsivity	Higher impulsivity can increase the likelihood of acting on suicidal thoughts, particularly in acute crises or when substances are involved.

Table 2. Effective suicide protective factors

Protective factor	Clinical relevance and considerations
Adaptive coping skills	Skills such as emotional regulation, distress tolerance, and helpseeking can reduce the likelihood of suicidal thoughts escalating during periods of stress.
Effective problemsolving skills	The ability to identify options and take manageable steps can reduce feelings of entrapment and increase perceived control.
Selfunderstanding	Insight into personal triggers, warning signs, and needs can lead to earlier intervention and selfadvocacy.
Sense of competence or selfefficacy	Feeling capable or useful, through work, caregiving, creativity, or daily tasks, can strengthen hope and purpose.
Spirituality or personal belief systems	Spiritual, cultural, or philosophical beliefs can provide meaning, connection, and comfort during distress (where relevant to the individual).
Connection to family	Supportive family relationships can provide emotional safety, practical assistance, and a sense of belonging.
Sense of responsibility to others	Caring roles or commitments (eg to children, parents, pets, community) can strengthen reasons for living.
Involvement in social or community activities	Participation in groups, clubs, or cultural activities can foster connection and reduce loneliness.
Access to supports within financial means	Affordable, accessible services can increase the likelihood of ongoing engagement with care.
Cultural identity and connection	A strong sense of identity, culture, language, belonging, kinship, Elders, ceremony and community governance can be deeply protective, particularly for marginalised groups.
Affirming relationships and environments	Acceptance, affirmation, and access to inclusive healthcare and community spaces are strongly protective, particularly for those in marginalised communities.
Supportive work environment	Workplaces that are flexible, respectful and responsive to wellbeing needs can be important protective settings.
Positive relationships with colleagues	Feeling valued and connected at work can reduce isolation and provide informal support.
Access to professional development	Opportunities for learning and growth can support identity, purpose, and future employment possibilities.
Access to employee assistance or wellbeing programs	Timely, confidential support can lower barriers to care during periods of increased stress.

Mental disorders associated with suicide risk in primary care

Many people with mental disorders may experience periods of elevated risk at specific times, but there are also many who will never experience suicidal thoughts.

In general practice, early recognition, compassionate enquiry and ongoing follow-up are key protective factors.

Suicidal ideation

Suicidal ideation may fluctuate and may not be volunteered unless the consumer is asked about it directly in a supportive manner.

Below are some of the mental disorders you will commonly come across that may lead to suicidal ideation. This is not a conclusive list.

Depression

Depression is one of the mental disorders most strongly associated with suicide, particularly when symptoms are severe, persistent, accompanied by hopelessness, or complicated by substance use, chronic pain, social isolation or major life stressors.¹¹

In primary care, depression frequently presents indirectly.¹² Many consumers do not initially describe low mood, but instead mention their somatic, sleep or energy-related complaints. This is especially common in older adults, people from culturally and linguistically diverse backgrounds, and those with co-existing physical illness.

When physical symptoms persist without a clear explanation, or when functional decline is evident, you need to be alert for depression and suicide risk.

Common presentations and warning signs

Consumers experiencing depression may describe:¹³

- withdrawal from usual activities, work or relationships
- changes in sleep (insomnia, early waking or hypersomnia)
- persistent fatigue, low energy or feeling 'run down'
- somatic symptoms such as headache, gastrointestinal upset or musculoskeletal pain
- reduced appetite or increased appetite with weight change

- difficulty concentrating, slowed thinking or indecisiveness
- increased reliance on alcohol or other substances
- feelings of guilt, worthlessness, shame or of being a burden
- irritability, agitation or emotional numbness
- thoughts of failure, hopelessness or feeling 'stuck'.

Anxiety disorders

Anxiety disorders are the most prevalent mental health conditions in Australia¹⁴ and are an independent risk factor for suicidal ideation and behaviour, particularly when symptoms are severe, chronic, or co-occur with depression, substance use or trauma exposure.¹⁵ Suicide risk may also increase during periods of panic, perceived loss of control, or prolonged distress accompanied by exhaustion and hopelessness.

In general practice, anxiety frequently presents as physical symptoms, repeated reassurance-seeking, or difficulty managing chronic illness.

Common presentations and warning signs

Consumers experiencing anxiety may describe:¹⁶

- persistent or escalating worry that feels difficult to control
- racing heart, palpitations or chest tightness
- shortness of breath or feeling unable to get enough air
- dizziness, light-headedness or nausea
- hot or cold flushes, sweating or trembling
- muscle tension or headaches
- sleep disturbance due to rumination or fear
- difficulty concentrating or feeling 'on edge'
- irritability or heightened sensitivity to stress.

GPs should be alert to suicide risk when anxiety is associated with entrapment, avoidance, functional impairment or comorbid depression.

Bipolar disorder

Bipolar disorder carries a substantially elevated lifetime risk of suicide, particularly during depressive episodes, mixed states, and periods of rapid mood change.¹⁷ Suicide risk is highest when individuals experience depression combined with agitation, impulsivity or hopelessness.

In primary care, bipolar disorder is commonly misdiagnosed as unipolar depression,¹⁸ as many people seek help during depressive phases and may not recognise or report hypomanic or manic symptoms unless specifically asked.

Careful longitudinal history-taking is essential, particularly before initiating antidepressant treatment.

Common presentations and warning signs

People with bipolar disorder may experience:¹⁹

- recurrent depressive episodes with poor response to antidepressants
- periods of elevated or irritable mood
- increased energy, reduced need for sleep
- racing thoughts or pressured speech
- increased goal-directed activity or risk-taking behaviour
- impulsivity, agitation or emotional reactivity
- changes in judgement or insight.
- difficulty controlling use or unsuccessful attempts to cut down
- withdrawal symptoms (eg tremor, sweating, anxiety, irritability)
- neglect of responsibilities at work, school or home
- relationship conflict or social withdrawal related to substance use
- risktaking behaviours or impaired judgement when intoxicated
- sleep disturbance, fatigue or ongoing low mood
- physical health problems (eg liver disease, injuries, infections)
- use of substances to cope with distress, trauma or insomnia
- feelings of guilt, shame or loss of control related to use.

Antidepressant treatment without appropriate mood stabilisation can worsen their agitation, mixed symptoms or mood instability, potentially increasing the suicide risk. Any history that suggests bipolar disorder warrants specialist input and careful medication planning.

Use of alcohol and other drugs

Alcohol and other substance use disorders are strongly associated with suicide risk, particularly where use is heavy, chronic, or occurs alongside mental illness, social adversity, or trauma. Substance use can increase impulsivity, worsen mood symptoms and reduce inhibition, making consumers more likely to act on suicidal thoughts.

In primary care, alcohol and other drug use is often under-reported or minimised. Consumers may present with physical symptoms, mental health concerns or social difficulties rather than directly identifying substance use as a problem. This may be particularly evident in older adults, individuals experiencing stigma, and those with co-existing psychiatric or medical conditions.

Common presentations and warning signs

Consumers impacted by alcohol and other drugs may describe:

- increased frequency or quantity of alcohol or drug use

Chronic pain

Chronic pain is a significant and often under-recognised contributor to suicide risk, particularly when pain is persistent, poorly controlled, or associated with functional impairment, disability or loss of role. The interaction between chronic pain, depression, sleep disturbance and social isolation can further increase vulnerability.

In primary care, chronic pain commonly presents as a complex and multifactorial condition. Consumers may focus on physical symptoms, while associated psychological distress or hopelessness may not be immediately disclosed. This is particularly common in consumers with longstanding conditions, injury-related pain or multiple comorbidities.

Common presentations and warning signs

Consumers experiencing chronic pain may describe:

- persistent or recurrent pain lasting longer than expected healing time
- reduced ability to perform usual activities or maintain employment
- sleep disturbance due to pain or discomfort
- fatigue, low energy or reduced physical functioning
- reliance on medications, including opioids or sedatives
- frustration with limited treatment response or diagnostic uncertainty
- withdrawal from social, recreational or meaningful activities

- low mood, irritability or emotional distress related to pain
- feelings of hopelessness, helplessness or loss of purpose
- passive thoughts that life is not worth living due to ongoing suffering.

Sleep disorders (eg insomnia)

Sleep disorders, particularly insomnia, are independently associated with increased suicide risk. Persistent sleep disturbance can impair emotional regulation, worsen mood disorders, and contribute to cognitive difficulties, fatigue and reduced coping capacity. The risk is heightened when insomnia coexists with depression, anxiety, substance use or chronic health conditions.

In primary care, sleep problems are very common and frequently present as standalone complaints. Consumers may prioritise sleep difficulties over underlying psychological distress, and clinicians may focus initially on behavioural or pharmacological management without recognising broader risk factors.

Common presentations and warning signs

Consumers experiencing sleep disorders may describe:

- difficulty falling asleep, staying asleep, or early morning waking
- non-restorative or poor-quality sleep despite adequate opportunity
- daytime fatigue, low energy or reduced concentration
- irritability, mood changes or increased emotional reactivity
- reliance on alcohol, sedatives or other substances to initiate sleep
- worry or rumination at night, including racing thoughts
- disrupted daily routines or irregular sleep–wake cycles
- reduced productivity, motivation or engagement in daily activities
- exacerbation of anxiety, depression or pain symptoms
- increased feelings of distress, being overwhelmed or difficulty coping.

Suicide and specific populations

Although suicide does not discriminate (anyone from any population or demographic can be affected by suicide), some populations are at higher risk – not because the consumer identifies as belonging to that particular population, but rather because of the struggles these people can experience. For example, despite strong community resilience of First Nations people, as well as their cultural continuity and longstanding traditions of healing, the impacts of colonisation and systemic inequity can lead to struggles that continue to create barriers to wellbeing. These struggles include intergenerational trauma, discrimination, societal views, and lack of access to education and healthcare.

Intersectionality

Intersectionality recognises that people's experiences of distress and suicide risk are shaped by the overlap of multiple identities and social conditions, not by any single factor alone.

For example, someone who is LGBTQIA+, living with HIV and residing in a rural area may face compounded stigma, confidentiality concerns, limited access to culturally safe and specialised services, and social isolation, all of which can intensify vulnerability.

Similarly, an intersex person who is also a refugee may experience the combined impacts of trauma, displacement, barriers to healthcare, language and legal challenges, and discrimination related to their sex characteristics.

Suicide prevention responses must therefore consider how these intersecting factors interact in a person's life and ensure care is inclusive, trauma-informed, culturally safe, and tailored to each individual's lived experience.

A GP's role is to listen openly and nonjudgmentally, validate the person's lived experience and create a safe space where complexity is acknowledged rather than minimised.

Aboriginal and Torres Strait Islander peoples

Statistics

- Aboriginal and Torres Strait Islander peoples continue to demonstrate strong cultural resilience and community leadership in suicide prevention. Despite this, ongoing structural inequities contributed to the 2023 suicide rate for Aboriginal and Torres Strait Islander people across six of the seven states and territories being the highest since recording began in 2018 (30.8 per 100,000 deaths).²⁰
- In 2023, suicide accounted for 5.2% of all deaths among First Nations people, with men experiencing suicide at 3.5 times the rate of First Nations women (48.5 compared to 13.8 per 100,000 deaths).²¹

Why

- The impacts of colonisation (including dispossession, forced child removals and systemic discrimination) continue to affect Social and Emotional Wellbeing.²² These impacts occur alongside enduring cultural strengths, such as community connectedness, identity, kinship and spirituality.
- Many Aboriginal and Torres Strait Islander peoples are also survivors, or descendants of the Stolen Generations. The impacts of historical, intergenerational and ongoing trauma including influence trust in services, disclosure, and helpseeking.
- Structural inequities in housing, employment and access to culturally safe care can create barriers to wellbeing, despite strong community and cultural strengths.²³
- Ongoing structural inequities in justice and child protection systems increase First Nations peoples' exposure to traumatic events such as incarceration and child removal, both of which are linked to increased suicide risk.²⁴
- While Aboriginal Community Controlled Health Organisations (ACCHOs) provide strong, culturally grounded care, gaps remain where Social and Emotional Wellbeing (SEWB) frameworks are not adequately supported or funded.

What GPs need to know

Suicide risk amongst First Nations people is shaped by systemic, social and historical factors. Cultural strengths, such as connection to Country, kinship, identity, community governance and spirituality, are powerful protective factors and central to care.

- SEWB encompasses mind, body, community, culture, and connection to Country, which need to be key considerations when conducting a clinical assessment
- GPs need to conduct conversations with First Nations peoples with cultural humility, acknowledging the person's strengths, community supports and resilience.
- Some First Nations people and young people may be late to engage with health services because of past experiences of racism, exclusion or system harm, reinforcing the importance of culturally safe, trust-building care.²⁵

How to provide trauma-informed care for this group

- Use SEWB frameworks when assessing risk, and explore the consumer's connections to culture, family, land, language, and spirituality.
- Engage with local community organisations and people:
 - Partner with ACCHOs and refer to community-led supports
 - Engage with Indigenous mental health workers, Elders, and liaison officers, where appropriate²⁶
- Adopt culturally appropriate practices and language:
 - Provide longer appointments and continuity of care, allowing for culturally appropriate pacing
 - Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors that impact individual and community health, while recognising the resilience, leadership and cultural continuity of Aboriginal and Torres Strait Islander peoples
 - Use strengths-based language and validate the consumer's cultural context and lived experiences. For example, instead of saying, 'You're not following your care plan properly', try something like: 'You've shown a lot of resilience managing your health while balancing cultural and family

responsibilities. Many people in your community stay strong through cultural practices, time on Country, and support from Elders. If you'd like, we can build your care plan around the strengths you already have'

- When assessing risk:
 - use SEWB frameworks
 - explore and validate the consumer's connections to culture, family, land, language, spirituality
 - avoid assumptions, ask about cultural identity and experiences of racism, discrimination, or trauma.

LGBTQIA+ community

Statistics

- Self-harm among LGBTQIA+ Australians occurs at almost six times the rate of non-LGBTQIA+ people (41.2% compared to 7.4%).²⁷
- 74.5% of LGBTQIA+ people experience a mental disorder in their lifetime compared to 41.7% of non-LGBTQIA+ people²⁷.
- LGBTQIA+ people experience disproportionately high rates of suicide attempts²⁸ and suicidal thoughts (nearly 48% of LGBTQIA+ Australians have seriously thought about taking their own life at some point²⁷).
- 85% of non-binary people, and 70% of transgender people have experienced a mental disorder at some point in their life.²⁹

Why

- Stigma, discrimination, bullying, violence, exclusion, and minority stress are key drivers,²⁷ along with issues such as family rejection, homelessness, and relationship strain experienced by this population, especially trans and gender-diverse youth,³⁰ all of which contribute to higher rates of psychological distress and mental illness.
- LGBTQIA+ people face a range of barriers to safe and inclusive healthcare, including past negative experiences.²⁹
- Lack of protective social environments and a sense of belonging to the community in some regions.³¹

What GPs need to know

- Sexuality and gender are expressions of human diversity and strength, therefore assessment should

focus on experiences of harm, stress and social determinants, as well as stressors that are unique to this population, such as gender affirmation barriers and unsafe housing.

- LGBTQIA+ people often show strong resilience despite past experiences of discrimination, GPs can build on this by prioritising trust, safety and respect.
- This population carries significant strengths and community connections, while also facing higher rates of psychological distress due to social determinants and minority stress.
- Trans and gender-diverse people may benefit from supported access to gender-affirming pathways that uphold autonomy, safety and self-determination.³²

How to provide trauma-informed care for this group

- Demonstrate acceptance:
 - Use inclusive language, and ask for their preferred pronouns
 - Ensure clinical spaces visibly affirm LGBTQIA+ identities
 - Validate their experiences of discrimination and minority stress
- Provide informed and compassionate care:
 - Ensure confidentiality, especially for young people who may not have disclosed their sexual orientation to their family
 - Provide affirming referral pathways (gender clinics, LGBTQIA+ mental health services, QLife)
 - Screen regularly for mental health concerns, self-harm and suicidal ideation
 - Incorporate strengths-based narratives (eg drawing on their community connections and resilience), build community connectedness and adopt protective factors listed in Table 2

Men

Statistics

- In 2024, 2,529 men died by suicide, accounting for 75–76% of all suicide deaths in Australia.³³
- On average, 7 men die by suicide every day.³³
- The population of working-age men is experiencing a rising suicide trend.³³

Why

- Social norms around masculinity discourage expression of emotions and vulnerability, which leads to a reluctance to seek help³⁴ and a tendency to present later in crisis.
- Men may use more lethal means to attempt a suicide.

What GPs need to know

- Men may downplay symptoms, so you need to be proactive in screening for distress and remember that presentations may be somatic (eg sleep issues, pain).
- There are numerous adverse circumstances linked to suicide in men, including legal issues, substance misuse, economic hardship, relationship breakdown, job loss, financial pressure and isolation.
- A single recent stressor (eg separation, job loss) can greatly elevate risk – especially if coupled with social isolation and/or difficulties regulating emotional pain.³⁵
- Men aged 40–59 are the highest-risk age group in Australia, with suicide rates peaking at 30.9 per 100,000 deaths in men aged 55–59.³⁶ This reflects in part the clustering of major life stressors around this life stage (such as family breakdown, job loss and financial hardship).
- Men's depression can manifest as a mix of internalising (eg persistent sadness, loss of interest or pleasure in previously enjoyable activities) and externalising (eg anger, substance misuse, risk-taking) symptoms. Mood disorders are the leading risk factor for suicide in men.³⁷ It is therefore important to screen for depression in men using tools that capture both externalising symptoms (eg the Male Depression Risk Scale³⁸) and internalising symptoms (eg the Consumer Health Questionnaire).

How to provide trauma informed care for this group

- Create a supportive environment:
 - Create a safe, non-judgmental environment where expressing distress is acceptable
 - Normalise help-seeking, validate emotional experiences, and avoid reinforcing stoicism
 - Explore recent adverse events (eg legal, financial, relationship) that strongly correlate with suicide in men

- When offering advice and support:
 - remember that some men can prefer practical, action-oriented conversations
 - offer structured follow-up, safety planning, and practical support (eg referral to financial counselling, men's support programs)
 - provide information on male-specific services (eg MensLine, men's wellbeing groups).

Talking about suicide

If you are concerned about a consumer and have noticed some signals of risk, ask questions to identify and act on risk factors.

Beginning a conversation about suicide

If you are hesitant about raising suicide or mental health concerns (due to fears of increasing the risk of suicide by talking about it, or of intruding, causing distress, or increasing stigma), evidence shows that:

- asking directly and respectfully about suicide does not increase risk. In fact, initiating a calm, non-judgmental, and empathetic conversation creates a safe space for consumers to share their experiences, describe current stressors, and talk openly about suicidal thoughts³⁹
- the therapeutic relationship between the GP and consumer is a significant protective factor in reducing suicidal ideation and self-harm. A GP's ability to convey empathy, genuine concern, and openness to discussing emotional wellbeing can strongly influence a consumer's readiness to disclose distress.

Conversations can be introduced with clear, reassuring statements that normalise help-seeking, such as:

'Part of my role is to check in on how you're really going. I'm concerned that things might be feeling harder for you at the moment. Would it be okay if we talked about that?'

Assessing suicide risk

A comprehensive assessment explores multiple, interconnected risk factors, including:

- the presence and nature of suicidal thoughts
- the frequency, intensity and intrusiveness of suicidal thoughts
- any history of suicidal behaviour or self-harm
- current plans, intent and access to means
- the person's overall mental state.

Understanding protective factors and supports early (such as support persons, relationships, reasons for living, coping strategies, and access to formal and informal supports), is equally important and provides a more balanced picture of risk and resilience.

Exploring a consumer's thoughts of suicide

When asking about a consumer's suicidal thoughts, your primary role is to create a safe, calm space where your consumer feels heard and respected. It is less about saying the right thing and more about how you listen and respond.

The questions listed below will help you to understand your consumer's risk of suicide:

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

When talking to a consumer about stressors and suicidal ideation, the following techniques will help reinforce the therapeutic relationship.

- Use active listening. Remember that presence, posture, tone and silence are just as important as words. To indicate that you are listening and understanding:
 - maintain eye contact
 - repeat back (or paraphrase) what they have said, without judgement

- use non-verbal indications (eg nodding, maintaining an open posture) to confirm that you are listening
- let them finish sentences and ideas.

- Validate their distress without trying to minimise the distress or change the consumer, and acknowledge systemic trauma, stigma and past experiences where relevant.
- Maintain the consumer's agency and remain collaborative throughout the conversation by inviting the consumer to guide the conversation, asking questions and exploring options together.
- Talk about mental health issues, mental illness and mental disorders as being separate to the person, instead of something that defines them.
- Avoid premature reassurance or a premature focus on recovery, as this can leave the consumer feeling unheard, dismissed, rushed and invalidated
- Tell them that you will provide ongoing support and share with them the next steps.
- Recognise that relapse or recurrence of suicidal thoughts can be part of a consumer's normal experience, and explain this to your consumer.
- Acknowledge their courage in disclosing suicidal thoughts.

Validating their distress (instead of 'normalising' their feelings)

Attempting to normalise a person's lived experience of distress (eg by saying 'this happens to everyone'), can unintentionally minimise or universalise their distress, whereas validation acknowledges their experience as real, understandable, and worthy of care, without comparison or reassurance.

To put this into practice:

Replace this:	With this:
'Anyone in your situation would feel this way.'	'Given what you've been dealing with, it makes sense that this feels overwhelming.'
'A lot of people feel like this sometimes.'	'I can hear how intense and exhausting this has been for you.'
'I'm sure you'll feel better soon.'	'What you're describing sounds really painful, and I'm glad you told me.'
'It's not that bad, things could be worse.'	'I'm not here to judge or fix this straight away, I want to understand what this has been like for you.'

Responding to suicidal thoughts

When a consumer shares suicidal thoughts, respond with calm, attentive listening and clear validation, and remember to:

- acknowledge the courage it takes to speak openly
- avoid minimising their distress
- avoid rushing to solutions
- use supportive statements that reinforce presence and collaboration.

The focus should be on understanding the person's experience and identifying next steps together, while maintaining their sense of agency. For example, you could say:

- 'Thank you for trusting me with something this difficult.'
- 'I want to be clear – I'm really glad you told me, and I'm here with you.'
- 'These thoughts sound like they've been a way of coping with a lot of pain.'
- 'You're still the expert in your own life. My role is to support you and help look at options together.'
- 'We don't have to solve everything today. Let's focus on what would feel most helpful right now.'

Using 'people-centred' language

When talking to consumers about mental health issues, the language that you use can have a significant impact on how the person thinks and feels about themselves. Therefore, always talk to and about a consumer (if you have consent to liaise with other professionals and their family members) as an individual human being first and foremost, rather than defining them by their condition, illness or issue.

To put this into practice:

Replace this:	With this:
'You are suicidal.'	'You've been having thoughts about suicide.'
'You're relapsing a lot.'	'I can hear that you've been living with ongoing emotional distress.'
'You're not complying with the treatment.'	'You've had periods where things have felt this hard before.'
'Your depression seems quite bad today.'	'It sounds like parts of our plan haven't worked for you. Is that right?'

Supporting hope and ongoing wellbeing

The large majority of people who experience mental health distress will develop ways to live meaningful and valued lives, even when symptoms recur or persist. Contemporary practice has moved away from focusing mental health care on 'recovery' as an end point, to fostering hope by recognising mental health as dynamic and fluctuating, while supporting each person to define what wellbeing, safety and quality of life mean for them.

Mental health professionals have an important role in sustaining hope by adopting a person-centred, strengths-based approach and recognising that supportive environments (such as health services, social systems, and relationships) shape outcomes over time. Rather than focusing solely on symptom resolution, you can support ongoing wellbeing by:

- recognising and affirming the person's strengths, values, interests and capacities
- working in genuine partnership, with respect for the person's autonomy and lived experience
- supporting each individual to identify their own goals, priorities and indicators of progress
- conveying a consistent belief in the person's capacity to adapt, cope and find meaning over time.

In this context, improvement does not necessarily mean the absence of distress or a return to previous levels of functioning. Many people reach a point where they can integrate their experiences of mental health into a broader sense of self, without being defined by them. Hope is supported through a focus on connection, purpose, agency and dignity, alongside practical strategies that enhance safety, stability and participation in life.

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

Consider using comments such as those listed below to help them understand the nature of their condition and how you can support them.

- 'What you're experiencing feels overwhelming right now, and we can take this one step at a time together.'
- 'This won't always feel exactly as it does today, even if it's hard to imagine that right now.'

- 'You've found ways to cope with very difficult situations before, even if it doesn't feel clear what might help this time.'
- 'You've shown strength and persistence in getting through other challenges, and we can build on that together.'
- 'It's not uncommon for people to experience thoughts like these when things feel unbearable, and support can help ease the weight over time.'
- 'You're not alone in this – I'm here with you, and we can look at options together.'
- 'This distress is part of what's happening for you right now, but it doesn't define who you are.'
- 'There's more to you than the pain you're carrying – your values, relationships and strengths still matter.'

Suicide risk assessment

Why undertake a suicide risk assessment?

Current evidence consistently shows that suicide cannot in fact be reliably predicted using risk factors, scales or categorical risk labels (eg 'low/medium/high risk').⁴⁰ Therefore, suicide risk assessment is no longer just about trying to predict suicide. A collaborative, therapeutic process supports clinical understanding, safety planning and care decisions.

For these reasons, a consumer experiencing suicidal distress needs an effective care plan informed by a comprehensive, person-centred assessment that explores their suicidal thoughts and behaviours openly, directly and compassionately.

It's therefore important to understand that asking about suicide does not increase suicidal ideation or risk, but is, in fact, associated with improved disclosure and engagement in care.⁴¹

What is a suicide risk assessment in general practice?

A suicide risk assessment is a structured but flexible clinical conversation that collects key information about:

- the consumer's current mental state and level of distress
- the presence, frequency and intensity of suicidal thoughts

- any plans, intent, access to means, or preparatory behaviours on their part
- current and historical risk factors, including previous self-harm or suicide attempts
- precipitating stressors, including health, relationship, financial, legal or occupational pressures
- protective factors, such as reasons for living, relationships, cultural or spiritual supports
- available supports and the consumer's willingness to engage with them.

Risk is understood as dynamic and context-dependent – something that changes with a consumer's circumstances, supports and stressors. This is why best practice emphasises understanding the individual person, right at that time, rather than assigning a static level of risk.

When should GPs complete a suicide risk assessment?

You should consider completing a suicide risk assessment whenever there are concerns about elevated risk, including when a consumer:

- expresses hopelessness, feeling like a burden or feeling trapped
- presents with depression, anxiety, substance use or significant psychological distress
- experiences major life stressors (eg relationship breakdown, bereavement, chronic illness, legal or financial stress)
- has a history of self-harm or suicide attempts
- shows marked changes in mood, behaviour or engagement with care.

Some consumers will disclose suicidal thoughts spontaneously, while others may require gentle or explicit enquiry. A helpful, evidence-based opening question could be something like, 'With everything that's been going on, have you had thoughts that life isn't worth living, or thought about harming yourself?'

Using risk-assessment tools

Validated tools can support, but must not replace, clinical judgment and therapeutic engagement. These tools are most useful for:

- guiding consistent enquiry
- supporting the documentation of the risk assessment
- facilitating communication across the care team.

In Australia, you can use structured tools to help you organise assessment information and identify areas requiring further exploration. However, no tool can accurately predict suicide, and you should never use scores by themselves to determine risk or make care decisions.

Current best practice recommends that assessment findings can be used to develop a shared understanding of risk and safety, but need to be followed with active consumer management, including safety planning and followup.

When using tools, build in cultural safety (eg explain the purpose of the tool, offer an opt-out, consider using an interpreter or liaison, and avoid pathologising cultural expressions of distress).

Some risk assessment tools

General mental health assessment tools that may help you to establish a consumer's level of wellbeing include:

- STARS (Screening Tool for Assessing Risk of Suicide)
- PHQ-9 item 9 (as a trigger)
- ASQ (brief screening)
- C-SSRS (brief version)
- SAFE-T framework
- Risk formulation and safety planning.

The level of risk informs the treatment plan

Suicide risk is evaluated from the interaction of multiple factors which vary over time and context, including warning signs, long-term and current risk factors, protective factors and situational stresses.⁴² The purpose of a suicide risk assessment is to identify and plan timely, proportionate, person-centred action and treatment – not just to assign a fixed level of risk

The assessment findings should directly inform decisions about:

- immediate needs to maintain a consumer's safety. Where there is uncertainty about immediate safety, or where suicidal distress is escalating, consultation with local crisis or specialist mental health services is recommended. Shared care and early advice can also help you to make other decisions and plan follow-ups for this consumer

- ongoing supports and interventions that are needed over the coming days and weeks. Depending on the consumer's current presentation, history, supports and preferences, you could consider one or more of the following:
 - urgent referral for specialist or crisis mental health assessment
 - same-day or early GP follow-up
 - collaboratively developing a safety plan
 - involving family, carers or trusted supports (with consent)
 - referral for non-urgent psychological or psychiatric care
 - increased community, peer or cultural supports.

Importantly, risk assessment should be viewed as an intervention in its own right. Open, empathetic discussion of suicidal thoughts can reduce isolation, strengthen the therapeutic relationship, and help consumers feel heard and supported. Evidence indicates that such conversations can foster hope, engagement and a sense of safety, particularly when linked to clear next steps and follow-up.

How to conduct a risk assessment

The following table sets out what you need to find out in order to determine a consumer's risk. Typically, you would acquire this information during an open and respectful conversation.

Action	Description
Observe and assess verbal and non-verbal cues	Examples of non-verbal cues: • Downcast eyes • Less attention to appearance • Psychomotor retardation of speech or movement Examples of verbal cues: • 'Everyone would be better off without me.' • 'I don't think I can take this much longer.'
Ask probing questions	By asking some probing questions, such as those listed below, you can begin to assess the risk of suicide. • 'Other people with similar problems sometimes lose hope and can have thoughts of suicide. Are you having thoughts of suicide?' • 'Have you ever thought about killing yourself?'
Explore current suicidal thoughts	• Are suicidal thoughts present? • If so, when did they begin and how persistent are they? • Can the consumer control them? • What has stopped the consumer from acting on their thoughts so far?
Determine if there is a suicide plan	• Has the consumer made any plans to end their life? • If so, is there a specific method and place? • How often does the consumer think about the plan? A suicide plan or preparation for death, such as saying goodbyes and putting affairs in order, indicates serious suicidal intent. If you assess a high or imminent risk of suicide, immediate action must be taken.

Action	Description
Assess immediate safety	If someone has developed a potentially fatal or effective plan and has the means and knowledge to carry it out, the chances of dying from suicide are much higher. • Ask if they have access to means of harm (eg medication, weapons) and about any plans they may have to end their life. • Ask if they have already taken any steps towards ending their life. • Encourage them to remove or step away from any means, if possible. • Ascertain the lethality of the means. • Remain alert to the fact that some occupations have ready access to means (eg police officers and farmers have access to guns, health workers to medication). • If you are consulting via telehealth, ask the consumer if they are able to stay safe while you're speaking to them. • Establish if the consumer is living alone or with others and if they feel they can reach out to their support networks. • Ask if the consumer feels they could call 000 to call for help if anything happened.
History of suicidal behaviour	• Has the consumer felt like this before? • Has the consumer previously tried to take their life? • What were the details and circumstances of the previous attempts? • Are there similarities in the current circumstances?
Review protective factors	Identify and foster protective factors, which reduce the risk of suicide. See Risk factors, protective factors and social determinants of suicide.

After assessing the presence of risk

Safety planning

Safety planning is a collaborative, person-centred process that supports people to navigate periods of distress and suicidal thinking.⁴³ Its purpose is to strengthen the consumer's safety, agency and connection, and to help them identify what might support them when their distress escalates. Whether a consumer's suicidal thoughts are vague or intense in nature, a safety plan can help to contain distress and offer ideas to improve their mental health.

Importantly, a person may not be assessed as at risk during one consultation, but may be at risk in a subsequent consultation.

Effective safety planning acknowledges that risk can ebb and flow, and that plans need to be flexible enough to adapt to changed circumstances.

In general practice, safety planning needs to be:

- dynamic and revisited over time, not conducted as a single conversation
- tailored to the consumer (ie with consideration of their identity, culture, preferences, capacity, circumstances, and so on)
- relational, grounded in empathy and trust
- practical, focusing on what the person is willing and able to use.

When to develop a safety plan

Safety planning is most pertinent when:

- you believe the risk of suicide is serious
- someone is ambivalent about living or dying.

Safety planning may occur:

- during a longer mental health consultation
- across multiple shorter appointments
- informally during routine care
- as part of crisis followup or review.

Introducing the idea of a safety plan

Early in the discussion, it can be helpful to ask:

- 'Would it be okay if we talked about what might help when things feel overwhelming?'
- 'What would make this conversation feel useful for you?'
- 'Have you ever tried a plan like this before? What worked or didn't?'

Using person-centred language

The way you introduce and discuss safety planning is critical: Evidence consistently shows that kind, compassionate, empathetic and non-judgmental conversations reduce shame, increase disclosure and strengthen therapeutic alliance.⁴⁴ The process should feel like something done with the person, not to them. When done respectfully, asking directly about suicide does not increase risk, and is associated with reduced distress.

Therefore, good safety-planning questions need to be kind, compassionate, empathetic and person-centred, and should not dismiss or invalidate the person's thoughts.

To implement best practice person-centred communication:

- validate the person's experience without normalising suicidal behaviour
- avoid rushed or overly procedural questioning
- use curiosity rather than interrogation
- check in with consumer every now and then about how they are feeling about the questions.

Consider alternatives to the term 'safety planning'

Because some people may find the term 'safety planning' to be clinical, restrictive or associated with loss of control, consider using alternative phrases, such as:

- 'a plan for tough moments'
- 'support and healing plan'
- 'a staying-safe plan'
- 'a support and coping plan'
- 'a communication plan in case things get worse'.

Remain flexible about completing a detailed plan, as some people may not be able to complete a full plan in one sitting, or at all. Partial plans, brief check-ins, or a single agreed next step are still meaningful.

Remaining collaborative

Having collaborative conversations about potential means of suicide is a key evidence-based component of suicide prevention. These conversations need to:

- be respectful and practical
- identify ways of keeping the consumer's immediate environment safe by reducing or eliminating their access to potentially lethal means
- help the consumer be aware of, and avoid, stressful or upsetting situations
- with the consent of your consumer, include a family, friend or carer in safety planning. They can provide valuable insights and an outside perspective to help make the plan realistic and helpful.

Discussing what to include in the safety plan

Working with a consumer to develop a safety plan involves curious, compassionate questioning and discussion, rather than the completion of a checklist. The process needs to be collaborative and consider the consumer's individual circumstances and preferences.

Frame your questions appropriately

- Ask open-ended questions (ie questions that can't be answered with a 'yes', 'no', or other one-word answers) that will help your consumer think about what has helped them in the past, what feels realistic now, and what support they may need if distress escalates.
- Ask questions that invite reflection rather than demand solutions.
- Adapt questions, based on the consumer's circumstances.
- Make the prompts relational and strengths-based, such as:
 - 'What are the things you do that help you feel calmer or more in control?'
 - 'Are there strengths or abilities you'd like us to build into your safety plan?'

– 'What has worked for you in the past that we should include?'

- Allow space for the consumer's story, values and lived experience.

Avoid rushing or being prescriptive

- Take a break from asking questions if the consumer seems overwhelmed.
- Don't feel that the plan has to be completed in one sitting. It can be developed gradually, revisited regularly, and adjusted as circumstances change. Even identifying one or two helpful strategies or contacts can be a meaningful and protective step.

Focus on being collaborative, rather than prescriptive

- Focus on what is realistic for the consumer.
- Focus on what the consumer is willing and able to do, especially on difficult days.
- Prioritise relationship-building as well as practical strategies.

Possible contents of a safety plan

Having developed a nuanced, comprehensive understanding of this consumer's suicide risk, you are able to work collaboratively with them to develop an appropriate plan. The plan can include:

- safety planning
- increased monitoring
- referral to specialist services
- involvement of supports (with consent)
- crisis intervention.

Maintaining a transparent and empathetic approach during each conversation helps preserve trust and reinforces the therapeutic relationship as a central component of effective care.

Core elements of an effective safety plan

An effective safety plan will address the following information.

Early warning signs

When the consumer is aware of changes in their thoughts, moods and behaviour that may signal a developing crisis, it means they can act earlier, which helps to reduce further risk.

Warning signs could include:

- moods such as sadness, anxiety and irritability
- thoughts involving hopelessness, helplessness and self-criticism
- behaviours such as drinking more alcohol than usual, avoiding social situations, and arguing more often with friends and loved ones.

To help the consumer identify warning signs, you could ask:

- 'When things start to feel harder, what do you usually notice first?'
- 'Are there particular thoughts, feelings or situations that signal you need extra support?'
- 'How will you know when you should use your safety plan?'
- 'What are some of the difficult thoughts, feelings or behaviours that you experience leading up to a crisis?'

Creating a safe environment

To help the consumer understand how they can create a safe environment, you could ask:

- 'When people are feeling overwhelmed, access to certain items can increase their risk. Would it be okay if we talked about what might help keep you safe?'
- 'Are there any specific situations or people that you find stressful or triggering, or that contribute to your suicidal thoughts?'
- 'What things do you have access to that might be used in a suicide attempt?'
- 'How can we develop a plan to limit your access to these things and avoid these situations?'

Strategies to limit access

Strategies to limit access could include:

- temporary changes to medication access (eg removing the medication, asking someone else to manage the consumer's access to the medication)
- removing glass, knives and blades that may be used to cause harm
- having a support person remove or secure firearms and other weapons.

Strength-based reasons for living

Some commonly asked questions that ask for significant answers (such as 'What's the best thing about living?') can feel invalidating or burdensome when someone is experiencing suicidal ideation. However, developing a list of things that bring them joy and meaning, or something to look forward to, can help to change their focus, so consider framing the question so they can think of concrete everyday examples.

To help the consumer identify their strengths-based reasons for living, you could ask:

- 'Who or what brings strength, meaning, or connection to your life?'
- 'When you've felt even a little better in the past, what helped?'
- 'What gives you hope or purpose, even when things feel heavy?'
- 'Are there moments, people or experiences that have mattered to you?'
- 'Is there anything you'd miss if you weren't here?'
- 'What reminds you of who you are and what keeps you strong?'

Actions the consumer can do for themselves

Identify enjoyable activities (eg watching a favourite movie, listening to their favourite music, spending time on a hobby) and internal coping strategies (eg breathing and relaxation exercises, going for a walk, doing yoga or other exercise) that a consumer can do without involving or contacting anyone else. They should be simple, realistic and achievable, and the list should not be overwhelming.

These activities and strategies can help to regulate the consumer's emotions, reduce distress, change the focus of their thinking and distract them from suicidal ideation, potentially preventing a further escalation into crisis.

Connection and community networks

Just being around other people can help distract the consumer from suicidal thoughts. This could be as simple as spending time with friends and family, spending time with mob, yarning with family or Elders, attending cultural activities or men's/women's groups. Socialising can also include activities that don't require much talking or engagement (eg watching TV together)

or going somewhere where there are other people (eg coffee shop, park, place of worship, meeting group).

You could also discuss with the consumer whether there is anyone they would like to include to support with their safety planning. The family, friends and carers of your consumer know them well and can offer valuable insights into safety planning. This may include being able to identify what has worked well before, answering questions your consumer may be unable to, and offering valuable insights to improve the safety plan.

Inclusion of family, friends and carers in the development of a safety plan also means they understand the plan and can encourage adherence or support with key actions in the plan when the consumer is outside of formal care settings.

To help the consumer identify their connections and networks, you could ask:

- 'Who helps you to feel good when you socialise with them?'
- 'Where can you go and be around other people in a safe environment?'
- 'Among your friends and family, who do you feel you could talk to when you're having suicidal thoughts?'
- 'Who do you feel you could contact to support you during a suicidal crisis?'

Professional supports and services

A safety plan needs to clearly outline:

- who the consumer can contact
- when and how to do so
- what to do if their GP is unavailable.

To help the consumer identify their professional supports and services, you could ask:

- 'Which services could you turn to for support?'
- 'What health professionals can you involve in your treatment plan?'

Writing the safety plan

A safety plan can be written on paper, in the clinical record, or in secure digital tools such as websites or apps. When choosing the format, be guided by what will be the most accessible, acceptable and useful for this consumer, particularly if they are distressed.

Although many people find apps and online tools convenient and easy to use, they are not suitable for

everyone. Some people may prefer a handwritten plan, a brief summary documented in the clinical notes, or a verbal plan reinforced at each follow-up. What matters more than the actual format is that the plan feels personally meaningful, usable in moments of distress, and easy to revisit and revise.

Using digital tools

Digital tools, such as the BeyondNow suicide safety planning app, may be useful for consumers who will appreciate easy, on-demand access to their plan via their phone or other device. Using these tools, consumers can review their coping strategies, their support contacts and the steps to take when their distress increases. They can also share parts of their plan with trusted people or health professionals if they choose.

Make sure you:

- are familiar with commonly used tools so you can confidently explain the options, including their benefits and limitations
- remain flexible if it looks like a consumer may prefer an alternative approach, including a non-digital plan.

When considering the use of these tools:

- assess whether a digital format is appropriate for this consumer, based on their needs, preferences, literacy, access to technology, cultural safety and other individual considerations
- find out if your consumer is comfortable using technology when they are distressed
- discuss privacy, data storage and confidentiality in clear, plain language
- clarify that apps are in addition to care, and do not replace professional and relational support
- emphasise that the plan belongs to the consumer, and that sharing details of their plan is always their choice
- always offer non-digital alternatives.

Assertive aftercare and follow-up actions

Whether your consumer is at immediate risk of harm or not, be assertive in initiating appropriate aftercare and follow-up to prevent gaps in their mental health care. For example, you could do one or more of these, as appropriate:

- Schedule one or multiple follow-up appointments to:
 - review their situation and suicide risk
 - develop a Mental Health Treatment Plan (MHTP) or Social and Emotional Wellbeing (SEWB) plan
 - conduct some Focussed Psychological Strategies (FPS) sessions, if you are an eligible FPS provider.
- Refer the consumer to an appropriate service:
 - If you've already prepared an MHTP/SEWB, refer them to an allied health professional, as appropriate, and follow up with your consumer to make sure they have arranged appointments
 - Refer the consumer to an e-mental health resource, and follow up with your consumer to make sure they have arranged appointments
- Schedule some activities (eg choosing a small task to complete, arranging a yarn with someone they know, or writing or journalling), for the consumer to complete before you see them next, or before they have an appointment with an allied health practitioner
- Provide them with some psychoeducation, explaining and normalising their mental health condition/issue
- If the consumer has consented to include a family member, friend or carer in their safety plan, talk to them about scheduling appointments, adherence to safety planning, assisting with referrals or paperwork, and/or providing emotional support
- Be proactive by:
 - sending a follow-up text message to remind the consumer about their next appointment with you, or to encouraging them to make a follow-up appointment
 - suggesting brief check-in appointments or phone calls
 - contacting and coordinating with allied health providers and community supports.

Reviewing the safety plan

A safety plan should be regularly reviewed to ensure its effectiveness, especially after changes in the consumer's circumstances or mental state. At a follow-up appointment, you should ask your consumer:

- How often have you needed to use the safety plan?
- What was the most helpful part of the plan?
- Were there anything about it you found difficult or unhelpful?

- What could we change to make it more useful?

Consider modifying the action plan if there are new or changed circumstances, particularly if the consumer's risk of suicide is higher.

Remain positive about their recovery

Always give your consumer hope, because with the right treatment and support, most people will be able to manage their illness and live a normal life.

Self-care for GPs

GP wellbeing and suicide prevention

General practice is emotionally demanding work: GPs are frequently exposed to distress, trauma, risk, and uncertainty, often while working under sustained workload pressure and professional isolation.⁴⁵

Australian and international evidence shows that doctors, including GPs:

- experience higher rates of psychological distress, burnout, suicidal ideation and suicide than the general population
- face unique barriers to help-seeking, because of stigma, confidentiality concerns, and a fear of regulatory consequences.⁴⁶

Burnout and cumulative stress

The World Health Organization recognises burnout as an occupational syndrome arising from chronic, unmanaged workplace stress, and that it is characterised by emotional exhaustion, depersonalisation (cynicism or emotional distancing), and reduced professional efficacy.⁴⁷

Australian data indicates persistently high levels of burnout across the healthcare workforce, with more than 80% of health professionals reporting symptoms of burnout since 2020.

For GPs, risk factors include repeated exposure to suicidal consumers, moral distress, administrative burden, workforce shortages, regulatory scrutiny, and limited time for recovery, while prolonged exposure to

consumers at high risk of suicide can lead to vicarious trauma and compassion fatigue, particularly when combined with long hours and inadequate systemic support.

Suicide risk among female GPs

Recent research indicates suicide rates among female GPs are approximately 76% higher than women in the general population, and Australian studies show this is worsening.⁴⁸

Factors contributing to this increased risk include gendered workload expectations, higher rates of combining part-time work with unpaid caring responsibilities, greater emotional labour in consultations, exposure to consumer trauma, and systemic inequities in medical workplaces.

Treating doctors and mandatory reporting obligations

Doctors often find it difficult to identify, approach or support colleagues who may be distressed or suicidal.

Barriers include:

- professional hierarchies
- fear of 'getting it wrong'
- concerns about confidentiality
- uncertainty about mandatory reporting obligations.

These barriers can contribute to delayed intervention and increased isolation for doctors in distress.⁴⁹

A major barrier for doctors who may otherwise seek help is the fear of mandatory reporting, however, in almost all Australian jurisdictions, treating practitioners are only required to make a notification if a doctorconsumer poses a substantial risk of harm to the public (an intentionally high threshold). A mental health condition alone does not constitute impairment, nor does it trigger mandatory reporting. Western Australian law exempts treating practitioners from mandatory reporting altogether.

Understanding the treating doctor's obligations can reduce fear, encourage early care, and support the wellbeing and safety of Australia's GPs.

If you are a GP experiencing suicidal thoughts

If you are feeling suicidal or experiencing thoughts of selfharm, this is not a personal or professional failing: it is a health issue and possibly a medical emergency.

Confidential help is available, and evidence shows that timely access to care significantly reduces risk and supports recovery.

Please seek support early through trusted colleagues, your own GP, Doctors' Health Services, or dedicated practitioner support services.

Caring for yourself as a GP

Self-care is an essential component of safe practice. Although protecting your wellbeing is a personal responsibility, it is also a responsibility of the health system.

Protective factors include:

- strong professional connection
- regular reflective practice
- access to confidential care
- meaningful professional development.

Practical strategies include:

- maintaining a trusted GP and/or mental health provider
- engaging in peer support or supervision
- setting boundaries around workload and availability
- prioritising sleep, physical health and recovery time
- incorporating wellbeingfocused activities into CPD.

Resources

Suicide

- Medicare Mental Health Centres www.medicarementalhealth.gov.au/provider/on-the-line-15536
- Suicide Call Back Service: Mental health counselling www.suicidecallbackservice.org.au
- Australian Institute of Male Health & Studies (AIMHS): Male suicide www.aimhs.com.au/cms/uploads/AIMHS%20Suicide%20Fact%20Sheet.pdf
- Minds Together <https://mindstogether.org.au>
- Living Is For Everyone (LIFE): Fact sheets www.livingisforeveryone.com.au/resources/individual-fact-sheets
- Lifeline: Facts about suicide www.lifeline.org.au/Get-Help/Facts-and-Information
- Life In Mind <https://lifeinmind.org.au>
- Mental Health First Aid (MHFA) Australia: First aid guidelines – Suicidal thoughts and behaviours www.mhfa.com.au/wp-content/uploads/2023/12/MHFA_Suicidal-Thoughts-and-Behaviours-Guidelines.pdf
- Suicide Call Back Service www.suicidecallbackservice.org.au
- Suiceline www.suiceline.org.au/health-professionals/estimating-the-risk-of-suicide
- Suiceline: Warning signs and risk factors www.suiceline.org.au/worried-about-someone/recognising-suicide-warning-signs
- Mindframe <https://mindframe.org.au>
- Suicide Prevention for Autism Neuro-affirming Toolkit www.spantoolkit.com

Depression

- Black Dog Institute: Consumer resource www.blackdoginstitute.org.au/clinical-resources/depression/types-of-depression
- headspace: Youth mental health information www.headspace.org.au/young-people/understanding-and-dealing-with-depression-for-young-people/
- headspace: Youth mental health video www.headspace.org.au/get-info/depression#understanding-depression-video
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tools. *Aust Fam Physician* 2011;40(6):382–86: www.racgp.org.au/afp/2011/june/anxiety-and-depression

- Australian Psychological Society: Depression tip sheet www.psychology.org.au/publications/tip_sheets/depression

Anxiety

- Australian Psychological Society: Anxiety tip sheet www.psychology.org.au/publications/tip_sheets/anxiety
- Beyond Blue: Symptoms of anxiety www.beyondblue.org.au/the-facts/anxiety/signs-and-symptoms
- headspace: Youth mental health resource library, anxiety factsheet headspace.org.au/explore-topics/for-young-people/anxiety
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- Mindhealthconnect: Anxiety: Symptoms, treatment and causes www.mindhealthconnect.org.au/anxiety

Bipolar

- Black Dog Institute: Bipolar disorder symptoms fact sheet www.blackdoginstitute.org.au/resources-support/bipolar-disorder/signs

Specific populations and suicide

- The RACGP: National guide to preventive healthcare for Aboriginal and Torres Strait Islander people www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/national-guide
- Gayaadhuwi (Proud Spirit) Australia www.gayaadhuwi.org.au
- The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention <https://cbpatsisp.com.au/>
- Shared Roses in the Ocean: Peer CARE Companion Warmline <https://rosesintheocean.com.au/peer-care-companion-warmline/>
- The Healing Foundation: Understanding trauma GP fact sheet https://healingfoundation.org.au/media/k4wpcwqr/hf_understanding_trauma_fact_sheet_gp_services_may2025_web.pdf

Talking about suicide and reducing stigma

- The Analogy Bank: An analogy resource for mental health clinicians www.theanalogybank.wordpress.com
- Department of Health: Principles of recovery oriented mental health practice www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-policy-and-theory.pdf%20
- Mental Health Coordinating Council: Recovery oriented language www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf
- Mindhealthconnect: Do's and don'ts of discussing mental health issues www.mindhealthconnect.org.au/dos-and-donts-discussing-mental-health-issues
- SANE Australia: Reducing stigma www.sane.org/information-and-resources/facts-and-guides/reducing-stigma
- SANE Australia: Personal storie www.sane.org/information-and-resources/people-like-us

Risk assessment

- Sivasankaran B. Mental health risk assessment: A guide for GPs. *Aust Fam Physician* 2011;40(6): 366–69: www.racgp.org.au/afp/2011/june/mental-health-risk-assessment
- Hayes P. GP Communication: Suicide in general practice, *Good Practice*. August 2015: https://hnc.org.au/wp-content/uploads/2021/02/GP_Aug_Suicide_2015.pdf
- Suicide Questions Answers Resources (SQUARE): Risk assessment questions www.rasa.org.au/training-tools/square/
- Lifeline: Facts about suicide www.lifeline.org.au/Get-Help/Facts-and-Information
- Suicideline: Estimating the risk of suicide www.suicideline.org.au/health-professionals/estimating-the-risk-of-suicide

Tools

- Initial Assessment Referral Decision Support Tool (IAR): <https://iar-dst.online/>
- Sphere-12: A self-rated, 12-item tool to screen for anxiety, depression and somatisation in primary care https://searchlibrary.adelaide.edu.au/discovery/fulldisplay/alma9916097603001831/61USOUTHAUS_INST:ROR
- Beyond Blue: K10 anxiety and depression checklist. A simple self-report checklist aiming to measure whether consumers have been affected by depression or anxiety in the past four weeks www.beyondblue.org.au/the-facts/anxiety-and-depression-checklist-k10
- Psychology Foundation of Australia: Depression Anxiety Stress Scales (DASS). A 42-item self-report instrument designed to measure the three related negative emotional states of depression, anxiety and tension/stress www2.psy.unsw.edu.au/dass
- Black Dog Institute: Depression self-report questionnaire (DMI-10 and DMI-18). Self-report measures for assessing depression in the medically ill www.blackdoginstitute.org.au/docs/default-source/psychological-toolkit/dmi-10.pdf?sfvrsn=2
- Griffith University: Screening Tool for Assessing Risk of Suicide (STARS). A guide to gathering information about a person's presenting experience of a 'suicidal state' in order to support decision making about safety planning www.griffith.edu.au/griffith-health/australian-institute-suicide-research-prevention/systematic-tailored-assessment-for-responding-to-suicidality
- Black Dog Institute: Antenatal risk questionnaire. A questionnaire to be administered by clinicians, designed to consider specific key risk factors thought to increase the risk of women developing perinatal mental health morbidity (eg postnatal depression or anxiety disorder) and sub-optimal mother infant attachment www.blackdoginstitute.org.au/docs/default-source/psychological-toolkit/anrqclinicians.pdf?sfvrsn=2 www.blackdoginstitute.org.au/wp-content/uploads/2020/04/postnatal-risk-questionnaire-pnrq.pdf
- Black Dog Institute: Edinburgh Postnatal Depression Scale (EPDS). A 10-item self-report measure designed to screen women for symptoms of emotional distress during pregnancy and the postnatal period www.blackdoginstitute.org.au/wp-content/uploads/2020/04/edinburgh-postnatal-depression-scale.pdf

Safety planning

- Beyond Blue: 'Finding our way back', a resource for Aboriginal and Torres Strait Islander peoples after a suicide attempt https://edge.sitecorecloud.io/beyondblue1-beyondblue1td-p69c-fe1e/media/Project/Sites/beyondblue/PDF/Resource-Library/Suicide-prevention/bl1289-finding-our-way-back-booklet_lr.pdf?sc_lang=en
- Beyond Blue: 'Finding your way back', a resource for people who have attempted suicide <https://s3-ap-southeast-2.amazonaws.com/everymind/assets/Uploads/Finding-your-way-back.pdf>
- Beyond Blue: 'Guiding their way back', a resource for people who are supporting someone after a suicide attempt <https://zerosuicide.edc.org/resources/resource-database/guiding-their-way-back-resource-people-who-are-supporting-someone-after>
- Beyond Blue: Safety app. www.beyondblue.org.au/mental-health/suicide-prevention/suicide-safety-planning
- Conversations Matter: Resources for professionals and those working with communities. www.conversationsmatter.com.au/professional-resources
- Lifeline: Tool kits www.lifeline.org.au/get-help/get-help-home
- Melvin GA, Gresham D, Beaton S. Safety first – Not last! Suicide Safety Planning Intervention (SPI). InPsych 2016; 38(1):14–15: www.psychology.org.au/inpsych/2016/feb/melvin
- Suicide Prevention Resources Centre: Safety planning template <https://sprc.org/resources/stanley-brown-safety-plan/>

Mental health first aid for practice staff

- Community Response to Eliminating Suicide (CORES) www.cores.org.au/contact
- LivingWorks www.livingworks.com.au/programs
- Mental Health First Aid (MHFA) Australia www.mhfa.com.au
- Wesley Mission: Suicide prevention www.wesleymission.org.au/get-support/suicide-prevention

Ongoing care

- The RACGP: e-Mental health: A guide for GPs www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Mental%20health/e-mentalhealth-guide.pdf
- GPMHSC: GPMHTP templates www.gpmhsc.org.au/info/detail/8a218292-d2d3-47c0-b8a8-43ab7eddeb04/gp-mental-health-treatment
- Black Dog Institute: Supporting you through anxiety and depression, online tool kit www.blackdoginstitute.org.au/docs/default-source/education-resources/bdi_cbh_toolkit_2019_final.pdf?sfvrsn=0

Psychoeducation

- Beyond Blue: Depression guide www.beyondblue.org.au/mental-health/depression
- Beyond Blue: Anxiety guide www.beyondblue.org.au/mental-health/anxiety
- Black Dog Institute: Understanding your depressive episode www.blackdoginstitute.org.au/clinical-resources/depression/types-of-depression

Activity scheduling and other clinical interventions

- Centre for Clinical Interventions: GP resources www.cci.health.wa.gov.au/resources/for-clinicians
- Department of Health: Phase 5: Pleasant event and activity scheduling www1.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~profile~strategies-activities

GP self-care

- Black Dog Institute: Self-care plan for GPs www.blackdoginstitute.org.au/news/how-to-use-self-care-planning-to-improve-your-emotional-wellbeing-even-when-you-dont-think-you-need-it
- Black Dog Institute: TEN – The Essential Network for Health Professionals www.blackdoginstitute.org.au/the-essential-network
- The National Rural Health Alliance: Case studies on rural GP self-care www.ruralhealth.org.au/7thNRHC/Papers/general%20papers/roach.pdf

- The RACGP: *Abuse and violence: Working with our consumers in general practice, Chapter 14. The doctor and the importance of self-care* www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/abuse-and-violence/preamble
- *Psychiatric Times: Consumer suicide: Impact on clinicians* www.psychiatrictimes.com/view/impact-consumer-suicide-clinicians
- Drs for Drs www.drs4drs.com.au
- Hand-n-Hand Peer Support www.handnhand.org.au
- RACGP Wellbeing Hub www.racgp.org.au/wellbeing
- Life In Mind: Every Doctor, Every Setting <https://cdn.lifeinmind.org.au/assets/src/uploads/Every-Doctor-Every-Setting-Medical-Framework.pdf>

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