



After suicide

A resource for GPs

After suicide: 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 that this resource may contain references to distressing topics. Some linked resources may include images, names or voices of people who have passed.

Introduction

Every day in Australia, approximately nine people die by suicide. In 2024, 3,307¹ such deaths were recorded nationally. Each death has profound and long-lasting impacts on families, communities and clinicians. Suicide bereavement is often described as ‘grief with the volume turned up’, reflecting the intensity and complexity of such a loss.

This guide – After suicide: A resource for GPs – supports GPs who are responding to suicide in their communities and practices. A loss by suicide is different from other types of loss, and there is deep complexity in the experience. Aligning with broader suicide-prevention and postvention reform in Australia, it provides practical guidance, links and resources for bereaved individuals, families and communities. As a companion resource to the GPMHSC’s Suicide prevention: A resource for GPs, it complements existing clinical guidance and mental health training.

As a trusted point of contact, GPs play a central role in providing compassionate, informed and culturally safe postvention care within Australia’s evolving suicide-prevention system. This guide supports GPs to fulfil that role sustainably and collaboratively, while also supporting GPs affected by suicide.

When supporting Aboriginal and Torres Strait Islander peoples affected by suicide, GPs need to understand suicide and postvention within a Social and Emotional Wellbeing (SEWB) framework, which recognises the central importance of connection to Country, culture, spirituality, family, kinship and community, as well as the ongoing impacts of colonisation, racism and intergenerational trauma. The [Victorian suicide prevention and response strategy 2024–2034](#) emphasises the need for approaches that are coordinated, culturally responsive and led by those with lived experience. Nationally, postvention is also embedded in the [National Suicide and Self-Harm Monitoring System](#), led by the Australian Institute of Health and Welfare (AIHW).

GPs and the weight of suicide

Being a GP can be isolating, and there may be times when you feel as though you are carrying the weight alone. In these moments, remember that you are a person, not a robot, and offer yourself the same compassion, care and understanding that you extend to your patients. Losing a patient to suicide can be deeply distressing and, while the pain should not be minimised, it’s also okay to allow the experience to shape your growth over time, deepening your capacity for compassion, empathy and professional resilience.

If you are experiencing suicidal thoughts, please call Lifeline on 13 11 14 or reach out to organisations like [drs4drs](#) or RACGP’s GP Support Program on 1300 361 008.

About suicide

Useful terms

Term	Definition
Suicide loss survivor	The increasingly preferred term in postvention practice to describe any person who has experienced the loss through suicide of someone close to them. This includes family members, friends, colleagues, peers and others who feel significantly impacted by the death.
Bereavement	The situation or state of having recently lost someone close through any form of death, including suicide. This can affect the person's relational and social circumstances.
Grief	The natural emotional, cognitive, physical and behavioural response to bereavement. It encompasses sadness, longing, guilt, confusion, physical symptoms and changes in behaviour that arise after the death of someone close.
Mourning	The process of adapting to loss and integrating grief into one's life. Mourning includes the expressions of grief through cultural, spiritual, personal and relational rituals and behaviours that help people adjust to a changed life as the result of a death.
Postvention	The range of supports and responses provided after a suicide to assist individuals, families and communities to cope and heal, with the aim of reducing further harm.
Suicide cluster	A group of suicides or suicide attempts that occur closer together in time or place (geographically or digitally) than would be expected. Note: Avoid using this term with patients or in public communication because it refers to an act rather than people and may be perceived as dehumanising and upsetting.

Australia's suicide statistics

Category	Latest Statistics
Deaths by suicide in 2024	3,307 deaths (12.2 suicides per 100,000 people) ¹
Estimated suicide attempts per year	65,000 ²
Gender distribution	More than 75% of people who die by suicide are men, the majority of whom are aged 40–59 and 85+ ³ . Females are hospitalised for intentional self-harm (with and without suicidal intent) almost twice as frequently as males ⁴ .
Attempts-to-deaths ratio	20 attempts per one suicide
Geographical distribution	More common in small, remote and regional communities ⁵ . Major cities have the lowest rates of suicide; rural and regional areas have the highest ⁶ .
Socioeconomic index	According to the Australian Bureau of Statistics (ABS) Index of Relative Socio-economic Advantage and Disadvantage, people in the lowest socioeconomic group have a suicide rate 2.5 times higher than people in the highest group ⁷ .
Aboriginal and Torres Strait Islander suicide rates	The suicide rate of Indigenous peoples is 2.6–2.9 times the national rate ⁸ . Note: These rates must be understood in the context of SEWB, which recognises the central role of culture, community, Country, family and spirituality, and the continuing impacts of colonisation, racism and intergenerational trauma.

For in-depth information about the risk factors for suicide, please refer to the GPMHSC [Suicide prevention and first aid: A resource for GPs](#).

Suicide bereavement

Suicide bereavement is often prolonged, and those who are bereaved may repeatedly revisit the circumstances of the death, especially if there is trauma, stigma or unanswered questions. This highlights the need for continuity of care in general practice that may extend beyond immediate postvention into long-term and sometimes lifelong support.

While bereavement after suicide has many of the elements of other sudden or traumatic losses, emerging evidence^{9,10,11} indicates that some experiences, including those listed below, may be more common or more intense among people bereaved by suicide.

- Stronger feelings of rejection or abandonment, particularly when the death challenges deeply held assumptions about how close they were to the deceased person, and their perceived responsibility for the suicide.
- Greater shame and stigma, which may lead to them hiding the cause of death, avoiding conversations, or delaying help-seeking.
- Heightened self-destructiveness or suicidality, reflecting the trauma exposure and the well-documented elevated risk of suicide.
- Stronger feelings of guilt and self-blame, often linked to ruminative questioning (eg 'Why?', 'What did I miss?').
- Rumination, activism, or preoccupation with suicide, sometimes as an attempt to make meaning or prevent future deaths.
- Anger, directed at self, others, or systems they perceive as having failed the deceased.

Not everyone bereaved by suicide will experience these responses, and each person's experience of bereavement is unique.

Physical and mental health impacts of suicide

People bereaved by suicide, including children and adolescents, are at increased risk of developing adverse physical and mental health reactions,¹² including:

- suicidal ideation and suicide
- complicated grief or prolonged grief disorder
- post-traumatic stress disorder (PTSD)
- depression and anxiety
- substance-use disorders.

Stigma and barriers to seeking help

Social stigma remains a major barrier to accessing support for people bereaved by suicide.¹³ Shame, fear of judgement, cultural expectations and concerns about being misunderstood may prevent people from engaging with postvention services or even disclosing the suicide. This can significantly compound their distress and delay recovery.

Understanding reactions and the absence of them

Reactions to suicide loss vary widely between individuals, families and cultures. Some people may experience intense emotional, physical or behavioural responses, while others may feel numb and disconnected or report little immediate reaction. These variations are normal, culturally mediated and not indicative of a lack of care or future risk of suicide.

Regardless of whether a person's reaction is strong, mild or delayed, you can encourage them to seek support and remind them that help is appropriate at any stage of the bereavement journey.

Supporting Aboriginal and Torres Strait Islander peoples during Sorry Business after a suicide

When supporting Aboriginal and Torres Strait Islander peoples after a suicide, you should work within a SEWB framework, recognising that wellbeing is collective, cultural and relational. The following table explains what this means in practice. See the resources at the end of this guide for more information.

Principle	Action
Prioritise Aboriginal-led care	If there is a local Aboriginal Community Controlled Health Organisation (ACCHO) or SEWB team, contact them, or refer your patient to them, as early as possible. Take a collaborative role and support decision-making led by Aboriginal and Torres Strait Islander communities and leaders, rather than coordinating responses independently.
Ask, don't assume	Ask how the person, family or community understands the loss, and what support they'd like. Ask who should be involved (eg family, Elders and Aboriginal Health Workers (AHW)) and who should not.
Respect Sorry Business	Understand that Sorry Business is central to healing and may take precedence over clinical schedules. Be flexible with appointments, paperwork and the timing of follow-ups.
Use culturally safe communication	Listen without judgement, avoid clinical jargon, and allow space for silence or story-based ('yarning') conversations. Follow local guidance about whether naming the deceased is appropriate.
Support connection as a protective factor	Encourage cultural, community and family connection, if welcomed by the bereaved person. Ask about connection to Country, community, spirituality or cultural practices that may support their healing.
Work with community, not around it	Seek guidance from leaders and community before reaching out or attending events such as memorials. Avoid actions that may unintentionally breach cultural protocols or community governance.
Monitor wellbeing gently and over time	Recognise that grief may be collective, delayed or cyclical. Offer ongoing, low-pressure follow-up, rather than assuming the patient has processed the loss or resolved the suicide.
Reflect on your role and limits	Recognise that cultural safety is defined by Aboriginal and Torres Strait Islander peoples themselves. Seek cultural advice and supervision when unsure, rather than relying solely on your personal judgement.

Post-suicide risks in specific populations

The experience of suicide loss varies across communities, cultures and contexts. As people can belong to many different groups (intersectionality), each person's experience will be individual.

Therefore, the postvention support you provide should always be:

- culturally safe
- trauma-informed
- based on listening non-judgementally
- based on asking questions, so that you understand this person's individual experience.

The following table, which explains how suicide risk varies across populations, highlights the need for variations in postvention approaches.

Support for Aboriginal and Torres Strait Islander peoples must be grounded in self-determination, cultural governance and Aboriginal-led models of care, rather than solely on a person's clinically determined risk.

Population	Why are they at higher risk?
People with mental health risk factors	
People with lived or living experience of suicide	A history of suicidal distress or attempts is one of the strongest predictors of future suicide.
People bereaved by suicide	They face an elevated risk of complicated grief, mental ill -health and suicide, particularly in the period immediately following a suicide.
People with mental illness or psychological distress	They experience higher risk of suicide, especially when their access to timely, continuous care is limited.
People with alcohol and other drug use issues	Substance use can increase impulsivity, worsen mental health symptoms and reduce protective factors.
People experiencing family violence or abuse	They are at increased risk due to trauma, fear, coercion and loss of safety.
Communities exposed to suicide clusters	They are at heightened risk of further suicidal behaviour in the community and of cumulative grief.
People with ongoing suicidal ideation	They may experience prolonged psychological exhaustion and cognitive habituation to thoughts of dying.
People with cultural and other identities	
Aboriginal and Torres Strait Islander peoples	They experience disproportionately high rates of suicide due to the ongoing impacts of colonisation, racism and systemic disadvantage. Cultural continuity, community leadership and connection to Country are key protective factors that support healing and recovery.
People from culturally and linguistically diverse (CALD) backgrounds	They may face barriers related to language, migration stress, stigma and limited access to health services.

Population	Why are they at higher risk?
People with cultural and other identities (continued)	
Refugees and asylum seekers	They may experience high levels of trauma, uncertainty and isolation, and restricted access to supports.
LGBTQIA+ people	They face an elevated risk due to stigma, discrimination, minority stress and social exclusion.
People with disability or chronic illness	They may experience pain, functional limitations, stigma and reduced independence.
People of specific ages and genders	
Children and young people	They may have a reduced coping capacity, heightened vulnerability to transitions and stressors, and limited access to appropriate supports.
Older people, particularly older men	They may experience social isolation, bereavement, chronic illness and reluctance to seek help.
Men, particularly middle-aged and older men	They have higher rates of death by suicide and lower help-seeking behaviour.
People experiencing relevant socio-economic circumstances	
People living in rural and remote areas	They have higher rates of suicide, and may experience service shortages, social isolation and reduced access to specialist care.
People experiencing socioeconomic disadvantage	They may experience unemployment and financial stress, which are strongly associated with psychological distress and suicide risk.
People experiencing homelessness or housing insecurity	They are exposed to high levels of trauma, instability and barriers to healthcare.
People in contact with the justice system	They face elevated risk due to trauma and isolation. People who have been incarcerated also experience transition stress.
People with particular occupations	
Veterans and defence personnel	They may experience cumulative trauma, moral injury, transition challenges and barriers to help-seeking.
Emergency service workers and first responders	They have greater exposure to trauma, death and occupational stress.
Health and care workers, including clinicians affected by patient suicide	They experience occupational stress, professional responsibility and exposure to suicide.
People in blue collar work industries	These industries involve suicide risk factors such as workplace culture, job insecurity and stress, isolation and physical toll.

Supporting suicide loss survivors

General principles

Supporting people who have been bereaved by suicide requires a compassionate, flexible and culturally safe approach that:

- recognises the diversity of grief experiences
- avoids assumptions about how bereaved people 'should' feel or behave.

The appropriate support for a bereaved person will depend on:

- their wishes and those of their community
- their cultural identity
- their access to networks and support services
- their preferences
- your recognition of the right of Aboriginal and Torres Strait Islander peoples to self-determination, choice and control in postvention care.

Communication and engagement

- Listen without judgement and allow the bereaved person to lead the conversation. Avoid making assumptions about their emotions, needs, coping style or cultural practices.
- Use validating, respectful and non-directive language. In other words, avoid telling them how they should feel or what they should do; instead, reflect on what they have shared and invite them to identify what support feels right for them.
- Avoid minimising their feelings, giving unsolicited advice, or attempting to 'fix' their grief.
- Provide space for them to express their cultural identity, community relationships, spiritual beliefs and family structures, as these not only shape grief but may also influence why and how they seek help (or avoid seeking help).
- Work transparently, clearly articulating your role and boundaries, and regularly ask what kind of support they feel comfortable receiving.

Understanding grief experiences

- Post-suicide grief is highly variable, fluid and deeply individual. Some people may always appear distressed, others may appear detached or in disbelief, and others may seem calm and function normally, while struggling internally. A person's responses can change over the days, weeks and years following a suicide, and they can differ depending on cultural expectations, family roles, and past trauma.
- While it is common for people bereaved by suicide to grapple with feelings of stigma, isolation and difficult questions (such as wanting to understand why it happened), do not assume that everyone will have these experiences.
- Recognise that different family and community members may cope in different ways, and that this can create tension or misunderstanding between them.

Providing support that is proactive, practical and emotionally safe

Immediately after a suicide, some people may be overwhelmed, traumatised, or unable to seek help on their own. Proactively reaching out to a bereaved person sensitively and respectfully, while seeking their consent, may help them cope with their feelings and thoughts.

Some people may wish to undertake practical tasks such as organising cultural or community ceremonies, or managing administrative processes, but others may not feel ready for this. Suggest these options, without applying any pressure or expectations.

Ask what practical, cultural, and community supports and trusted people would be helpful to them (eg Elders, community leaders, spiritual advisors, AHWs).

Trauma-informed care

Approach every interaction with an awareness that the bereaved person may be experiencing trauma. Prioritise their safety, empowerment and choice, and always work collaboratively to build trust.

Supporting wellbeing and safety

People bereaved by suicide have an increased risk of suicide, self-harm and mental health challenges¹⁴.

To reduce this risk:

- provide support within 48 hours where possible, while recognising that effective wraparound postvention support is ongoing and extends well beyond the immediate aftermath
- provide opportunities for open, gentle conversations about their wellbeing, risk factors, and how they are coping
- offer ongoing monitoring, resources, and support pathways (such as counselling, peer groups, culturally appropriate healing supports, or community-led programs), while respecting how ready and able they are to accept different forms of support
- help them to identify protective factors, such as cultural connection, community belonging, relationships, strengths, and coping strategies.

To support the community:

- reduce the risk of further suicidal behaviour in the community, especially in families, schools, workplaces, and close social groups, by reducing access to means and implementing supports such as buddy systems to check in on family and friends
- support the restoration of community functioning, including strengthening connections with practical, social and cultural supports
- use the experience as an opportunity to educate community members effectively and safely about suicide and postvention-specific services, such as StandBy Support After Suicide, to reduce risk among others affected by or exposed to the death

Postvention

The aims of postvention

The main aims of postvention are to support a grieving person, to support the community and to lessen the impact of suicide.

To support a grieving person:

- listen without judgement and hold space for the person to speak – do not move into solutions
- be sensitive to their cultural, spiritual and personal beliefs, and help them make sense of the loss, without reducing it to a single explanation
- help them to move safely through their grief and understand that suicide loss is often complex and may involve shock, guilt, anger, confusion, trauma, shame, relief and other unexpected emotions
- promote healthy grieving by validating their responses, supporting their coping strategies and reducing stigma
- identify any increased risk they may be experiencing (including risk of suicide, complicated grief, depression, anxiety, and post-traumatic stress) and provide appropriate support
- help them to strengthen their protective factors, including social connection, coping skills, cultural identity, community support, and access to ongoing care
- provide comfort and stabilisation for those experiencing distress, uncertainty, or trauma.

Postvention interventions to consider

Individual clinical interventions

Name and description of intervention	Why use this intervention?
Psychotherapy (first-line response) This includes grief counselling, trauma-informed therapy, CBT, ACT, narrative therapy and culturally informed healing approaches.	It helps the bereaved person process complex emotions, rebuild safety, make meaning, and reduce the risk of complicated grief or trauma responses ¹⁵ .
Short-term pharmacological support (as needed) This may address acute insomnia, severe anxiety, intrusive thoughts, and overwhelming physiological distress.	It provides stabilisation during periods of acute grief ¹⁶ . Caution: Medication is not a treatment for grief and should be used cautiously and only when clinically indicated.
Longer-term medication (selected cases) Consider using this when depressive syndromes, PTSD, or severe anxiety persist.	It supports people whose grief has progressed into a diagnosable mental health condition ¹⁶ .

Social and peer support interventions

Name and description of intervention	Why use this intervention?
Support groups (in-person or online) This includes general suicide bereavement groups, as well as groups that are youth-specific, LGBTQIA+-specific, First Nations-led, and culturally aligned groups.	Peer support groups can provide connection with others who have experienced suicide loss, reduce isolation, and help people make sense of their grief. A 2024 scoping review found that people bereaved by suicide often require formal support, including support groups, online resources and discussion forums ¹⁷ .
Family outreach and family-based support This may involve family meetings, SEWB teams, ACCHO workers, social workers or postvention coordinators.	Because suicide affects family systems, interventions that strengthen communication, safety, and connections in the family can help prevent intergenerational and cumulative distress ¹⁸ .

Community-level interventions

Name and description of intervention	Why use this intervention?
Community healing responses This includes cultural ceremonies, memorial activities, community gatherings and trauma-informed collective healing practices.	Suicide can affect whole communities, so facilitating connection and helping people and communities make meaning of the death can reduce the risk of further suicides in the community ¹⁹ .
Education and gatekeeper training For schools, workplaces, sporting clubs, health services.	It helps communities recognise distress, respond safely and reduce the risk of further harm ²⁰ .
System-level supports Coordinated postvention programs (eg StandBy), ACCHO-led SEWB responses, multicultural organisations, veteran services.	It ensures continuity of care, cultural safety, and skilled early intervention ²¹ .

GPs and postvention

Postvention is not the responsibility of any single person or service, but a shared, community-based effort. Nonetheless, GPs have a critical role²² for two reasons:

- many people turn to their GP as a first point of contact for support during and after bereavement
- GPs contribute to community resilience by providing education with a focus on suicide prevention.

A strong GP relationship provides a stable and trusted source of support during a highly destabilising period,²³ and enables the bereaved person to understand that their grief responses are normal.

In addition to coordinating referrals, medications (if needed), and ongoing supports, you can also:

- provide continuity in a system that can often feel overwhelming, particularly after trauma
- detect complicated grief, new and developing mental health issues and suicide risk.

When supporting someone who has lost a person to suicide, adhere to the principles listed below.

- **Provide safe, culturally sensitive consultations**
 - Provide a safe, non-judgemental space where they can be listened to, talk about the death, including its emotional, cultural, and practical impacts.
 - Embed cultural humility into discussions (eg ask, rather than assume, how they and their family understand grief and death, and what kind of support would best help them).
 - Sensitively screen for significant distress, including suicidal ideation, while normalising a range of grief responses.
- **Support the use of other services and networks**
 - Help them stay connected to protective support, such as family, cultural and spiritual groups, peer networks, and community leaders.
 - Provide information about available support, such as local bereavement services, crisis support, multicultural services, and online communities.
- **Support families and children**
 - Provide guidance, monitor their wellbeing, and make early referrals where appropriate.
 - Offer support or referral pathways for social determinants such as housing and food security.

- **Consider their long-term needs**

- Offer regular follow-up appointments, acknowledging that their needs may change over time and distress may return.
- Assist their health maintenance (eg sleep, nutrition, chronic conditions, substance use, and stress-related physical symptoms).
- Be mindful that, while some people may report little or no reaction initially, grief responses may emerge weeks or months later, and patients can still benefit from support.

The therapeutic role of the GP

For many bereaved people, the GP relationship is one of the most protective interventions.²² Even brief check-ins have therapeutic value.

Practical action you can take

- Maintain a non-judgemental, compassionate presence
- Validate the person's grief and pace ('There's no right way or fixed timeline')
- Suggest coping strategies, including sleep, safety, support networks, and cultural needs and connections
- Provide practical guidance and connection to specialised services
- Schedule regular, gentle review appointments

Proactive contact

Proactive contact is an important element of postvention,²⁴ particularly because some people may not seek help due to shame, cultural beliefs, stigma, trauma, or a lack of awareness of available services and how they may help.

Proactive contact is usually made by a GP, peer worker, postvention coordinator, or community-based team. If the bereaved person is Aboriginal or Torres Strait Islander, do not make proactive contact before seeking guidance from an Aboriginal Health Worker, Elder, SEWB clinician, or someone known to the family.

Postvention frameworks (eg the Australian Institute for Suicide Research and Prevention Postvention Australia Guidelines, the StandBy Support After Suicide model and the National Suicide Prevention Strategy 2025–2035), emphasise that services must not passively wait for people to contact them, but instead offer gentle, timely, culturally safe contact that respects

the diversity of bereaved people. This means that proactive contact must always be ethical, culturally safe and trauma-informed.

Before contacting a bereaved person

To minimise the risk of causing distress, consider:

- the circumstances of the suicide, including any exposure to trauma
- the impact of the death on the bereaved person's community
- the relationship between the bereaved person and the deceased
- cultural, spiritual, or kinship protocols that may shape the person's communication preferences
- how familiar the bereaved person is with you and your practice.

Before contacting Aboriginal and Torres Strait Islander peoples who are bereaved

To provide culturally safe care, consider:

- Seek guidance from local ACCHOs or SEWB teams about cultural protocols
- Check whether naming the deceased is appropriate
- Listen to and follow family or community guidance
- Respect Sorry Business, which may temporarily limit the bereaved person's availability or affect the timing of your contact

When making contact

Ideally, gentle contact would be made by someone known by the deceased or the bereaved.

Depending on your relationship, you may consider writing a card expressing your condolences and an offer to support them through their bereavement.

When making contact:

- acknowledge the loss
- offer compassionate presence
- provide information and options, not pressure.

When contacting Aboriginal and Torres Strait Islander peoples who are bereaved

Ensure that the form and timing of your contact is culturally safe and considers the context of the death and bereavement.

Where appropriate, offer home visits, community-based contact, or yarning-style conversations, which may be more culturally appropriate.

Offering practical support

When talking to a bereaved person, offer as much practical support as possible. For example, you could:

- ask if they would like information about coronial and other formal processes
- explain how to access crisis or counselling supports
- talk about what they can expect during the period of early grief
- help them navigate health systems.

Connecting the bereaved person to appropriate services

Evidence shows that, when people are struggling with a suicide loss, timely connection with appropriate services can reduce isolation and strengthen safety²⁵ (eg reduce complex grieving, reduce likelihood of substance abuse, and reduce suicide risk). These services include:

- grief counselling
- peer support
- community-based support
- crisis services.

How to answer 'Why?'

Bereaved family members commonly ask, 'Why did this happen?', 'Why didn't I see the signs?' or 'Could I have done more?'

These questions often reflect deep distress, guilt, and a search for meaning, rather than a literal request for a definitive explanation.

For many survivors, asking 'Why?' can be an important part of their grieving process, and you can help by responding with compassion and honest answers about what can and cannot be known.

Sitting with the question rather than attempting to answer it

You may feel pressure to provide answers or 'fix' the unfixable, however, the goal is not to offer a complete explanation (which may not exist), but to make space for the bereaved person's pain.

To help make this space and let the bereaved person 'sit' with their questions, you could:

- acknowledge the impossibility of fully knowing the deceased person's inner world at the time of their death

- acknowledge that suicidal thinking is often driven by overwhelming psychological pain, emotional tunnel vision, or impaired judgement, rather than rational decision-making
- normalise their search for meaning, while gently reinforcing that you cannot provide a definitive answer.

A possible response

'I wish I had a simple answer. What I can say is that when someone is in emotional pain, their ability to see options or reach out can become very limited. It doesn't mean you missed something, or that you should have known.'

Responding to 'Could I have done more?'

Self-blame is common after suicide.²⁶ To help ease this feeling, you can:

- validate the survivor's feelings without reinforcing guilt
- emphasise that suicide is complex and can have many reasons behind it, and that families often do act with love and care, even if it doesn't feel that way afterwards
- reassure them that many warning signs are subtle or short-lived, and that sometimes there are no such signs.

A gentle way to frame this response could be:

'Many people ask themselves that. Often the signs are not easy to see, and even when something feels different, it can be challenging to understand what's going on or how best to help.'

Balance openness and confidentiality

If the deceased was a patient of yours, their family may seek detailed explanations from you about their medical history, such as their mental health before their death. However, as your confidentiality obligations remain after death, you must navigate this carefully.

Without breaching your obligations, you can:

- acknowledge the family's need for information and connection
- explain why confidentiality still matters and what can reasonably be shared
- respond with empathy and non-defensive openness within the limits of the law.

Providing grief education and support

Most people have never experienced suicide bereavement before, and many are unprepared for the intensity and range of emotions that follow. Providing gentle education about what grief can look and feel like helps survivors understand their reactions and can reduce their confusion, shame, and fear.

Monitoring a person's grief

GPs also have an important role in recognising whether a person's grief is progressing in a healthy, adaptive way or whether additional support or intervention may be needed. This requires a solid understanding of the different ways grief can present.

Grief responses

Grief responses vary widely between individuals and across different losses. Some people show only subtle outward signs of grief, while others experience profound emotional, cognitive, physical, or functional disruption. The intensity and duration of a person's grief can be influenced by many factors, including the nature of their relationship with the deceased, individual personality and coping style, age, health, spirituality and cultural identity, the support available to them, and whether the loss was sudden and unexpected or gradual and anticipated.

People experiencing suicide bereavement describe:

- shock
- anger, directed at the world or at times at the person who has died by suicide
- guilt and regret (eg 'Why didn't I notice something?', 'Why didn't I do something?', 'I did do something, but it didn't work – why not?')
- loss and loneliness
- fear
- anxiety and depression
- intrusive images
- dissociation
- feeling overwhelmed.

In addition, these feelings can be intermingled with relief, joy, peace and happiness, making the grieving process feel like a roller-coaster, particularly as these 'positive' emotions can also cause distress and guilt.

It is also not uncommon for people to dream of the deceased, half-look for them in crowds, sense their presence, or feel them watching out for them.

The grief process over time

In the early period of acute grief, the bereaved person's thoughts and feelings about the loss may feel constant and overwhelming.

However, over time, most people begin to move towards integrated grief, where the person who died is no longer at the centre of every thought, and can be remembered without the same level of acute distress. Sadness and longing may remain, and the deceased person may still be easily called to mind, but the grief becomes more manageable. This shift commonly begins a few months after the death.

Even when grief is fully integrated, people do not 'get over' the loss: the connection remains, and they can experience feelings of sadness and of missing the person for the rest of their life.

Providing practical support

When someone loses a loved one to suicide, you may be one of their first and most trusted points of contact. Your role can extend well beyond clinical care and may include emotional, practical and procedural support. For example, you can:

Provide immediate emotional and clinical support

- Offer compassionate, non-judgemental space for the bereaved person to talk about what happened and how they are coping
- Assess them for acute distress, including suicidal thoughts, self-harm risk, substance use, or symptoms of complicated or traumatic grief
- Create a safety plan if needed
- Arrange follow-up appointments proactively rather than waiting for the patient to book

Facilitate access to mental health services

- Prepare a Mental Health Treatment Plan
- Refer to psychologists or grief counsellors
- Refer to specialised suicide-bereavement services, such as postvention programs, support groups or trauma-informed clinicians
- Provide information about helplines, peer groups, and community resources

Assist with coronial matters

Because reading a coronial report can trigger trauma and guilt, sensitive support from you can help to reduce confusion, fear and rumination.

- Explain the purpose of a coronial investigation
- Advise them that the report may cause harm and/or re-traumatise them, receive consent to proceed
- Help them read and understand the coroner's report
- Clarify the coroner's findings in plain language
- Support them emotionally if reports are distressing
- Encourage them to ask questions and to take time to process the information in the report

Provide documentation

- Medical certificates
- Letters for employers, schools, and insurance companies
- Reports explaining the mental health history of the deceased (if appropriate and legally permitted)

If working in a rural or remote area

If you are working in a rural or remote area, you may also need to:

- identify the deceased, if no other local authorised person is available
- confirm the death, if emergency services are limited or distant
- communicate with police and other first responders
- notify or liaise with the coroner's office, if there are no local coronial staff.

Providing culturally safe support

Grief is a universal human experience, but the ways people understand, express and cope with loss are profoundly shaped by culture. Cultural identity influences beliefs about death, acceptable emotional expression, family roles, spiritual practices and help-seeking behaviours.

Some people from other cultures, and Aboriginal and Torres Strait Islander peoples, may not use the word suicide. This is due to factors including stigma, as suicide is still criminalised in some countries. They may use other words for suicide or speak indirectly about suicide. It is important to note that this is not avoidance, and for many people indirect language is the only safe way they know how to talk about suicide. In these cases, simply listen to the words the person uses and follow their lead when providing support.

Additionally, western models of grief do not fully capture the collective, cultural and ongoing nature of grief as it is experienced by many Aboriginal and Torres Strait Islander peoples, for whom grief is shaped by

cultural identity, kinship responsibilities, connection to Country, spirituality and community obligations. Sorry Business involves cultural, spiritual and community governance processes, including extended mourning, ceremony and collective decision-making. These practices are central to healing and wellbeing, and clinical systems need to adapt to them, rather than expecting cultural obligations to fit western models.

Because each person's cultural identity is shaped by race, language, gender roles, religion, migration and community ties, best practice involves approaching grief with cultural humility: asking, not assuming, and recognising that cultural variations are unique and deeply personal.

Avoid assumptions

- Avoid making assumptions about your patient's cultural identity or practices: ask respectfully what is important to them and who they want involved
- Invite them to guide you as to how their cultural practices, rituals and community supports need to be acknowledged or incorporated

Providing culturally safe support to Aboriginal and Torres Strait Islander peoples

Understand that cultural safety is determined by Aboriginal and Torres Strait Islander peoples themselves and is shaped by relationships, power, trust and systems, not solely by a person's clinically observed behaviour.

To do this, ask:

- 'Are there cultural or community practices you would like me to be aware of?'
- 'Would you like support from your ACCHO, SEWB team, Elders, or Aboriginal Health Worker?'
- 'Is there anyone from your community you would like present when we talk about this?'

Supporting cultural connection is an important protective factor in recovery and postvention.

Providing culturally safe support to people from other cultures

Adopt cultural humility

Ask questions that align with recommendations that emphasise cultural humility in grief care. For example:

- 'Are there any cultural or spiritual practices that are important for you in this time of grief?'

- 'How does your family or community usually support someone after a loss?'
- 'Is there anything you would like me to understand about the way you grieve?'

Ask about their preferred type of support

- 'Would you prefer support that involves family, community leaders, or would you prefer a private individual approach?'

Ask about their cultural rituals

Invite your bereaved patient to talk about any rituals that support their coping (eg lighting candles, making offerings to ancestors, gatherings such as funerals, memorials and wakes). Acknowledging and talking about these rituals can foster resilience and help your patient make meaning of their loss. You can ask:

- 'Are there any rituals that are important to you and your community?'
- 'Are there any rituals that are important to you that you'd like to do today?'

Maintain a list of culturally responsive referral options

Develop and maintain a local list of:

- culturally specific grief services
- multicultural mental-health practitioners
- community leaders or faith-based supports.

Grief and mental health disorders

The symptoms of grief, such as low mood, sleep disturbance, difficulty concentrating, or withdrawal from others can resemble those of mental health disorders, such as depression, anxiety and post-traumatic stress. Grief can also sometimes contribute to the development of these mental health disorders.

For these reasons, it's important to focus on the bereaved person and their lived experience of grief and mourning, rather than assuming their responses indicate a clinical diagnosis.

Grief is a natural, adaptive process, and while it can be intense and prolonged (especially after suicide loss), it should be understood within the context of the person's relationship, circumstances and meaning-making.

The following table summarises the symptoms of complicated grief, and the symptoms of other mental health disorders.

Disorder	Symptoms
Complicated grief²⁷ About 10% of bereaved people experience complicated grief²⁸ (also referred to as prolonged grief disorder and persistent complex bereavement-related disorder). This is a syndrome of prolonged (eg well beyond six months) or intense grief, resulting from a failure to transition from acute to integrated grief. Complicated grief is associated with substantial impairment in work, health and social functioning.	• Difficulty accepting the death • Separation distress (recurrent pangs of painful emotions with intense longing for, and preoccupation with, the deceased, and over-involvement in activities related to the deceased) • Traumatic distress (eg disbelief, anger and bitterness, pronounced avoidance of reminders of the loss)
Depression²⁹ Grief and depression share some of the same symptoms (low mood, sadness and social withdrawal), making clinical depression sometimes difficult to diagnose in the context of bereavement.	• Mood and ideation are almost constantly negative • Difficulty in experiencing positive feelings • Recognisable and stable cluster of debilitating symptoms • Feelings of worthlessness and self-loathing
Post-traumatic stress disorder³⁰ Approximately one-third of PTSD presentations are the result of 'interpersonal-network traumatic experiences', which include the death of a loved one. Most bereaved people will have an emotional reaction when remembering or thinking about the suicide, however those with PTSD will experience marked cognitive, affective and behavioural responses, which lead to considerable social, occupational and interpersonal dysfunction.	• Intrusive thoughts • Nightmares and flashbacks of past traumatic events • Avoidance of reminders of trauma • Hypervigilance • Sleep disturbance
Suicidal thoughts in bereaved patients³¹ Although it is appropriate to have a case-finding approach to suicidal thoughts and behaviour in bereaved patients, there is no data to show that the use of a diagnostic screening tool alone in primary care reduces mortality. Additionally, it is difficult to accurately predict which patients with suicidal thoughts will go on to attempt suicide. Assessing suicide risk involves direct and unambiguous questioning about suicide ideation, planning, and intent. Although some patients may be reluctant to mention their thoughts of suicide, someone with suicidal ideation will generally tell their clinician about such thoughts when asked.	• passive thoughts of death (eg 'I wish I wouldn't wake up' or 'life is not worth living') • active thoughts of harming themselves or ending their life • thinking about methods, plans, or timing of suicide • feelings of hopelessness, helplessness or being trapped • perceptions of being a burden to others • intense emotional pain, distress, or inability to cope • withdrawal from family, friends, or usual supports • increased use of alcohol or other substances • sudden changes in mood (including unexpected calmness after distress) • giving away possessions, settling affairs, or saying goodbye • reduced concern for personal safety or engaging in risk-taking behaviour

Impacts of patient suicide on GPs

Losing a patient to suicide is a profoundly distressing and often life-altering experience for a general practitioner, and yet it is not uncommon: one study suggests that 85% of people who died by suicide were in recent contact with their GP³².

Common emotional responses and professional stressors

Following a patient's suicide, you may experience a mix of shock, grief, guilt, anger or self-doubt. It is common to replay clinical encounters with the deceased, question your decisions, and search for answers to 'Why?'. Although this is a normal response, it can become distressing if it turns into persistent self-blame.

Suicide bereavement can be exacerbated by fears about responsibility for the death, and fears of professional judgement and scrutiny from families, colleagues and the wider community. This is particularly the case in rural and remote settings where GPs are highly visible.

In addition, confidentiality constraints can make it hard to seek support, and this can lead to isolation.

As you may also experience additional stress relating to procedural and medico-legal stress (eg contact with the coroner), it is strongly advised that you seek early guidance from your professional indemnity insurer.

Barriers to seeking help after a patient's suicide

Many GPs who have had a patient die from suicide feel unable to talk about their experience, even to close colleagues.³³ Typically, this is because they:

- are worried about being judged or seen as incompetent
- are worried about breaching confidentiality
- are worried about medico-legal consequences
- feel responsible and therefore undeserving of support
- feel they must remain 'professional' and emotionally unaffected.

How patient suicide can influence clinical practice

After a patient dies from suicide, it is common for their GP to:

- feel less confident during mental health consultations, and consequently:
 - experience increased anxiety, particularly about assessing suicidal risk
 - fear that they may miss warning signs in other patients
 - avoid high-risk presentations
 - over-service patients with mental health conditions
- become more cautious or hypervigilant about likelihood of other patients to attempt suicide
- lower their thresholds for referrals
- provide more intensive follow-ups.

These reactions are understandable, but are often temporary, and generally diminish with support, reflection, and supervision.

Available support services

Suicide bereavement in a professional context is different from personal grief, and it can feel harder to receive an appropriate level of support. If you have lost a patient to suicide, you may benefit from specialised, confidential support services, such as those listed below.

Confidential services

- drs4drs
- Professional services provided by a psychologist or your own GP
- RACGP members can contact the RACGP GP Support Program (1300 361 008)
- Australian College of Rural and Remote Medicine (ACRRM) members can contact their Confidential Member Support line (1800 818 728)
- Doctors' Health Advisory Services
- State-based Doctors' Health Programs
- Other Employee Assistance Programs (EAP)
- CRANApplus Bush Support Service for rural and remote GPs (1800 805 391)
- Lifeline
- StandBy Support After Suicide

Professional supervision and/or groups

- Professional supervision
- Balint Groups
- RACGP case base discussions groups
- Australian Society for Psychological Medicine (ASPM) peer reflection groups
- GPMHSC mentorship program
- Black Dog Institute groups for health professionals

Peer support

- Talking with peers who have also lost a patient can reduce feelings of isolation and shame.
- Confidential peer support provided by medical colleges and GP networks can help normalise your experience.
- Talking to other people in your practice team who worked with that patient (they may not have the same confidentiality constraints).

GPs in rural and remote settings

If you're working in a small community, you may have additional burdens that can intensify your distress and limit your opportunities for privacy and support. These burdens include:

- identifying the deceased
- confirming the death when emergency services are limited
- communicating with police or the coroner
- supporting multiple bereaved people across one or more families and communities
- being personally connected to the patient.

In these situations, adopt some of the GP self-care and wellbeing strategies listed below.

GP self-care and wellbeing

- Acknowledge the impact on yourself (that losing a patient to suicide can evoke shock, sadness, guilt or self-doubt), and that your reactions and emotions are real, valid and common
- Seek support early, even if you feel uncertain about whether you need it or not:
 - Find out what support services your workplace has available to you
 - Where possible, access peer support, professional supervision, medico-legal advice, or confidential

counselling (eg doctor health services, EAPs), even if this requires telehealth or out-of-area options

- Engage in regular supervision or check-ins with others
- Give yourself time and space:
 - Ensure you take adequate rest and breaks
 - Reduce your workload, and/or reduce the number of patients who are high-risk
- Limit self-blame by recognising the complexity of suicide
- Practise grounding and stress-management strategies
- Maintain your boundaries in the community. Where informal contact is common, be mindful of your limits around availability and emotional labour and allow yourself time away if needed
- Remember that reflecting on the experience over time can contribute to deeper empathy, clinical insight and resilience, even though this growth does not negate the loss
- Attend to professional obligations as soon as practicable (eg coronial processes, clinical documentation, and risk-management), and seek advice if you are unsure of the correct processes

If the death involves Aboriginal and Torres Strait Islander people, defer leadership to Aboriginal Community Controlled Health Organisations (ACCHOs), SEWB teams, Elders or community-nominated leaders, and adopt a supportive, collaborative role rather than independently coordinating community responses.

If you are also a suicide loss survivor

If you have experienced suicide bereavement at any time in your personal life, the emotional impact of losing a patient may be amplified when a patient dies by suicide.

In these cases, consider the following actions, all of which can be beneficial:

- Personal grief support services
- Time away from work
- Peer support from clinicians with lived experience
- Adjustments to your workload

Best practice is to extend to yourself the same compassion you extend to your patients.

Supporting other staff at the clinic

When a clinic's patient dies by suicide, the impact can be felt across the whole practice, including GPs, nurses, reception staff, practice managers and allied health professionals. They may all experience shock, grief, guilt or anxiety, even if their contact with the patient was brief. Early acknowledgement of this impact helps reduce their sense of isolation and distress.

To provide practical help to staff:

- hold a timely, optional staff check-in to connect with others
- communicate clearly and openly
- acknowledge the loss
- remind yourself and your team that suicide is complex and influenced by many factors that are beyond the scope of clinical care
- normalise a range of emotional responses: remind yourself and others that people will have different coping styles, and that these need to be respected
- remind staff about what they can say to other patients to reduce uncertainty and fear (and what they shouldn't talk about)
- encourage staff to take care of themselves and to watch for signs of distress in each other
- encourage staff to access support such as employee assistance programs, peer support, or external counselling if needed
- consider the circumstances of the person you are speaking to before sharing specific details of the death. Vulnerable people may be adversely impacted by this information.

Legal and administrative considerations

When a patient dies by suicide, their GP can face a range of legal, administrative and confidentiality issues. Understanding and implementing your obligations and relevant legal processes can help support the bereaved family and ensure your compliance with relevant legislation.

Confidentiality and access to records

Confidentiality continues after a patient's death. State and territory health records legislation covers the confidentiality of a deceased person's health information typically for up to 30 years after death. During this time:

- rights to access the health record are held by the deceased person's legal representative (their executor or administrator of the estate)
- health services must continue to protect the patient's privacy and only disclose information in accordance with legislation
- before sharing any details, GPs must verify who is legally entitled to obtain that information.

Always identify and adhere to legal obligations that determine what you can and cannot discuss with families and other parties.

If you are asked to share or disclose information about a deceased person

1. Identify the requester (eg family member, next of kin, executor, police, coroner, or person from another agency).
2. Confirm the requester's legal authority: only the legal representative has rights of access unless disclosure is otherwise required by law.
3. Identify what information you can share with this person or agency: consider the purpose of the request, the sensitivity of the information, and whether it is a legally permitted disclosure.
4. Document your decisions clearly, including your rationale and any advice you sought.

You may also refer to:

- medico-legal guidance from your Medical Defence Organisation (MDO)

- the Office of the Australian Information Commissioner Guide to Health Privacy (2025) for relevant federal privacy principles (keep in mind that its primary focus is on the privacy of living people).

Coronial processes

Sudden, unexpected, or violent deaths, including suspected suicide, must be reported to the coroner. You may be required to:

- provide clinical records or statements
- clarify the patient's history, treatment, or risk factors
- assist with information that supports the coronial investigation.

It is important to tell families that coronial investigations are standard practice when a suicide occurs and that the investigation may take some time. You can offer support by explaining the general process while meeting confidentiality obligations.

Working with families and community

Family members seeking clarity, reassurance, or access to information after a suicide may experience distress because of coronial timelines, police involvement, or administrative formalities. As a result, they may:

- ask you for detailed explanations of the deceased person's care
- pressure you to disclose information that you are not legally permitted to disclose.

To support families, you can:

- acknowledge their need for information and provide general explanations of processes
- clearly explain your legal and confidentiality obligations
- offer emotional support without breaching privacy
- direct them to coronial support services, bereavement programs, or community resources.

At times, you may be constrained by legal responsibilities that mean you are unable to answer all of the family's questions. Providing clear, compassionate explanations of these limits can help families understand the boundaries while still feeling supported.

Other legal and administrative considerations

- Families of patients who have died by suicide can raise concerns about a GP's care to Ahpra. As a GP, you can also contact Ahpra to discuss what happens in this situation.
- Police who are investigating the circumstances of a suicide and acting on behalf of the coroner can call you or arrive at your practice or home at any time (including to inform you of the death).
- Lawyers can contact you regarding a deceased patient's estate.
- You may receive requests from third parties, such as insurance companies, WorkSafe and Transport Accident Commission.
- You may receive a notice to complete medical certificates or other documentation for the coroner.

If you find yourself in any of these situations, contact your Medical Defence Organisation for more information.

Resources

Suicide bereavement and postvention resources

- Roses in the Ocean: Lived experience helpline and online resource hub <https://rosesintheocean.com.au>
- SafeSide Prevention: Suicide prevention education, consultation and evaluation <https://safesideprevention.com.au>
- StandBy: Support for those bereaved or impacted by suicide <https://standbysupport.com.au>
- Postvention Australia: Helping people bereaved by suicide <https://postventionaustralia.org>
- Life in Mind: Knowledge exchange portal for suicide prevention data, policy and resources <https://lifeinmind.org.au>
- Beyond Blue: 24-hour mental health counselling, coaching, and peer support programs www.beyondblue.org.au
- Suicide Prevention Australia: Member directory www.suicidepreventionaust.org/member-directory
- headspace: *Suicide Postvention Toolkit – A guide for secondary schools* www.headspace.org.au/assets/School-Support/Compressed-Postvention-Toolkit-May-2012-FA2-LR.pdf

- Support After Suicide: Counselling, support groups and resources for those bereaved by suicide www.supportaftersuicide.org.au
- Lifeline: 24-hour crisis support and suicide prevention services www.lifeline.org.au
- Mindframe: Safe and sensitive media reporting and public communication about suicide, mental health concerns and alcohol and other drugs <https://mindframe.org.au/suicide/communicating-about-suicide>

Specific populations

- Australian Institute of Male Health & Studies: Fact sheet on factors contributing to male suicide and prevention www.aimhs.com.au/cms/uploads/AIMHS%20Suicide%20Fact%20Sheet.pdf
- Life in Mind: Conversations matter – resources for discussing suicide <https://lifeinmind.org.au/conversationsmatter>
- Roses in the Ocean: Peer CARE Companion Warmline – call-back peer support service for people with lived experience of suicide <https://rosesintheocean.com.au/peer-care-companion-warmline>

Aboriginal and Torres Strait Islander peoples

Where available, Aboriginal-led services should be prioritised as the first point of contact, with mainstream services providing complementary support, as guided by the person or community.

- RACGP/NACCHO: *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
- Gayaa Dhuwi (Proud Spirit) Australia: Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention www.gayaadhuwi.org.au
- The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention: Evidence-based suicide prevention practice that empowers individuals, families and communities and respects their culture <https://cbpatsisp.com.au>
- Life in Mind: Aboriginal and Torres Strait Islander communities – data, resources and cultural context to support suicide prevention <https://lifeinmind.org.au/suicide-prevention/priority-populations/>

aboriginal-and-torres-strait-islander-communities

- BLKTRX: Service directory (Victoria) – mobile-friendly access to culturally safe SEWB services <https://blktrx.org.au/>
- Healing Foundation: Provides a platform to amplify the voices and lived experience of Stolen Generations survivors and their families <https://healingfoundation.org.au>
- 13YARN: 24-hour crisis support to yarn without judgement and provide a confidential, culturally safe space www.13yarn.org.au
- NACCHO (ACCHOs): Directory of 148 members, running Aboriginal Community Controlled Health Organisations (ACCHOs) across urban, regional, and remote locations www.naccho.org.au

LGBTQIA+ people

- LGBTQI+ Health Australia: Directory of LGBTQI+ community-controlled health organisations https://www.lgbtiqhealth.org.au/member_directory
- QLife: Free and anonymous peer support for LGBTQI+ people and their loved ones <https://qlife.org.au>
- ACON: Community health, inclusion and HIV resources for people of diverse sexualities and gender www.acon.org.au
- TransHub: Digital resource hub for trans people, their loved ones, allies and clinicians www.transhub.org.au
- Intersex Human Rights Australia: Support, education and policy development <https://equalityaustralia.org.au/take-action/campaigns/intersex-human-rights/>
- Switchboard: Peer support groups for LGBTQIA+ people bereaved by suicide www.switchboard.org.au/lgbtiqa-bereavement-groups
- Switchboard: Preliminary findings to inform LGBTQIA+ suicide postvention planning <https://static1.squarespace.com/static/5f522c8128fa4e54ec5106d3/t/6029e205e0381e3ad457c192/1613357580444/Switchboard+LGBTIQA%2B+Postvention+Final+Launch.pdf>

Children and young people

- Kids Helpline: 24-hour counselling, peer support and resources for children and young people <https://kidshelpline.com.au>
- headspace: Mental health and wellbeing support for young people, including online services and community-based care <https://headspace.org.au>

- ReachOut: Online mental health support and resources for young people, parents, carers and schools www.reachout.com
- Emerging Minds: Online programs and resources to support the mental health of infants, children and families <https://emergingminds.com.au>

Resources for GPs who have lost a patient to suicide

- StandBy: Support and resources for people and communities bereaved or impacted by suicide <https://standbysupport.com.au>
- Drs4Drs: Wellbeing support, advice and referral services for doctors and medical students www.drs4drs.com.au
- RACGP: The GP Support Program – 24-hour wellbeing support, counselling and resources for members www.racgp.org.au/running-a-practice/practice-management/gp-wellbeing/the-gp-support-program
- ACRRM: 24-hour wellbeing support and counselling for members www.acrrm.org.au/support/wellbeing
- Doctors' Health Advisory Services: State and territory-based health and wellbeing support services for doctors (search online for your local service)
- Drs4Drs: Directory of doctors' health services, mental health support and wellbeing resources across Australia www.drs4drs.com.au/getting-help
- CRANaplus: Bush Support Line – 24-hour counselling support for rural and remote health workers, students and their families www.crana.org.au/mental-health-wellbeing/bush-support-line
- Suicide Call Back Service: 24-hour telephone, video and online counselling for those experiencing suicidal thoughts, people bereaved by suicide and health professionals www.suicidecallbackservice.org.au
- SANE: Support and resources for people with complex mental health issues, their families and communities www.sane.org

Mental health training resources

- RACGP: *Mental health: A guide for GPs* – resource to support GPs in using e-mental health interventions with patients www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Mental%20health/e-mentalhealth-guide.pdf
- GPMHSC: Accredited mental health training and education <https://gpmhsc.org.au/infosection/index/78cb509e-c80e-441d-ac4b-82b414ba2c44/gp-mental-health-training-and-education>
- RACGP Early assessment for safety and learning www.racgp.org.au/education/registrars/fellowship-pathways/policy-framework/program-handbooks-and-guidance-documents/progressive-assessment-and-wba/wba-tools/early-assessment-for-safety-and-learning-easl
- LivingWorks: Suicide prevention training for workplaces and communities <https://livingworks.com.au>

Mental disorders resources

- Department of Veterans' Affairs: GP summary on complicated grief, <https://at-ease.dva.gov.au/professionals/client-resources/summary-advice-gps-complicated-grief>
- Open Arms: Treating complicated grief www.openarms.gov.au/health-professionals/assessment-and-treatment/treating-complicated-grief
- Phoenix Australia: Clinical guidelines for acute stress disorder, PTSD and complex PTSD <http://phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-ASD-PTSD-Guidelines.pdf>

Legal and administration considerations

- Australian Medical Association: *Ethical Guidelines for Doctors on Disclosing Medical Records to Third Parties* https://ama.com.au/sites/default/files/documents/Ethical_Guidelines_for_Doctors_on_Disclosing_Medical_Records_to_Third_Parties_2010_Revised_2015.pdf
- MDA National: Guidance on creating, managing, storing and accessing patient medical records [www.mdanational.com.au/~media/Files/MDAN-Corp/Medico-Legal/Medical-Records.pdf?la=en](http://mdanational.com.au/~media/Files/MDAN-Corp/Medico-Legal/Medical-Records.pdf?la=en)

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