The Victorian Section of the College of Clinical Psychologists, Australian Psychological Society, appreciates the opportunity to make this submission to the Senate Community Affairs Reference Committee Inquiry into Suicide in Australia. We also wish to acknowledge the contributions of Professor Nicholas Allen, Mr Jeffrey Kelly and Ms Anne Graham to this submission.

The College applauds the Senate on its decision to enquire into such an important and under-resourced area. This submission will comment in relation to the following terms of reference:

c. the appropriate role and effectiveness of agencies, such as, police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;
d. the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;
e. the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;
f. the role of targeted programs and services that address the particular circumstances of high-risk groups;
g. the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy;
h. the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

Specifically, in this submission we wish to address the following issues: (1) *Service Provision* for individuals at risk of suicide, (2) issues relevant to management of *Borderline Personality Disorder*, a complex mental disorder with a particularly high risk of suicide that presents significant challenges for management by a variety of community services, and (3) the most critical issues requiring *Research* in the future. Throughout the submission we wish to highlight the critical role that clinical psychologists can play in a national response to these challenges.

Preamble

Clinical psychologists are well placed to meet the challenges of providing treatment to those individuals most at risk of suicide. Clinical Psychologists with specialist postgraduate masters or doctoral training have the necessary qualifications, training and expertise to make a real difference to individuals at risk of suicide by providing treatment for individuals with major psychiatric disorders, particularly those with more complex presentations, and in guiding the provision of suicide prevention through quality research. Clinical Psychologists are able to provide effective, evidence-based treatments for some of the key risk factors for suicide, such as mental illness and substance abuse. The complexities of suicide require a thorough and thoughtful assessment of risk factors, the management of that risk in the acute phase, as well as the linking of

the suicidal individual with follow-up treatment services and the provision of effective treatments once the crisis has passed.

While the College supports the importance of the need to de-stigmatise community attitudes to suicide and mental illness, as outlined in the National Suicide Prevention Strategy (NSPS), we are concerned that removing the emphasis on assessment and treatment for people with a mental illness may increase the risk of further stigmatising and neglecting this group.

Contemporary theories of suicide emphasise that an individual is at risk of a suicidal act when they have both the desire and the capacity to do so (Joiner, 2005). Prevention or treatment of suicide therefore must address at least one of these risk factors. In terms of suicidal desire, research has particularly identified four psychological themes that place individuals at high risk of suicidal acts; (1) unlovability/lack of belongingness ("Nobody cares about me", "I don't belong"), (2) perceived burdensomeness to others ("Others would be better off without me"), (3) helplessness ("Suicide is the only option to solve my problems"), and (4) poor distress tolerance ("I can't stand this pain any more") (Joiner, 2005; Rudd, Joiner & Rajab, 2001). Such suicidal desire is not sufficient to result in death by suicide however, the person must also have the capacity to enact lethal self harm.

Many of the most effective public health interventions (e.g., changes to analgesic packaging, mental health crisis teams) deal with reducing the capacity to enact lethal self harm either by reducing the availability to means, or by limiting the person's capacity to act during a period of high risk (e.g., by admission to a psychiatric facility). However, interventions that address the individual's level of suicidal desire are also critical, and here addressing mental health is preeminent given the close association between poor mental health and suicidal desire, a link that has recently been reinforced by a large cross national study (Nock et al., 2009). In terms of addressing suicidal desire and the cognitive themes that accompany it, psychological interventions have proved to be amongst the most effective methods of working with acutely suicidal people. For example, Vitiello and colleagues (2009) have recently described a treatment program for adolescent suicide attempters that has shown that when such individuals are vigorously treated with a combination of antidepressant medication and cognitive behaviour therapy suicidal adolescents can have outcomes that are comparable with those on non-suicidal adolescents suffering from major depression. Other cognitive behavioural models for treatment of suicidal individuals are also being developed and have shown good feasibility and acceptability (Stanley et al., 2009). Indeed a recent meta-analysis that pooled data across a number of studies has found that both cognitive behavioural and dialectical behavioural approaches to the reduction of suicidal behaviour are effective (Tarrier, Taylor, & Gooding, 2008).

Bateman and Fonagy (2008) found a psychodynamic mentalization-based therapy with partial hospitalisation was effective in reducing suicidality in patients with borderline personality disorder and that this effect continued during a five year follow-up. There was no difference in health service utilization

costs between this group and the 'treatment as usual' comparison group, the costs of partial hospitalisation being offset by less psychiatric inpatient care and reduced presentations to emergency departments. In an 18 month follow-up period there was a trend for costs to decrease in the mentalization-based treatment group but not in the comparison group (Bateman & Fonagy, 2003).

Suicide prevention programs (i.e., those that attempt to prevent suicidal behaviour before it occurs, as opposed to treating individuals who are acutely suicidal) have had variable outcomes, with universal prevention programs (i.e., those targeted at entire populations) having an especially disappointing record (Miller et al., 2009). A systematic review of suicide prevention strategies found that while physician education to improve recognition of depression and programs that reduce access to lethal means were effective in reducing rates of suicide, evidence for the effectiveness of other types of programs was still lacking (Mann et al., 2005).

Issues in Service Provision

As indicated above suicide risk in the context of mental health problems frequently requires a psychotherapeutic as well as a crisis intervention response. However there are a number of barriers to this, including the fact that at present psychotherapeutic intervention is not readily available in many clinical settings, especially in crisis services such as Emergency Departments and psychiatric Crisis Assessment and Treatment Teams (CATT), and the fact that many of those who present in suicidal crisis, or after self-harm/attempted suicide, do not attend follow-up appointments or engage with ongoing therapy or treatment. Additional issues inclide the following:

> 1. The first contact with a mental health service or clinician influences client/patient engagement with future therapy or treatment.

As well as performing an assessment function, the initial contact with health professionals should have a therapeutic element, or at least demonstrate that a helpful working alliance is possible. Michel and colleagues (2002) argued that when a patient presents at an Emergency Department after a suicide attempt there is too much emphasis on observable diagnostic criteria and risk assessment (although these are necessary), at the expense of empathy and trying to understand and share in the person's inner experience. Perseverance in psychotherapy and other treatments is based on a good working alliance with the therapist. So the early contact with the client needs to convey a sense of being understood (or at least that the clinician is listening) and to show clients that professional help involves empathy for their distress.

> 2. Beyond first contact, therapeutic services need to develop specific approaches to issues of non-engagement with services (Comtois & Linehan, 2006).

Due to hopelessness and pessimism, high risk patients may withdraw from or reject treatment. Also due to complex reactions of shame, humiliation, self-condemnation and expectations of being condemned by others, many people seek to minimise the extent or seriousness of their suicidal crisis. There is an impulse to say 'it wasn't really serious and I'm fine now' as a way of reducing shame and restoring self-respect. Effective referral processes and treatment programs will need to take into account these aspects of the client's inner experience.

3. Suicide prevention training and support for clinicians and community workers should include consideration of the client's reactions to their own suicidal crisis, and clinicians' responses to suicidal clients.

Clients/patients presenting in suicidal crisis or after suicidal actions are often struggling with feelings of shame, humiliation and helplessness. They may judge themselves harshly and expect others to judge them harshly. In response to these complex emotions the client may be defensively angry and uncommunicative. The person who has made a suicide attempt is both a victim and a perpetrator of a violent attack. In struggling to respond to this complexity the staff may respond to the perpetrator with condemnation or alternatively may respond with sympathy to the victim (McGinley & Rimmer, 1992). Either of these responses involves an unrealistic simplification.

The person who has attempted suicide can be unwelcome in busy Hospital Emergency Departments. Michel et al (2002, p.426) noted that health professionals are challenged by suicidal patients, a proportion of whom are 'suspicious and unwilling to accept help; frightened and oppositional, many are provocatively hostile'. The patients' self-inflicted wounds can be confronting. Maltsberger & Buie (1974) long ago suggested that staff aversion is based in the suicide attempt being experienced as an insult to staff's deeply felt aspirations to heal.

It is important that training and support programs help clinicians/hospital staff to recognise, reflect on and reach an understanding of the complex responses of both patients and clinicians. It is only through this understanding that clinicians will be able to meet the client with empathy and listen while maintaining clarity of thought.

4. The need for more support for families with a suicidal family member

Families can feel very unsupported especially where a Crisis team or Emergency Department has determined that a hospital admission for a suicidal family member is not warranted or not advisable. In some instances an older adolescent or young adult is left alone to support a parent who is struggling with suicidal thoughts. Not only is this extremely difficult and distressing but the apparent dismissal of the parent's struggle can lead the young person to lose trust in and become alienated from services. Where an admission is not considered necessary or advisable other support or intervention should be made available. (Having said this, the issue of the role of family members is a complex one. In

some instances the person in suicidal crisis does not want their family member(s) to be involved, a stance which needs to be respected but also explored. In this instance however family members may still require support, separate from the support or intervention provided to the suicidal family member.)

Borderline Personality Disorder

The mental disorder of Borderline Personality (BPD) disorder has a close association with suicide risk, and presents specific management difficulties for mental health, policing, medical and community services. According to the Diagnostic Statistical Manual of Mental Disorders-IV-TR (American Psychiatric Association, 2000), BPD is diagnosed when there is a persistent pattern of unstable interpersonal relationships, mood and self-image, as well as distinct impulsive behaviours, including self-harm and suicide attempts, beginning by early adulthood and present in a variety of contexts. It is a chronic, severe, and for some, lethal condition which is difficult to treat.

It is estimated that up to 80% of individuals with BPD attempt suicide (Linehan et al; 2006) and that 10% die from suicide (Paris, 2002). It is estimated that 2% of the general population experience BPD and that approximately 75% of these are women (men are more likely to be diagnosed with other disorders).

The NSPS notes BPD as a particular challenge and notes that an effective treatment is available, in Dialectical Behaviour Therapy (DBT). DBT is a well-researched and effective treatment for BPD, in particular, it is effective in reducing self-harm and suicidal behaviour (Linehan et al; 2006). Unfortunately, it is less effective in helping people deal with some of the factors that drive their risk behaviours such as their unstable moods and quality of life. Other treatments such as Acceptance and Commitment Therapy are showing promising results but require further research and evaluation. More traditional types of psychotherapy aimed at addressing childhood trauma remain important in treating this client group. DBT acknowledges the need to provide psychotherapy for childhood trauma and recommends referral of clients with BPD for trauma-focused psychotherapy once life-threatening behaviours are under control.

Victoria is uniquely served in Australia by a specialist Personality Disorder Service called Spectrum. Spectrum provides treatment for individuals with BPD as well as training programs, secondary consultation and supervision for staff of Public Mental Health Services throughout the state. Until the late 1990s this patient group was excluded from Public Mental Health Services. Therefore the following recommendations are made in relation to this patient group:

- Extending the role of services similar to Spectrum to other states in Australia should be investigated.
- Greater access to effective treatments, including but not limited to DBT.
- Experienced highly trained clinicians are required as this population can be one of the most challenging populations to work with. There is a need

to contain your own anxieties, for ongoing supervision and for secondary consultation.

- People with BPD present a unique challenge to clinicians in that their self-harm and suicide attempts are usually, but not always, an attempt to manage unbearable distress.
- For people with BPD suicide risk is chronic rather than episodic, as occurs for people with Depression or Schizophrenia.
- Highly trained clinicians are required to provide risk assessment and management in Crisis Assessment and Treatment Teams (CATT's) and Emergency Departments, and inpatient wards.
- Specialist treatments available to individuals with BPD including support and clinical interventions at times of risk and for psychotherapy once the crisis has passed.

Research

A large proportion of research into suicide (in Australia and internationally) is epidemiological research looking at rates of suicide or self-harm and identifying associated risk factors. While this research is of undoubted value, we also need research that focuses on a range of other issues and questions, often requiring different types of research methodologies.

1. We need more research into help-seeking. While mental health literacy/education, cultural/sub-cultural factors and previous experiences with health services are all relevant, clinical experience suggests there are also specific aspects of the suicidal pathway or suicidal state that may impede help-seeking. These may include hopelessness, feelings of humiliation, cognitive constriction or narrowing of attentional focus, and/or a sense of compulsion to move toward suicide. We need to understand more about these experiences and how to facilitate help-seeking before the person has moved too far down the pathway to suicide.

2. We need more research into engagement with services and effective referral processes and the experiences that underlie non-attendance at follow-up and premature withdrawal from therapy/treatment. There is a need for research into what constitutes an effective referral process. There is very little research into referral processes in general. In the context of suicide prevention this is significant given that a large proportion of clients/patients do not attend follow-up appointments or accept recommendations for therapy/ treatment after initial presentation for suicidal crisis (Dulit, 1995; van Heeringen et al, 1995). Research is needed to elucidate which elements or aspects of the referral process are effective in assisting people to engage with therapeutic interventions.

3. There is a need further research into the efficacy or effectiveness of interventions for suicidality.

a) Many randomised controlled trials investigating psychotherapeutic interventions and/or medication for a range of mental health problems (e.g. depression) exclude from the study people with suicidal thoughts or a history of self-harming. This is done for reasons of risk and safety. However it means we often do not know how the evaluated interventions work in the context of suicidality.

b) There is a need for further research specifically evaluating interventions for suicidal thoughts and behaviours. While studies to date have indicated that psychological interventions are often effective in reducing suicidality, there is a need to confirm and extend these findings. In particular we need to know more about the elements of effective therapy, effectiveness with particular patient groups and over longer follow-up periods. There are a number of complex methodological issues as well as significant risk and safety issues, which together with the need for longer follow-up mean that such studies need to be well-resourced.

4. We need more studies looking at the course of suicidality over time. Most studies of long-term outcome are based on examination of hospital or coroner's records (or similar). Beautrais and colleagues' (2004) study in New Zealand is one of the very few to use face to face contact (in this case over a 5 year period) in following up adults who had made a medically serious suicide attempt. This enabled them to look at a range of mental health and psychosocial outcomes in addition to the rate of eventual suicide.

5. We need to employ a range of methodologies. Quantitative methodologies are important in studying rates of suicidal behaviour, relationships between rates and risk and protective factors and in evaluating the outcome of interventions. Qualitative methodologies are important in studying internal suicidal processes, interpersonal processes in help-seeking and in psychotherapy and in identifying aspects of interventions which merit further study. Some issues, such as client experiences of interaction with health services, may be elucidated by using a combination of qualitative and quantitative methodologies.

Conclusion

In sum, effective responses to suicide risk that reduce the individual capacity to inflict lethal self harm appear to include public health interventions that reduce access to means, medical services that detect suicide risk and, during phases of acute risk, directly prevent suicidal acts through psychiatric admission or crisis team intervention. The *only* approaches that currently provide evidence of reducing suicidal desire and associated psychological themes are psychological interventions with at-risk individuals, especially cognitive behaviour therapy, dialectical behaviour therapy and mentalization-based therapy. Given the close association between mental health problems and suicidal desire, and the unique expertise of clinical psychologists in the delivery of these interventions, it is clear that a comprehensive evidence based response to reducing suicide must provide

suicidal and at-risk individuals with access to mental health professionals who are appropriately trained in the delivery of psychological therapies.

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