The Australian Psychological Society Ltd

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APS submission to

The Senate Inquiry into Suicide in Australia

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About the APS

The Australian Psychological Society (APS) welcomes the opportunity to provide input into the Senate Inquiry into Suicide in Australia.

The APS is the peak national body for the profession of psychology, with over 17,500 members, representing over half of registered psychologists. Members are supported within the APS by 9 professional Colleges, 32 Interest Groups and 40 Branches throughout Australia. The APS has a number of Colleges specifically relevant to mental illness and suicide prevention and management, such as the Colleges of Clinical Psychologists, Counselling Psychologists and Forensic Psychologists which currently have around 2500 members. Psychologists in these Colleges have a focus on excellence in clinical practice, teaching, and research in mental illness and legal issues for community members within Australia.

The vision and mission of the APS is to “raise the profile of psychology and enhance its standing, as a discipline and a profession, throughout all sections of the Australian community”, and “to represent, promote and advance psychology within the context of improving community wellbeing and scientific knowledge”. Consistent with its vision and mission, the APS has produced a number of publicly available Position Papers and Statements. (See APS website: http://www.psychology.org.au/publications/statements/.) As the representative body for psychologists, the APS has access to a vast pool of psychological expertise from both academic and professional service delivery perspectives. The APS has responsibility for setting professional practice standards, providing ongoing professional development and accrediting university psychology training programs across Australia. It is represented on a number of advisory groups involved in the planning, implementation and ongoing input to Government policy initiatives.

Executive Summary

The APS wishes to make the focus of its submission and emphasis on the application of evidence-based practice for interventions with suicidal clients. In particular, it wishes to seek support for programs that focus on the individual community member who experiences significant suicidal ideation rather than programs that focus on just education/prevention programs in the broad community. Programs with an individual focus must include appropriate and comprehensive risk assessment and tailored treatment incorporating interventions that are known to be of benefit to suicidal clients; as well as follow-up that significantly reduces risk of recurrence of suicidal behaviour. It is the view of the APS that such programs should acknowledge the broad spectrum of risk factors, the central need for connectedness and engagement with the community by the individual and focus on the interventions that will help people connect and engage with services. It is argued that there needs to be a commitment to proactive engagement with people at risk rather than a perspective that only responds when they seek help.

In addition, the APS would like to stress the importance of ongoing evaluation of the effectiveness of interventions, the role that psychologists can play in the education and training of other health professionals and emergency services and particularly the role of psychologists in school. The importance of the application of these sound principles in the area of indigenous health is stressed as is the need for responsiveness to the cultural needs of people in the indigenous communities. This submission makes some reference to other aspects of the Terms of Reference regarding the accuracy of suicide reporting, the role and effectiveness of major agencies, and the effectiveness of public awareness and government supported programs. There needs to be a coordination and implementation of an effective community response. The Society's major concern is to focus resources on the identification, intervention with, and ongoing support of, individuals at high risk of suicidal behaviour while still maintaining some emphasis on community education and prevention programs.

Recommendations

Recommendation 1: That the Senate recognise that the personal and social costs of suicide for many people never fully resolve.

Recommendation 2: That it is acknowledged that the major factors in the limited accuracy of data about suicide rates are inconsistent terminology, lack of standardised criteria, procedural hindrances and social and cultural barriers, and that initiatives to address these, where possible, are needed.

Recommendation 3: That the consequences of under-reporting are multiple and far reaching affecting risk identification, preventative support and effective interventions.

Recommendation 4: That the important role of collaborative care be integrated with the role of specific professions who bring unique and essential skills and effective interventions to suicidal clients and need support and resourcing.

Recommendation 5: That resources to ensure effective team collaboration and integrated care between services be considered an important part of an effective community response. It is also critical to maintain and support at risk individual's access to pathways to stepped-care. This is particularly vital following discharge from institutional care as this is known to be a particular point of increased risk of suicide and places marked stress on team collaboration.

Recommendation 6: That all funding of community education and awareness raising be accompanied by rigorous and meaningful evaluation of effectiveness and relative benefit.

Recommendation 7: That the Senate strongly endorse the need for training and support of front–line workers and seeks to see the profession of psychology play an ongoing and extended role in the planning, development and delivery of that training.

Recommendation 8: That working with suicidal clients is always demanding and stressful and not only requires extensive training and support but requires the provision of practitioner debriefing, support and health intervention or self-care.

Recommendation 9: That careful consideration be given to the more effective utilisatiion of funds and resources in intensive interventions and support of those individuals identified as at risk for at least twelve months after that identification.

Recommendation 10: That programs of suicide prevention and postvention for indigenous people and groups be guided and conducted by trained, and where possible local indigenous, practitioners.

Recommendation 11: That consideration be given to setting up or funding an established organisation that sources, reviews and disseminates research findings in this area. This organisation might also act as a resource for the design of, and consultation about, evaluation of funded projects and initiatives.

Recommendation 12: That the major focus of suicide prevention strategy should be the identification, intervention with, and ongoing support of, individuals at high risk of suicidal behaviour while still maintaining some emphasis on community education and prevention programs.

Responses to the Terms of Reference

TOR (a) the personal, social and financial costs of suicide in Australia;

The APS has previously written (1999) that "It [suicide] is a salient preoccupation and 'issue' for many cultures, for contemporary western societies and media, for the many individuals and families whose lives have been touched by the suicide death of others. For many psychologists, engagement with the issue of suicide is in the context of clinical practice, and the questions these psychologists seek to illuminate are the conundrums of assessment and therapeutic intervention."

The purpose of such an analysis is to point out that the costs of suicide cannot be measured in financial terms when it is the personal, social and psychological consequences that impinge mostly on the community. What the APS is keenly aware of, and as a result of its learnings from its members, is that the personal, psychological and social consequences of suicide on family members and related individuals are lifelong and difficult to resolve.

Recommendation 1: That the Senate recognise that the personal and social costs of suicide for many people never fully resolve.

TOR (b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);

Given its significant emotional associations, it is of considerable importance that we have accurate information about rates. Given our uncertainty about how accurate the reporting of suicide is, and the reasons that prompt organisations to view it as inaccurate, it is reasonable to conclude that the current reported rates of suicide are an underestimate. De Leo (2007) gives an example of how different rates of suicide can be obtained, between for example, the Australian Bureau of Statistics and Australian Institute for Suicide Research and Prevention. To some extent the actual data is affected by the purpose for which it is collected. The awareness of the significance of the data may well prompt behaviours that interfere with the accuracy of collection. This is particularly so where cultural differences significantly overshadow the process and make both data collection and comparisons difficult.
To summarise in a more structured and concerted fashion, the APS identifies a set of factors that might impede the accurate identification and recording of possible suicides:

1 Inconsistent terminology and lack of standardised criteria

Moscicki (1995) has demonstrated that there are no worldwide standardised criteria for the classification and reporting of suicide deaths, which means that international comparisons must proceed with caution. Even within countries which have standard criteria, the way in which these criteria are applied may vary. This is particularly so where there are legislated variations which may reflect some social or religious sensitivities.

This highlights the need for a common glossary of terms (see work by Diego De Leo, Australian Institute for Suicide Research and Prevention, Griffith University) and guidelines an education for the relevant agencies and professions to adopt and apply common nomenclature to increase a shared understanding and improve the reliability of suicide reporting. This would be a useful outcome of this Senate enquiry.

2 Social pressure and stigma associated with suicide

There has been some debate in the literature about the possible extent of under-reporting of suicide, citing social pressures to avoid a suicide verdict and the possibility of some suicides being obscured by the manner of death, such as single car road accidents.

Moscicki (1995) argued that epidemiological studies in the United States which have included a re-examination of death certificates have suggested that under-reporting is likely to be relatively modest. On the other hand Diekstra and Garnefski (1995) argued that under-reporting has increased recently due to the non-counting of 'doctor-assisted' deaths. They suggested that in the Netherlands suicide statistics could be one-fifth to one-fourth higher if these deaths were counted as suicides.

In this context, it may be noted that even with intent to accurately ascribe both the intent and the outcome it could be that the manner of death might be ambiguous (e.g. single occupant, fatal motor vehicle accident). In addition, people who have survived suicide attempts might deny that they were attempting suicide or coroners and emergency service personnel might be motivated, at a personal level, to "protect" the family of the deceased. Above all, there are difficulties determining, retrospectively, whether there was intent to commit suicide.

Consequences of under-reporting

The consequences of the under-reporting of suicides, however, are multiple and significant from a social and societal perspective. They become the driving force for the need for accurate and valid data. For instance, the following can be identified as likely results from inaccurate suicide reporting:

- a lack of services to at risk communities and families;
- delayed responses to addressing new at-risk groups or potential variables/targets for intervention;
- services (services for people who survive suicide, and family and friends of those who do die) and interventions that do exist might not receive funding support if there is under-reported need for them. This is especially relevant for minority and underprivileged groups.

Recommendation 2: That it is acknowledged that the major factors in the limited accuracy of data about suicide rates are inconsistent terminology, lack of standardised criteria, procedural hindrances and social and cultural barriers and that initiatives to address these, where possible, are needed.

Recommendation 3: That work is needed to address the issues of under reporting as the consequences are multiple and far reaching affecting risk identification, preventative support and effective interventions.

TOR (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;

The APS feels very strongly that this is an issue that should attract both policy decisions and considerable resources. There is a general need for a wide range of service providers (e.g.

school staff, police and emergency workers, hospital staff, chaplains) to have at least a basic, if not extensive, level of suicide or mental health 'literacy'.

It is also important to emphasise in this context the need for a model of collaborative care. As with other programs that are designed to improve the general health of the community, agencies and people working with those at risk of suicide must work together at all levels of the process: risk assessment, interventions, follow-up and review.

In addition, given the multiple agencies involved in working with people at risk of suicide, there is an urgent need for a common approach across disciplines/professions particularly in assessment, evidence-based interventions, discharge procedures and follow-up.

However, although the issue of collaborative and integrated service is critical it is important to recognise that there are both collaborative and profession-specific contributions that need to be both acknowledged and supported. For instance, it is essential to understand the relationship between psychological perspectives and the multidisciplinary collaborations which are so crucial in efforts to understand and respond to suicide and suicidal behaviour. In recent years, youth suicide has become a significant focus of Government policy and planning. The National Youth Suicide Prevention Strategy was launched in 1997, and there have been numerous State Government inquiries and initiatives (e.g., Victorian Suicide Prevention Task Force, 1997). Working within a multidisciplinary context, psychologists have made significant contributions to these policy and planning processes. As a parallel activity however, it was important to foster a wider engagement and discussion within the profession of psychology itself, creating a forum in which to reflect on the particular contributions which a psychological perspective brings.

For many psychologists, engagement with the issue of suicide is in the context of clinical practice, and the questions these psychologists seek to illuminate are the conundrums of assessment and therapeutic intervention. Specifically, psychologists assess and explore how cognitive, emotional, behavioural, familial and interpersonal factors and relationships can be harnessed to both reduce risk of suicide and improve mental wellbeing. Again multidisciplinary collaboration is vital, but the underlying philosophical rationale is that each discipline brings its own special contribution to the collaborative endeavour. To lose sight of this in the context of a stress on collaborative care is to risk losing the rich array of, and critically important, contributions that each profession brings.

A relevant example of the interface of collaborative and professional care is to be found in the school setting. This is a vital area of importance in the identification of risk in the education of youthful community members. As in all areas where suicidal behaviour is to be found, psychologists bring particular expertise in risk assessment, an understanding of human cognitions, emotions and behaviour and training in proven effective psychological interventions. It is vital that at risk individuals be identified and that a context of awareness and responsibility is encouraged. The educative and awareness aspects need to be a collaborative exercise as does, to some extent, the risk assessment. Psychologists play a vital role in the school setting in their function as counsellors (and confidants) and in their capacity for psychological risk assessment. Additionally, psychologists have the expertise to support and educate teachers and other school staff regarding suicide – thereby directly supporting teachers and other school staff to enhance the collaborative nature of the intervention. It is vital that the role of a psychologist in this context is identified, supported and adequately resourced.

Another example of the relevance of both individual and collective impact on the care of suicidal clients is the management of discharge. It is well understood that people who have becomes suicidal, or who may have attempted suicide, are at serious risk of a repeated episode for at least 12 months after the previous event (Appelby, Shaw & Amos et al, 1999).

The crucial importance of a service maintaining some form of contact with the client and providing pathways to stepped-care cannot be overstressed. The APS recommendation is that at this point a program of proactive and persistent management of the client at risk needs to be instituted.

It is vital that the processes which make multidisciplinary care work effectively be carefully examined and incorporated in interventions. Multidisciplinary care has become something of a mantra, but the processes necessary to make it work are not always considered. Multidisciplinary care requires a high level of trust between professionals. System-wide issues here concern the extent to which current structures facilitate good working relationships between medical, psychiatric, nursing, psychological, social work, educational and welfare practitioners. Anecdotal evidence indicates the existence of strong and effective partnerships, but also that working relations, are often marred by a mistrust of the other disciplines' potential contribution or by unresolved issues around professional roles. It can be particularly difficult to establish and maintain trust in the face of the anxiety aroused by suicidal ideation and behaviour.

Recommendation 4: That the important role of collaborative care be integrated with the role of specific professions who bring unique and essential skills and effective interventions to suicidal clients and need support and resourcing.

Recommendation 5: That resources to ensure effective team collaboration and integrated care between services be considered an important part of an effective community response. It is also critical to maintain and support at risk individual's access to pathways to stepped-care. This is particularly vital following discharge from institutional care as this is known to be a particular point of increased risk of suicide and places marked stress on team collaboration.

TOR (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;

The APS is keenly aware that the effectiveness of public awareness programs is extremely difficult to assess. Even with reasonably structured evaluation initiatives built into public awareness programs, the multi-factorial nature of the origins of community knowledge, attitudes and awareness makes ascribing causation to changes, or limited changes, very difficult. As with so many initiatives in the community, highly emotive events supported by media attention can shift perspectives and attitudes with considerable relative pace. What is also clear is that awareness does not always mean a change in behaviour so demonstrating a shift in knowledge or attitudes does not necessarily mean a shift in behaviour.

However, on the positive side, it is clear that prolonged and consistent campaigns, such as that pursued by beyondblue, has begun to have positive effects in reducing negative perspectives of depression in the community. What is vital in all of these is the content and its focus which have to be appropriate and effective.

Recommendation 6: That all funding of community education and awareness raising be accompanied by rigorous and meaningful evaluation of effectiveness and relative benefit.

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

The APS has always maintained a commitment to evidence-based psychological interventions. This is based upon, and in turn fosters, a commitment to both clinical services based on academic research. The APS fosters a model of professional activity which it terms the scientist-practitioner model. The notion suggests that each practitioner is focused on the best practice evidence available in responding to the specific needs of the client; whether that be an organisation or individual.

For that reason, it highlights the need for all suicide prevention training and all education of professionals (health or other community agencies) to be based upon the best available research evidence when individual or community interventions are selected or endorsed. Mann et al (2005) also cite the need for ongoing, well-planned evaluation of interventions for preventing suicide.

To this end the APS draws the Senate's attention to the fact that there now exists significant evidence of effective and cost-effective interventions for the prevention of suicide. In the popular media there is a good summary of this in the LIFE report on research and evidence in suicide prevention. Another important reference is the report by Tarrier, N., Taylor, K., & Gooding, P. (2008, "Cognitive-behavioral interventions to reduce suicide behaviour. A systematic review and meta-analysis." *Behavior Modification*, 32:77-108.) The importance of this study lies in the fact that it is a systematic review of a number of previous studies in the area. Its major finding is that there is now sound evidence that cognitive behavioural interventions do have an impact on suicidal behaviour. See also Comtois & Linehan (2006).

As evidence of the APS commitment to evidence-based interventions is its recent training of Access To Allied Psychological Services (ATAPS) workers in the assessment and management of suicidal community members in regional, rural and remote areas of Australia. Critical notions within this program have been that it serves to integrate all services likely to be associated with suicidal clients, comprehensively trains practitioners in the identification of people at risk and then ensures comprehensive follow-up and referral of such people to appropriate services for treatment and support.

The APS, as one of the prime agents for training in the identification and treatment of suicidal members in the community, wishes to remain at the centre of consultation and planning regarding policy and practice within the Australian community.

In the training domain there is a necessity to recognise a pyramid of service provision and the training of professionals needs to reflect that hierarchy of intervention. For instance, the skills and education required of police and emergency service professionals will distinguish it from that needed for nursing and emergency department staff. In turn, this will be distinguished from that required for psychologists and psychiatrists who would require training to provide different more intensive services.

A distinction is needed between suicide prevention training – a specialist set of skills - and support for front-line health and community workers to provide systemic interventions. As noted above, there is now a body of evidence that points to the efficacy of crisis intervention and CBT interventions for individuals at risk of suicide and serious self-harm. However, it is also important to acknowledge the complexity of this work and the regular reports from practitioners in the field that there are important therapist characteristics such as confidence and competency that appear to be critical aspects when working effectively with clients at risk of suicide and serious self-harm. Such characteristics usually require in-depth training and extensive clinical experience.

With regard to the support for front-line workers, three things require emphasis:

(1) the need for well-developed and articulated processes, procedures and measures to support workers in this area (risk-assessment protocols, crisis management procedures, referral processes, collaborative agency protocols, documentation procedures);

(2) an understanding of worker role in relation to the person at risk and where each worker fits in the provision of service to that person as set out in the hierarchy of intervention notes above;

(3) well-established supervision, consultation, and clinician self-care practices.

The timing of community education and awareness raising initiatives is critical. Although community events with a high media profile can provide opportunities to educate and inform, it is important to be considerate and sensitive of when and how such material is framed and presented. The possibility of utlising families and peers as a vehicle of education and support needs consideration.

It is in this context that the APS would stress the critical importance of clinician self-care. The Australian Psychological Society has recently revised the Society's ethical guidelines for working with suicidal clients (attached). The guidelines note the importance of careful assessment, recognise that most suicidal crises can be worked through and canvass issues around recognising the limits to one's own clinical competence and referral on where appropriate.

Stone (1993) suggested that it is when therapists "have the courage to face the possibility of a patient's death - without losing faith in their ability or their profession" (p.270) that they are free to be of most help to a potentially suicidal client. However the work is not for everyone, or not for every stage of one's professional life. Psychologists need to know when to refer on.

Finally, this work is not suitable for everyone and people should feel free to decline involvement or participation even at the minimal level.

Essential Elements

Important components of intervention in the context of suicide risk are crisis intervention (including risk identification and referral), medical/psychiatric treatment, hospitalisation, longer-term psychotherapy, ongoing case management and/or re-linking with support systems. While a full discussion of intervention is beyond the scope of this paper, these selected aspects are contained and detailed in many of the documents referred to above. These would include the materials associated with the ATAPS (DVD and workbook based training package for Allied Health Professionals working with people with suicidal behaviour) and headspace initiatives (provision of psychological services for youth – part of the National Youth Mental Health Foundation) as well as mental health first aid (a population based educational approach to improving recognition of signs of mental illness and the provision of basic support), and mental health first aid guidelines for suicidal ideation and behaviour kit led by Tony Jorm (see Kelly, Jorm, Kitchener & Langlands 2008).

Recommendation 7: That the APS strongly endorses the need for training and support of front–line workers and seeks to see the profession of psychology play an ongoing and extended role in the planning, development and delivery of that training.

Recommendation 8: That working with suicidal clients is always demanding and stressful and not only requires extensive training and support but requires the provision of practitioner debriefing, support and health intervention or self-care.

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

As noted above, the APS is committed to an evidence-based approach and considers that this must be the foundation of any program of targeting high-risk groups. Even where the evidence is limited it is critical that the best-known practice be the foundation of programs of intervention. In this context the APS would urge that for all intervention initiatives and programs, evaluation of not only process but the clinical outcomes be built into the initiative from its inception. It is vital that the community is discovering in an ongoing way which programs assist both individuals and the community most effectively and which programs are of less effective value. Evaluation is crucial if the community is to spend its limited resources wisely.

Since the issue of risk assessment is so crucial, but also quite complex, this is also seen as a central and important element of any program. What is also stressed is that there must be a balance between addressing general and specific risk factors in determining the level of risk. Because the issue of suicidal intent or behaviour involves a complex set of factors it is vital to recognise the important balance of the range of risk issues that must be considered. Risk assessment is complex but greatly assisted by a risk assessment protocol that includes a series of questions that aim to assess current risk factors, warning signs, and tipping points across the individual, social and contextual levels, as well as any protective factors that may be evident upon questioning.

Of particular concern is the development of specific initiatives to more effectively deal with individuals at risk of suicide or self harm (Beautrais, 2006). The APS would particularly identify the following initiatives:

- developing protocols on discharge from emergency or mental illness treatment facilities and the critical need for follow-up within the community given that people are still at high risk following discharge from a service. It is here that collaborative care and cooperation between agencies is vital not only in coordinating monitoring but working on an agreed model of care;
- the development of standards for training and service management. The APS has had considerable experience in developing effective education and training in interventions for health service providers and has been deeply involved, not only in the ATAPS initiative but also with the *headspace* initiative. Associated with the latter has been the development of a document called "Principles of Effective Education and Training for Health Service Providers";
- the ongoing implementation and refinement of evidence based psychological therapies (e.g. cognitive behavioural and dialectical behaviour therapy) and interventions for suicidal behaviour (see also, Linehan, M.M., 2008).
- of critical importance is the development and implementation of intervention initiatives that includes the components of follow-up and close monitoring (Motto & Bostrom, 2001). This will require the appointment and resourcing of case managers and therapists who go to uncommon lengths to ensure the support and the engagement of suicidal clients in the community. Such a consequence might be regular phone calls, contact by mail (e.g. postcards), visits and collaborative interventions that may even require accompanying the individual to local community centres or events. It is understood that this is likely to be resource

intensive but is more likely, than many of the dollars spent on education and community awareness, to impact on the suicide rate.

Finally, the APS would urge the Senate committee to consider the submission from its associated organisation, the Australian Indigenous Psychology Association (AIPA). Its experience and understanding of the needs and requirements of a program for assisting in the reduction of suicide rates among the Indigenous community is significant. The Society recommends their submission to you.

Recommendation 9: That careful consideration be given to the more effective utilisatiion of funds and resources in intensive interventions and support of those individuals identified as at risk for at least twelve months after that identification.

Recommendation 10: That programs of suicide prevention and postvention for indigenous people and groups be guided and conducted by trained, and where possible local indigenous, practitioners.

TOR (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;

The APS acknowledges the extent and quality of the work completed by AISRAP with regard to suicide and suicide prevention in this country. It is probably the major organisation to comment on this vital area of importance. The APS's long history of support and involvement in academic and community research programs means that this is an area of considerable importance and commitment. It would be reflecting its membership concern if it was to comment on the dearth of appropriate funding and support for clinical research in the area of suicide prevention as a means of reinforcing and extending the evidence base for clinical practice.

One of the most useful contributions that could eventuate from the Senate enquiry would be the creation of an organisation that could disseminate research findings.

Recommendation 11: That consideration be given to setting up or funding an existing organisation that sources, reviews and disseminates research findings in this area. The organisation might also act as a resource for the design of, and consultation about, evaluation of funded projects and initiatives.

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

The achievements of the projects developed from the prevention strategy have been significant. However, consistent with the Society's comments above, the APS would suggest that there was too great an emphasis on education and population-based approaches to prevention and too little focus on specific initiatives and funding of programs to meet the needs of individuals at the highest risk.

Recommendation 12: That the major focus of suicide prevention strategy should be the identification, intervention with, and ongoing support of, individuals at high risk of suicidal behaviour while still maintaining some emphasis on community education and prevention programs.

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Guidelines relating to suicidal clients

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1. Introduction

1.1. Psychologists, by the nature of their work, are likely to encounter *clients* with suicidal thoughts. These *clients* may also have a history of suicidal behaviour and/or express an intent to harm or kill themselves now or in the future. These thoughts or behaviours are typically the result of many interacting factors.

1.2. These *Guidelines* outline some general and specific principles that should be taken into account by all *psychologists* in dealing with suicidal clients. Where appropriate and possible reference is made to the relevant sections in the Code, and relevant *Guidelines*.

1.3. It is important to note that these *Guidelines* highlight key principles for *psychologists* to follow, and are not practice guidelines.

1.4. While the welfare of *clients* is paramount, *psychologists* may also face a professional risk when working with suicidal *clients*. These *Guidelines* have been devised to assist *psychologists* to give consideration to the professional matters that are relevant to this specific *client* group, within the context of established regulatory bodies such as Psychologists Registration Boards and Health Care Complaints Commissions.

2. Training, experience and supervision

2.1. It is important for all *psychologists*, as a basic requirement, to acquire knowledge and training in how to recognise, assess and refer a person at risk of suicide.

2.2. Any *psychologists* working with high-risk populations or engaged in ongoing work with suicidal *clients* need to have training, experience and supervision relevant to their role and responsibility and to consult appropriately qualified persons as needed.

2.3. *Psychologists* familiarise themselves with knowledge, skills and standards of care relevant to their work with suicidal *clients* through relevant literature and training.

2.4. *Psychologists* familiarise themselves and comply with legislation that may be relevant to their work with suicidal *clients*. See also Section 5 below.

2.5. There are many potential ethical dilemmas working with this *client* group. These can include creating space to talk about what can be a sensitive subject, respecting the *client's* autonomy, and deciding whether and when to intervene. Sometimes these different elements will be in competition with each other. For such situations, *psychologists* are encouraged to seek consultation with an experienced colleague.

3. General overview

Refer to the *Code*, standard B.3. Professional responsibility.

> B.3. *Psychologists* provide *psychological services* in a responsible manner. Having regard to the nature of the *psychological services* they are providing, *psychologists*:
> (a) act with the care and skill expected of a competent *psychologist*;
> (b) take responsibility for the reasonably foreseeable consequences of their *conduct*;
> ...
> (e) are personally responsible for the professional decisions they make;
> ...

Refer to the *Code*, standard B.1. Competence.

> B.1.1. *Psychologists* bring and maintain appropriate skills and learning to their areas of professional practice.

B.1.2. *Psychologists* only provide *psychological services* within the boundaries of their professional competence. This includes, but is not restricted to:
(a) working within the limits of their education, training, supervised experience and appropriate professional experience;
(b) basing their service on the established knowledge of the discipline and profession of psychology;
(c) adhering to the *Code* and the *Guidelines*;
(d) complying with the law of the *jurisdiction* in which they provide *psychological services*; and
(e) ensuring that their emotional, mental, and physical state does not impair their ability to provide a competent *psychological service*.

Refer to the *Code*, standard A.1. Justice.

A.1.1. *Psychologists* avoid discriminating unfairly against people on the basis of age, religion, sexuality, ethnicity, gender, disability, or any other basis proscribed by law.

A.1.2. *Psychologists* demonstrate an understanding of the consequences for people of unfair discrimination and stereotyping related to their age, religion, sexuality, ethnicity, gender, or disability.

A.1.3. *Psychologists* assist their *clients* to address unfair discrimination or prejudice that is directed against the *clients*.

3.1. Many *clients*, even when suicidal, experience ambivalence about living and dying, and would prefer to find help to deal with their problems. Consequently, a basic guiding principle for *psychologists* is to promote *clients'* safety and support, pending a more thorough assessment of their needs, situation, and options for further help. *Psychologists* must at all times respect their *clients'* autonomy while also helping them identify and address psychological and circumstantial factors affecting decisions they are making about their life and safety.

3.2. In making these decisions, *clients* may indicate their ambivalence by expressing a desire to kill or deliberately harm themselves while at the same time seeking help to address problems in living. It is important for *psychologists* to understand and work with these conflicting thoughts and behaviours in ways that acknowledge the pain and desperation behind them while attending to immediate safety and strengthening supports for living.

3.3. *Psychologists* are aware of their own personal attitudes and values about suicide and suicide intervention, and whether those attitudes and values influence their professional judgement and response. Where *psychologists* identify attitudes and values that may interfere with their professional judgement, they seek consultation with a colleague and consider whether alternative treatment options are needed.

3.4. *Psychologists* are aware that some *client* sub-groups, e.g., terminally ill *clients*, have an elevated risk of suicide. *Psychologists* familiarise themselves with the research related to this area, and have an appreciation of the socio-cultural contexts that are associated with that heightened risk.

4. Specific principles

In their dealings with potentially suicidal *clients*, *psychologists* are guided by several specific principles:

4.1. Client safety

4.1.1. *Psychologists* remain alert to *clients'* current and ongoing signs of suicide risk. If signs are present, *psychologists* are ethically obliged to:
i) take steps to attend to the *client's* immediate safety; and
ii) undertake or arrange for a thorough and specific assessment of suicide risk; and
iii) if necessary, arrange appropriate psychological, medical, psychiatric and/or social care, and community response.

4.1.2. *Psychologists* have an ethical responsibility to have knowledge of, and use current practice guidelines that cover the following points:

4.1.2.1. Assessment is comprehensive in nature, addressing suicidal thoughts and behaviours directly in ways that attend to the pain, understand the potential for despair behind it, and provide foundations for immediate safety and ongoing help;

4.1.2.2. *Psychologists* explore the *client's* resilience and the existence of any protective factors, and build on the client's strengths;

4.1.2.3. Some assessment considerations are contextual and/or cultural. For example, it is pertinent to identify how factors in the *client's* past, current, or imagined future situation may be contributing to suicidal thoughts or acts, and to understand the meaning and significance they attach to these experiences. Family and significant others, and the sense of connection to them, are also relevant;

4.1.2.4. The mental health of a *client* features in any assessment of risk, as well as determination of needs for follow-up care and options for treatment planning. The *client's* mental health will affect how they view their current situation, their vulnerability to suicide, coping strategies, perceptions of options for help and openness to seeking help. There may be occasions that involve the need for administration or monitoring of medication, which would require the involvement of a psychiatrist and/or general practitioner;

4.1.2.5. A comprehensive assessment will also address factors specific to the presence, immediacy and level of risk, such as prior suicidal behaviour, suicide plans, access to means, evidence of impulsive behaviour and the *client's* use of alcohol or drugs;

4.1.2.6. While many common factors inform the assessment of suicide risk, each *client's* suicidal crisis needs to be individually understood and responded to. Internal and external factors in the *client's* life and that *client's* unique way of responding to them will facilitate an assessment that provides safe and helpful outcomes for the *client*. To assist this process *psychologists* are directed to relevant literature and training in managing suicidal *clients*;

4.1.2.7. *Psychologists* working with a suicidal *client* maintain a duty of care at least until an appropriate management plan has been developed and implemented and, if necessary, care has been passed on by mutual agreement to an appropriate professional or agency; and

4.1.2.8. Both assessment and response must be considered within the context of the need to maintain engagement with the suicidal *client* and the need to encourage the *client* to mobilise as much as possible their own resources and supports. However, it also needs to be recognised that the *client* may exhibit temporary limits in their capacity to mobilise resources, requiring a more active role from those attending to their safety and care.

4.2 Safety of others

4.2.1. While the focus with suicidal *clients* is on their immediate safety, those providing intervention also recognise and address factors that may pose direct risk to others (e.g., where suicide might be attempted by firearms, weapons, arson or motor accident, or involve potential homicide-suicide).

4.2.2. Where a suicidal *client* has dependent children, *psychologists* are aware of, and if necessary address, protective issues for those children.

4.3. Impact on others of suicidal behaviour

Psychologists are aware of the powerful and painful impact of suicidal behaviour on others, especially when it results in a death by suicide. Psychological support may be needed not only by those intimately affected (such as family and friends) but also by those linked in some other way to the person who committed suicide. Examples include suicides in educational, work and sports settings, or situations where people may identify strongly with a public figure who took his or her life. If a *client* commits suicide, the *psychologist* treating the *client* may have their own particular needs for support. In all these situations, provision of care needs to be matched by vigilance about potential suicide risk among those affected.

4.4. Confidentiality

Refer to the *Code*, standard A.5. Confidentiality.

A.5.2. *Psychologists* disclose confidential information obtained in the course of their provision of *psychological services* only under any one or more of the following circumstances:
(a) with the consent of the relevant *client* or a person with legal authority to act on behalf of the *client*;
(b) where there is a legal obligation to do so;
(c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information; or
(d) when consulting colleagues, or in the course of supervision or professional training, provided the *psychologist*:
(i) conceals the identity of *clients* and *associated parties* involved; or
(ii) obtains the *client's* consent, and gives prior notice to the recipients of the information that they are required to preserve the *client's* privacy, and obtains an undertaking from the recipients of the information that they will preserve the *client's* privacy.

Refer to the *Code*, standard A.4. Privacy.

A.4. *Psychologists* avoid undue invasion of privacy in the collection of information. This includes, but is not limited to:
(a) collecting only information relevant to the service being provided; and
(b) not requiring supervisees or trainees to disclose their personal information, unless self-disclosure is a normal expectation of a given training procedure and informed consent has been obtained from participants prior to training.

Refer to the *Code*, standard A.3. Informed Consent.

A.3.6. *Psychologists* who work with *clients* whose capacity to give consent is, or may be, impaired or limited, obtain the consent of people with legal authority to act on behalf of the *client*, and attempt to obtain the *client's* consent as far as practically possible.

4.4.1. Any decision to engage professional or social supports to manage the suicidal crisis raises issues about disclosing information that has been provided to the *psychologist* in confidence. In making such a decision, *psychologists* take into account the quality of these relationships and the capacity of those involved in providing support to respond appropriately.

4.4.2. Permission to contact professional or social supports is obtained from the *client* where possible, and disclosure is, at least in the first instance, limited to information pertinent to the suicide risk and the prevention of suicidal behaviour. If consent is not obtained, other protective interventions may need to be made. For situations where it has not been feasible to obtain the *client's* consent to inform other persons, an assessment of the degree of risk to the *client* and others will determine whether to breach confidentiality. The immediate safety of the person at risk is paramount.

4.4.3. In the case of young persons, this typically involves *psychologists* advising at least one relevant caregiver (e.g., parent, guardian, next of kin). In circumstances where advising a relevant caregiver is not appropriate, *psychologists* work with the *client* to identify one or more appropriate person/s to contact.

4.5. Role clarity and competence

Refer to the *Code*, standard B.1. Competence.

B.1.2. *Psychologists* only provide *psychological services* within the boundaries of their professional competence. This includes, but is not restricted to:
(a) working within the limits of their education, training, supervised experience and appropriate professional experience;
(b) basing their service on the established knowledge of the discipline and profession of psychology;
(c) adhering to the *Code* and the *Guidelines*;
(d) complying with the law of the *jurisdiction* in which they provide *psychological services*; and
(e) ensuring that their emotional, mental, and physical state does not impair their ability to provide a competent *psychological service*.

Refer to the *Code*, standard B.11. Termination of psychological services.

> B.11.5. When confronted with evidence of a problem or a situation with which they are not competent to deal, or when a *client* is not benefiting from their *psychological services*, *psychologists*:
> (a) provide *clients* with an explanation of the need for the termination;
> (b) take reasonable steps to safeguard the *client's* ongoing welfare; and
> (c) offer to help the *client* locate alternative sources of assistance.

4.5.1. The level of expertise required depends on the level of involvement of the *psychologist* in the care of the *client*.

4.5.2. Where a suicide risk emerges during work with existing *clients*, *psychologists* address issues of immediate safety as outlined in standard 4.1, and then clarify the nature and extent of the *client's* needs for continuing care. This is worked out collaboratively with the *client* and appropriate consultation with a supervisor and/or colleague.

4.5.3. Should a *psychologist* appraise a *client's* suicide risk and associated circumstances as beyond their professional competence, referral to or advice from an appropriately experienced colleague or other practitioner, or referral to or liaison with an appropriate agency, is required. Those making and accepting the referral should define their respective ongoing roles and ensure that these are clearly understood by the *client*.

4.6. Collaboration/consultation/referral

Refer to the *Code*, standard B.4. Provision of psychological services at the request of a third party.

> B.4. *Psychologists* who agree to provide *psychological services* to an individual, group of people, system, community or organisation at the request of a third party, at the outset explain to all parties concerned:
> (a) the nature of the relationship with each of them;
> (b) the *psychologist's* role (such as, but not limited to, case manager, consultant, counsellor, expert witness, facilitator, forensic assessor, supervisor, teacher/educator, therapist);
> (c) the probable uses of the information obtained;
> (d) the limits to confidentiality; and
> (e) the financial arrangements relating to the provision of the service where relevant.
> ...

Refer to the *Code*, standard A.4. Privacy.

> A.4. *Psychologists* avoid undue invasion of privacy in the collection of information. This includes, but is not limited to:
> (a) collecting only information relevant to the service being provided; and
> (b) not requiring supervisees or trainees to disclose their personal information, unless self-disclosure is a normal expectation of a given training procedure and informed consent has been obtained from participants prior to training.
> ...

4.6.1. Given the qualitative nature of suicide risk assessment, accessing consultative support from an experienced colleague or other practitioner is considered in order to ensure adequacy of the assessment, risk management and ongoing care.

4.6.2. In cases where *psychologists* choose to refer the *client* for professional support from others as well as, or in place of, their ongoing involvement, this is done in a supportive way that strengthens continuity of care.

4.7. Record keeping

Refer to the *Code*, standard B.2. Record keeping.

> B.2.1. *Psychologists* make and keep adequate records.
>
> B.2.2. *Psychologists* keep records for a minimum of seven years since last *client* contact unless legal or their organisational requirements specify otherwise.

B.2.3. In the case of records collected while the *client* was less than 18 years old, *psychologists* retain the records at least until the *client* attains the age of 25 years.

As with all psychological casework, clear documentation is essential. This should include reference to the circumstances surrounding the suicidal crisis, risk assessments, clinical decisions, steps taken to address safety, persons consulted and the nature and extent of these consultations. Rationale for intervention steps taken and the basis for any considered disclosure of information to appropriate third parties is also included.

5. Legal implications

Psychologists are aware of laws at the federal, state and territory level that relate to suicide. This includes, but is not limited to, laws against "assisted suicide".

6. References

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7. Further reading

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Definitions*

Code definitions used in these Guidelines:

Associated party means any person or organisation other than *clients* with whom *psychologists* interact in the course of rendering a *psychological service*. This includes, but is not limited to:
(a) *clients'* relatives, friends, employees, employers, carers and guardians;
(b) other professionals or experts;
(c) representatives from communities or organisations.

Client means a party or parties to a *psychological service* involving teaching, supervision, research, and professional practice in psychology. *Clients* may be individuals, couples, dyads, families, groups of people, organisations, communities, facilitators, sponsors, or those commissioning or paying for the professional activity.

Code means the APS Code of Ethics (2007) as amended from time to time, and includes the definitions and interpretation, the application of the *Code*, all general principles, and the ethical standards.

Conduct means any act or omission by *psychologists*:
(a) that others may reasonably consider to be a *psychological service*;
(b) outside their practice of psychology which casts doubt on their competence and ability to practise as *psychologists*;
(c) outside their practice of psychology which harms public trust in the discipline or the profession of psychology;
(d) in their capacity as *Members* of the *Society*;
as applicable in the circumstances.

Guidelines mean the Ethical Guidelines adopted by the Board of Directors of the *Society* from time to time that clarify and amplify the application of the Code of Ethics. The Guidelines are subsidiary to the *Code*, and must be read and interpreted in conjunction with the *Code*. In the case of any apparent inconsistency between the *Code* and the *Guidelines*, provisions of the *Code* prevail. A *psychologist* acting inconsistently with the *Guidelines* may be required to demonstrate that his or her *conduct* was not unethical.

Jurisdiction means the Commonwealth of Australia or the state or territory in which a *psychologist* is rendering a *psychological service*.

Legal rights mean those rights protected under laws and statutes of the Commonwealth of Australia, or of the state or territory in which a *psychologist* is rendering a *psychological service*.

Member means a Member, of any grade, of the *Society*.

Moral rights incorporate universal human rights as defined by the United Nations Universal Declaration of Human Rights that might or might not be fully protected by existing laws.

Multiple relationships occur when a *psychologist*, rendering a *psychological service* to a *client*, also is or has been:
(a) in a non-*professional relationship* with the same *client*;
(b) in a different *professional relationship* with the same *client*;
(c) in a non-*professional relationship* with an *associated party*; or
(d) a recipient of a service provided by the same *client*.

Peoples are defined as distinct human groups with their own social structures who are linked by a common identity, common customs, and collective interests.

Professional relationship or role is the relationship between a *psychologist* and a *client* which involves the delivery of a *psychological service*.

Psychological service means any service provided by a *psychologist* to a *client* including but not limited to professional activities, psychological activities, professional practice, teaching, supervision, research practice, professional services, and psychological procedures.

Psychologist means any *Member* irrespective of his or her psychologist registration status.

Society means The Australian Psychological Society Limited.

* Defined terms are designated in the *Code* and *Guidelines* by appearing in italics.