

CURRENT ISSUES IN SUICIDE PREVENTION

INTRODUCTION: THE REFORM OF MENTAL HEALTH

To establish a context for consideration of current issues, it is important to recognise that current national mental health policy directions are changing and being reformed. The changes reflect a shift in philosophy and practice from the institutionalisation of people with mental health problems, towards a wider base of community understanding, responsibility and care. This shift can be represented in the following way:

Institutional	Post Institutional
Hospital	Community
Segregation	Integration
Diagnosis	Needs assessment
Clinical leadership	Consumer sovereignty
Disciplines	Partnerships
Compliance	Rights/relationships
Custody	Emancipation
Chronicity/despair	Recovery/hope
Passive patient	Informed consumer
Hidden	Recognised/supported

There are necessarily complex practical and philosophical issues involved in such a directional shift. These include questions about discipline, boundaries and allegiances, competing values, the multiplicity of perceptions and interpretations, diversity of service types and number of agencies involved, ambiguity or absence of evidence, and hierarchical structures representing historical arrangements. In addition, successfully achieving reform in the ways outlined above is a costly and long term commitment – whereas the current system is predicated on concepts of brief intervention (adapted from Durrington, 2005).

This paper addresses some contemporary suicide prevention issues, several of which have recently been the subject of intense public interest and media scrutiny. While there are a number of factors (such as mental health problems, social isolation and marginalisation) that are relatively constant in their impact upon suicide risk, there are other factors which are only now starting to make themselves known. The research evidence about many of these issues is inconclusive and in some instances highly contested.

The discussion in the following pages is therefore intended to canvass these issues and engage the reader in the debates, rather than provide definitive answers.

This paper suggests that innovative ways of responding to suicide are now necessary because of new forms of suicide risk arising from new forms of relationships (e.g. the Internet), the availability of some new means to suicide, and the greater recognition of the impact of factors such as domestic violence, sexual abuse and alcohol and drug use.

Risk assessment therefore needs to engage with broader social and political issues, and health professionals need to keep abreast of these changes if they are to intervene effectively, provide current information to clients and advocate credibly for suicide prevention in the public arena. As society changes and new risks arise, these require appropriate, specific forms of intervention. These issues all have legal implications as well. While this paper does not seek to provide legal advice to practitioners, it does canvass some of the legal dimensions involved in suicide risk assessment, including issues such as duty of care, liability, confidentiality and consent. It also briefly addresses the topic of euthanasia.

The issues to be addressed in this paper fall into four main categories:

1. NEW INFLUENCES, NEW REPRESENTATIONS

- The media
- The Internet
- Alcohol and other drug use

2. POPULATION SPECIFIC ISSUES

- Stigma
- Domestic violence and sexual abuse
- Risky behaviours

3. LEGAL ISSUES

- Duty of care
- Liability
- Confidentiality
- Consent
- Euthanasia

4. SELF CARE

- Burn out
- Practitioner suicide

1. NEW INFLUENCES, NEW REPRESENTATIONS

This first section focuses on some of the ways in which particular social institutions (the media and the Internet) and practices such as alcohol and drug misuse, may influence suicide rates. We also look at how images of suicide are represented, and what this might mean for how suicide is understood within Australia. In doing so we also look at how such representations are resisted, challenging the simplistic notion that people always uncritically absorb messages from the media. This approach allows for a more complex, nuanced understanding of some of the influences on suicide, and may help the health care worker to better understand the complexities of living in a 'risk society'.

THE MEDIA

It is important that the effects of the media are not viewed one dimensionally. People bring to their media experience a complex array of information, social and cultural values, opinions, religious beliefs and differing levels of intelligence, experience and susceptibility. These factors all *mediate* the ways in which people take on board information or adopt attitudes or behaviours that are represented. Recent research on media effects, particularly in relation to suicide (e.g. Blood *et al.*, 2001), has suggested that most people do not uncritically take up media messages. People may actively resist media messages, or may reshape them to suit their own needs and interests.

Having said this, it does not mean that the media have no influence at all. The media are a part, and arguably a major part, of the myriad of influences which contribute to an individual's socialisation. They can play a powerful role in shaping public opinion and are a significant 'gatekeeper' for the information we can access about what is happening in the world.

For these reasons it is important to examine the ways in which the media represents suicide. Pirkis and Blood (2001) identify the following as problems in the media's coverage of suicide. (It is important to preface these, however, with the observation that there are great variations in the media's representation of any issues, ranging from the sensationalism of the 'tabloid' press and some commercial radio to the much more considered perspectives presented in other newspapers, radio and television).

- The methods used in suicide or self-harm are often explicitly described
- Inappropriate language is used, such as 'failed suicide attempt' or 'successful suicide bid' [We would also add to this the use of the term 'committed suicide', which implies the moral evaluation of suicide as a sin or a crime.]
- Mental health problems are sometimes described in stigmatising language
- There is a lack of an accompanying provision of information about support services for those at risk of suicide.

The report by Pirkis and Blood also outlines a number of negative outcomes that may arise from the types of media reporting outlined above. These include:

- The reporting of suicide can negatively impact upon those at risk
- Some research has found that reports of suicide can lead to an actual increase in suicide rates
- The reporting of new suicide means can lead to awareness and increased use of such means
- Negative reports of suicide can lead to increased stigmatisation within the community of those at risk
- Media reports of suicide may increase the impact upon those bereaved by suicide, particularly if they are approached by the media.

We should not over estimate the media's effect on suicide rates, however. Goldney (2002) points out that the role of the media is:

important in a small proportion of those who suicide....[but] even among young women, the group most likely to be influenced..., no more than 5-6% of suicides could be attributed to such publicity. It is doubtful whether the influence of the media could be considered responsible for more than 1-2% of suicides (p.28).

Goldney argues that 'if the media behave responsibly, by minimising sensational depictions about suicide, there will probably be fewer suicides by imitation' (p.28). Pirkis and Blood also suggest that media reports of suicide can lead to positive outcomes, pointing out that:

- News stories, when appropriately written and referenced, can provide the catalyst for those at risk to seek support
- The media can raise public awareness of the prevalence of suicide risk and assist people to understand and address this issue.

All of these points are directly relevant to primary health care workers. An awareness of these issues may assist practitioners to:

- Recognise the impact of their own comments to the media
- Advocate for appropriate media coverage of suicide
- Recognise some of the current cultural contexts that may inform suicide risk (such as high profile reporting, both nationally and internationally)
- Take into their own practice the imperative of using non-stigmatising language.

Suicide risk must be assessed as part of the broader social context within which people exist. While it is important that health workers understand some of the many influences that impact upon suicide risk, these should not be applied rigidly to each person, but instead may inform or guide the information that is gained within risk assessment. Being aware of factors such as media influence will assist in making a thorough assessment of risk.

THE INTERNET

The number of people who are connected to the Internet at home, or who have access in some form, is rapidly growing. While there are a number of potential gains to be made in using the Internet as a support and resource tool for those at risk for suicide, it may also work against these ends by providing access to increased knowledge about suicide means. Research by Baume *et al.* (1998) has shown that the Internet may be used by those at risk for suicide to:

- Gain information about effective suicide means
- Access advice (on suicide) from online chat rooms
- Feel supported in their decision to suicide.

The relative anonymity of the Internet may possibly encourage those contemplating suicide to explore thoughts and plans when they may not otherwise have had the opportunity to do. It has been suggested that while the Internet may be a valuable resource for those at low risk of suicide, it may only serve to promote suicide to those who are at high risk or in crisis (Becker & Schmidt, 2004).

Research has also suggested that media and Internet representations of suicide are seen to provide a model that some may seek to emulate (Blood *et al.*, 2001; Becker & Schmidt, 2004). The Internet in particular has been considered a key site for providing people with an opportunity to formulate suicide plans that can be shared with others (and indeed often commented on and supported by others).

One recent example of this is discussed by Rajagopal (2005), who suggests that the Internet may be a fertile ground for the formulation of 'suicide pacts', whereby relative strangers arrange to suicide at the same time. Whilst such pacts are not a new phenomenon, they have in the past typically been enacted by those in close relationships with one another, or by members of particular religious groups. The Internet has allowed strangers to make such pacts, and recent Japanese reports have shown that they are often followed through with (see Rajagopal).

Health workers may be able to make positive interventions by providing information about websites that support suicide prevention (see the website reference list). This may also involve encouraging people to seek offline counselling, or reconsider the information and choices available online. As the Internet continues to open up new possibilities for relating to one another and for promoting health, it is important that practitioners continue to develop an understanding of the implications of these ongoing changes.

ALCOHOL AND OTHER DRUG USE

The relationship between suicide and alcohol and other drug use is not simple or straightforward. While in some cases alcohol or drugs may be the actual means to suicide, this is not often the case (Dhossche, 2003). Instead, alcohol and drugs are often mediators, which may:

- Destabilise a person's sense of hope or social value
- Promote spur of the moment decisions or irrational thinking
- Exacerbate other problems such as mental illness or domestic violence
- Interact with one another, causing overdose.

As drugs and alcohol often work to cloud or impair judgement, they may leave those people already at risk susceptible to further risk and feeling that suicide is a viable option. The ongoing use of alcohol and other drugs, particularly in large quantities over a considerable length of time, can reduce a person's ability to cope with day-to-day stressors, and may leave them unable to deal with adverse life events.

Alcohol and drugs may also increase suicide risk in the context of volatile personal relationships (Rivara *et al.*, 1996). Regardless of whether a person at risk of suicide uses drugs and alcohol themselves, they may find it difficult to cope with a partner or housemate who does, especially if their use increases:

- Unpredictable behaviour
- Mood swings
- Misuse of personal property or money.

The research indicates that there are some gender-specific issues in the relationship between suicide and drug and alcohol use (e.g. Cottler *et al.*, 2005; Rivara *et al.*, 1996). For example, it seems that suicide ideation as a result of alcohol use may be higher among women than men. The research indicates too that different interventions may be appropriate for men and women. Cottler *et al.* propose that women may require interventions in relation to the use of alcohol and drugs that focus on depression. However, men may require interventions that focus on both the use of alcohol and drugs as a response to poor coping skills, and the increased aggression that some men may exhibit due to drug and alcohol use.

The research on alcohol and drugs and their relationship to suicide also highlights the importance of understanding how these substances may interact with one another to increase suicide risk (Wilcox *et al.*, 2004).

The use of illicit party drugs such as cannabis, ecstasy and amphetamines has been shown to be associated with mental illness and suicide, especially among young people i.e. 15-24 years. A Western Australian study revealed that of the 571 young people who died by suicide in the period 1986-1998, 30% had illicit drugs detected in their toxicology analysis. Alcohol is often consumed just prior to suicide, and where blood alcohol levels reached the point of intoxication there was an increased likelihood that illicit drugs were also present. Where drugs were detected at post mortem they were usually found in combination (WA Ministerial Council for Suicide Prevention).

It is clearly important that health workers include assessments for drug and alcohol use in their suicide risk assessment and that they have a high index of awareness of the possibility of suicide risk when they are responding to drug and alcohol related issues. The early detection of alcohol or drug misuse use (or a combination of both) may lead to more effective interventions to reduce suicide risk (Cottler *et al.*, 2005).

2. POPULATION SPECIFIC ISSUES

This section considers the influences on suicide and risk for specific target populations. There is no suggestion, however, that certain populations are inherently at risk. Rather, it is suggested that particular cultural and social factors may increase the suicide risk of particular groups at particular times. It is important that primary health care workers are aware of these risk contexts if they are to assist individuals in these groups to deal effectively with potential risk factors.

Stigma is an important consideration for ‘special population groups,’ as well as some particular individuals and may impact in any given consultation or interaction. People with mental illness often report that coping with stigma is just as difficult as the symptoms of their illness.

Some individuals and population groups who may be at risk, carry the burden of multiple aspects of their life and identity being stigmatised, e.g. people living with poverty, homelessness, non heterosexual preference, drug use. It is crucial that clients do not experience stigma in the very settings from which they seek assistance. Stigma is not only reflected in an individual’s particular use of words or labels. It is a much broader issue about being respected and taken seriously. The way in which a person is treated, relates to their whole experience in a particular setting, i.e. from reception to leaving the setting. It is therefore important that appropriate training takes place and that attention is paid to the ethos and style of communication within workplace settings.



(See the video interview with ‘Sarah’ for [a consumer perspective on stigma](#))

FAMILY AND DOMESTIC VIOLENCE AND SEXUAL ABUSE

There is growing recognition of the prevalence of family and domestic violence, together with acknowledgment of high rates of sexual abuse of both adults and children – issues which have been well publicised (eg Layton, 2003; Olsson & Chung, 2004; Breckenridge *et al.*, 2005). While family and domestic violence and sexual abuse occur in all population groups, it is predominantly women who are the victims, especially of domestic violence. It is now widely recognized that prevention responses that are specific to the population group who have experienced such abuse, are required.

CHILDHOOD ABUSE

A substantial amount of research has explored the relationship between suicide and experiences of interpersonal violence. It is becoming increasingly apparent that childhood sexual abuse, physical abuse and neglect are all strong independent suicide risk factors.

A solid research base also exists correlating histories of sexual assault with suicidal behaviour....A number of studies have demonstrated that abused women are significantly more likely to be suicidal than non-abused womenAlmost a decade ago, Stark & Flitcraft (1995) identified domestic violence as possibly the single most important precipitant of female suicide, a finding that has subsequently been confirmed by a number of other studies, both overseas and in Australia. (Stewart, 2004, p.11)

Childhood sexual abuse frequently goes unreported until adulthood, where it may be re-lived. The research literature is unequivocal in asserting that a significant proportion of adults who experience child sexual abuse will, as a result, experience social, emotional and psychological problems of a serious and disruptive nature when they are adults.

Much of the literature links child sexual abuse with higher rates in adult life of depressive symptoms, anxiety disorders, substance abuse, somatic and eating disorders and self-harm including suicide.

... [Australian studies] by Dusevic et al. (2001) and Fry (2000) give some indication of the prevalence of attempted suicide and suicidal ideation among women with histories of childhood abuse. Dusevic et al. found that domestic violence was seen to be the dominant risk factor (14%) among the immigrant women they surveyed, followed by 'relationship problems' (14%). However, sexual assault also accounted for 5% of responses. Abuse was also noted as a suicide risk factor by 14% of the non-English speaking background young people surveyed. (Breckenridge et al., 2005, pp.18-19)

DOMESTIC VIOLENCE, SUICIDE AND MURDER-SUICIDE

Domestic violence manifests in a range of ways. The abuse may be physical, sexual (including rape by strangers, acquaintances, spouses/partners), social (e.g. denial of freedom), economic, verbal, emotional, cultural or spiritual. The great majority of perpetrators are men, and the vast majority of those who experience abuse are women. This often occurs within the context of heterosexual marriage or relationships, though there is a growing recognition of abuse and violence within same-sex relationships.

In relation to domestic violence and suicide, there has recently been increased reportage of phenomena such as murder-suicide. Dawson (2005) suggests that murder-suicide typically takes two forms within the context of domestic violence:

- The murder is premeditated as a planned 'response' to suicide. This often occurs when the male partner harbors considerable mistrust against the female partner, or where his desire for suicide is matched by his desire for his partner to not survive his death. In this case the male plans to murder his partner and then suicides.
- In this instance the suicide is an unplanned response to a (potentially) unplanned murder that occurs in the context of domestic violence. Here the male (most often) partner kills his female partner in rage and then feels either guilt or fear of reprisal, and so suicides.

These two accounts demonstrate the complex ways in which suicide may occur in the context of domestic violence. While research has shown that women are at increased risk of suicide in the context of violent relationships (Ullman, 2004), recent research has also shown that men may be at risk for suicide in abusive relationships where the suicide behaviour is a response to their own violence (Dawson, 2005). Research has also shown that men may be at increased risk of suicide once they leave violent relationships. For example, men who lose custody of children as a result of violent behaviours are reported to be at greater risk for suicide and self-harm (Conner *et al.*, 2002).

It is important to reiterate that those primarily at risk within the context of domestic violence and sexual abuse are women. Yet, as previously mentioned, there is a growing recognition of the role that men's violence plays in their suicide rates. This suggests that when assessing risk, health practitioners must consider how men may be at risk, both of suicide and for murder-suicide. It is also important that practitioners understand how talk of suicide may potentially be used as a tool for further threatening or enacting violence against women in the context of a heterosexual relationship. While talk of suicide should not be understood only as a threat to others, it is important that practitioners adequately assess the intent behind suicide talk, particularly amongst men in violent relationships, and understand the role this may play in justifying or perpetuating abuse against partners.

In the instance of women who have experienced violence and abuse, practitioners may note feelings of despair and hopelessness, a history of abusive relationships, or physical symptoms of abuse. Dawson (2005) suggests that men who are at risk for murder-suicide may present signs of premeditation that may be evident in the clinical setting, such as plans to watch, monitor or stalk ex-partners, and plans for revenge or atonement. Behaviours such as these in the context of the clinical setting could therefore require risk assessment both for the client and for those family members who may be at risk for further violence. This could necessitate the involvement of police or other community agencies.

POWER IMBALANCES

Finally, as has long been demonstrated in research on domestic violence, it is important that practitioners understand the complex ways in which power is wielded in violent relationships (Pratt, Burman & Chandler, 2004), most often to the detriment of women. A common response when people hear about ongoing domestic violence is to ask: Why doesn't she leave?

Usually the person posing this question cannot, from his or her own experience and expectations, imagine staying for a minute. And, sometimes, implied in the question, is an assumption that at some level she must want it or else she wouldn't stay.

For women who experience family and domestic violence, the issue is usually much more complex, a major factor being that they want the violence to end but not necessarily the relationship. Their partner may be violent – but that is not how they experience the sum total of who he is or how he always behaves. It becomes double jeopardy for women if they not only experience the violence, but also the blame for not resolving the situation. And it is also incorrect to assume that if she leaves, she will therefore be safe. (PADV, 2005, Point of Contact, Book 4, p.17)

In some cases women don't leave violent relationships because they are too scared to. They may know that leaving, or making attempts to leave, will precipitate increased violence, threats to track them down or stalk them. Engaging with these women requires sensitivity to a whole range of logistical, interpersonal, social, economic, religious and cultural reasons why they may choose to stay in a violent relationship, or why it may be difficult for them to leave. It is important that victims of violence are responded to with compassion, non-judgemental attitudes and respect for their life choices. Rebuking or challenging someone for staying in a violent relationship is not a helpful response. Practitioners must also be informed about appropriate referrals to support services to ensure that people experiencing domestic violence are afforded the opportunity to access help as required.

RISKY BEHAVIOURS

The behaviours discussed in this section are often referred to as high risk. While they do not necessarily signify suicidal behaviour, they may precipitate later suicide behaviour. As such they represent an important site for intervention for primary health care workers who may be able to identify such risk taking behaviours within the clinical setting. Some of these behaviours may include:

- Binge drinking
- Dangerous or risky driving (i.e., speeding, racing etc.)
- Drink driving
- Unprotected sexual intercourse
- Dangerous behaviour such as 'playing chicken' with cars or trains
- Deliberate self harm
- Problem gambling.

Obviously many of these behaviours may be fairly typical of some young men in countries such as Australia, where peer pressure or a desire to conform may lead them to take risks. Yet research has shown an increase in adults (25 years and above) engaging in these behaviours. This suggests that far from being a phenomenon associated with youth or immaturity, such risky behaviours may constitute a broader social trend.

GENDER AND RISK TAKING

Historically, it has been predominantly men who engage in these risky behaviours, but recent research has shown a rise in the numbers of women engaging in them, particularly binge drinking (Langhinrichsen-Rohling *et al.*, 1998). The consumption of alcohol and drugs is correlated with a rise in risky behaviours, in both men and women, and as the number of women drinking heavily rises (particularly in the form of binge drinking), there is the potential for a concurrent rise in women engaging in other risky behaviours. This suggests an important role for health workers in monitoring such behaviour, and intervening early where appropriate, to detour such people from a pathway to suicide in times of despair later in life.

There has been concern in recent years in the Western world generally, about the issue of deliberate harm and injury, especially in younger people, i.e. up to 24 years (Government of WA Report to Parliament, 2001). Key concerns include: opportunities for clients to slip through the cracks at a number of points, e.g. during waiting periods; inadequate level of service provision; patients not always receiving appropriate risk assessment; and unclear duty of care obligations.

Deliberate self harm, which includes attempted suicide, is a predictor of death by suicide with the greatest risk being in the initial weeks after discharge from hospital (Government of WA Report, 2001). Jo, who was interviewed for this resource about her son's suicide, confirms the relevance of self harm in the following way:

One big thing I realise now that I feel we all misinterpreted – the importance of the self harm. Even though it wasn't severe, within itself the last and most serious act of cutting himself probably required stitches. We didn't stitch it, we pulled it together with butterfly closures and it healed quite well. But you know really, he probably should have had stitches and perhaps if we had had stitches it might have gone down a different track, because someone else might have picked up on it and alerted and said, hey look I think this needs to be treated more seriously. But because there wasn't any medical intervention at that point, maybe that was a missing link. Who knows? (Jo, Adelaide 2005).

The potential seriousness of the issue of deliberate self harm, including behaviours such as cutting or burning, may also be underestimated in primary health care and community settings. Such behaviours should alert health workers and others to the possibility of suicide risk.

A final form of risky behaviour that requires attention is a recently identified phenomenon known informally as 'suicide by cop'. This behaviour is typified by individuals threatening public safety in highly visible ways, the aim being to force police to shoot them (Hutson *et al.*, 1998). While this may not always be the intent of people who threaten public safety in this fashion, it is important that health workers who work in an advisory position to the police are aware of the potential for this type of behaviour to occur.

Together, these forms of risky behaviour demonstrate the changing nature of suicide behaviour within western societies. While all risky behaviour may not be informed by suicide intent, it is important that such behaviours are considered in risk assessment. Engagement in such behaviours may constitute an early warning sign for suicide risk, and may therefore be important factors requiring identification and monitoring by primary health care workers.

3. LEGAL ISSUES

This section briefly addresses some legal issues which practitioners need to be aware of to negotiate safe and accountable practice with clients at risk of suicide. Issues discussed include: Duty of care; Negligence and Liability; Confidentiality; Consent; and Euthanasia.

DUTY OF CARE

Health workers owe a duty of care to the people they treat. This means that they must take steps to ensure that the people they care for do not come to foreseeable harm by their actions or their failure to act.

Australian case law emphasises the need for the medical practitioner to be up to date with current medical knowledge, though this is still governed by the standard of reasonableness. Australian court decisions place greater emphasis on 'reasonable care' as opposed to standards of professional practice and custom.

NEGLIGENCE

If a health worker fails to use the standard of care and skills that a court would reasonably expect in the circumstances from someone with their professional skills, training and experience, they may be found guilty of negligence.

For a health worker to be found negligent, the patient (or representative) must demonstrate that they have suffered an injury or loss and that the health worker caused the loss/injury because of a failure to take reasonable care in the circumstances.

LIABILITY

Increasingly therapists and clinicians are concerned with the risk of litigation. The risk of clients harming themselves can inhibit the therapist from acting creatively and collaboratively, making their actions defensive and focused 'solely on risk assessment rather than therapeutic change'. Understandably then, in an under-resourced system, focus shifts to at least keeping these clients safe (Petrakis, 2004).

With suicide deaths the legal difficulty often lies not in proving breach of duty, but rather in establishing causation – i.e. was the wrongful act or omission of the practitioner a legal cause of the death when the most immediate cause was the act of the deceased? In many cases, the deceased's final act is seen to break the causal link between the defendant's wrongful act and the death.

However, there may be liability when the possibility of suicide is the very risk that it is the defendant's duty to guard against. In a 2004 case (*Da Pos v Mayne Corporation*) the plaintiff successfully relied upon the proposition that it was the hospital's duty to guard against the risk of deliberate self harm in a patient who sought treatment for mental distress. It was successfully contended that the content of the duty owed by the hospital to its patient required the hospital to take steps to protect him from causing harm to himself.

FORESEEABILITY AND CAUSATION

Packman *et al.* (2004) suggest a number of key elements that may result in litigation in regards to suicide. These include negligence by commission (doing something that shouldn't have been done), and negligence by omission (not doing something that should have been done). Some examples of these include:

- Failure to predict or diagnose suicidal intent
- Failure to control, supervise or constrain
- Failure to treat properly.

The practitioner must ensure that an appropriate risk assessment is undertaken, and that such assessments are regularly updated and monitored (Simon, 2000). While risk assessments cannot predict suicide, it is important that practitioners not only foresee potential suicide risk, but that this risk is adequately addressed and that a management plan is implemented.

At the same time, however, foreseeability does not equate with preventability (Simon, 2000). An individual will most likely not have a case against a practitioner who took all possible steps to assess risk and engage in prevention, but the end result was still death by suicide.

Legal action over causation may also occur when a practitioner fails to intervene when suicide means and plans are known, or when a practitioner's own comments, opinions or actions lead a client to suicide. These may include inappropriate or abusive actions or comments.

This demonstrates the importance of practitioners examining their own beliefs and behaviours around suicide, and being careful of what they say to clients within the clinical setting.

Risk assessment also requires an assessment of potential risks that the client may not be aware of. Thus as Simon (2000) suggests:

...it is a serious clinical error to equate the absence of suicide risk with a patient's denial of suicidal ideation, even if the patient is telling the truth. A patient may be at high risk for suicide because of the presence of other significant suicide factors (p.401).

This demonstrates that while it is important to value clients' subjective experiences of suicide risk, it is also important that practitioners adequately document their own assessment of risk.

RISK DOCUMENTATION

The literature on litigation and suicide suggests that it is of key importance that practitioners adequately document their actions and choices in regards to suicide risk. In addition to adequate documentation, it is important that practitioners:

- Consult with colleagues to ensure the validity of decisions
- Know their legal and ethical responsibilities
- Are adequately aware of risk factors for clients
- Obtain previous risk assessment data or conduct risk assessments
- Honestly determine their own competencies in regards to suicide risk assessment and, if necessary, seek further training
- Consult with family members, carers and significant others.

While such actions will not always fully protect workers from litigation, they will certainly ensure that a high standard of care is provided, and that such care is well documented and maintained.



(See also Dr Tori Wade talk in this excerpt about the [importance of good documentation](#))

CONTRACTS

There is some disagreement about the advisability of suicide prevention contracts, but it is beyond the scope of this paper to consider these arguments. It is however, important to point out here that the use of 'suicide prevention contracts' does not mitigate against legal action (Simon, 2000). Indeed, the irresponsible use of such contracts (e.g. where there is not a strong therapeutic bond as the basis, or where definite means and plans are known) may lead to litigation.

Dr Randall Long cautions in his [Risk Assessment discussion paper](#) that:

Professionals should take care if they plan to use so called 'suicide prevention contracts' either verbally or in writing. It can be argued that suicide prevention contracts in themselves can be counter productive as they may give the worker a false sense of security. Suicide prevention contracts do not work in themselves, but rather it is the intuitive therapy that a professional may deliver around the contract that can actively reduce suicide risk. It should be remembered that a contract is a technical and legal agreement with benefit for both parties. In general, a client may not enter into a contract if they lack autonomy in that specific area. A suicidal client, by definition, probably lacks autonomy in this area, or the professional would not be trying to intervene. Therefore, based on this ethical argument clients cannot credibly enter into suicide prevention contracts. Other disadvantages with suicide prevention contracts are that patients may feel ashamed if they believe they are 'breaking the contract', and will not contact the worker for fear of letting them down.

CONFIDENTIALITY

Information about a patient should not be given to anyone else without the patient's permission. A disclosure in the absence of a strong belief that the client presents an immediate risk to themselves potentially creates a situation in which the therapist could be sued by the client for breach of confidence. However, failure to disclose where there is a strong belief that the client presents an immediate risk to themselves, and if the client subsequently takes his/her own life, may lead to someone having to defend themselves against the accusation of failure in their duty of care.

Here are some examples of legislation in South Australia regarding confidentiality as it relates to health workers:

Duty to maintain confidentiality – [s34 Mental Health Act 1993 \(SA\)](#)

Duty to maintain confidentiality – [s80 Guardianship and Administration Act 1993 \(SA\)](#)

Duty to maintain confidentiality – [s64 South Australian Health Commission Act 1976 \(SA\)](#)

Schedule 3 National Privacy Principles – [s10 Sensitive Information - Privacy Act 1988 \(Cth\)](#)

Most people will readily give permission for you to communicate with other service providers or supportive family and/or carers

CONSENT

While different states and territories may have particular understandings and legislation around key issues, in South Australia consent to treatment means informed consent (Mental Health Act 1993 (SA) s3). For consent to be informed the patient needs information that enables him or her to understand the procedure or treatment, the consequences of not having or agreeing to the treatment and also alternative treatments. The person must also be deemed well enough to be able to give informed consent. The person must be given information as to the general nature of the treatment. Consent must also be effective – i.e. the person should be able to demonstrate in his or her words their understanding of the treatment.

A person at risk of suicide can consent to Voluntary Admission in an approved treatment centre (hospital, clinic or other premises or any particular part of such a place, declared under Part 2 of the Mental Health Act to be an approved treatment centre). While they can leave at any time, they can also be made subject to an order for detention if the criteria are satisfied ([Mental Health Act 1993 \(SA\) s11](#)).

DETENTION

Orders for admission and detention can be made in South Australia when the following criteria are satisfied:

- Person has a mental illness that requires immediate treatment
- Such treatment is available at an approved treatment centre
- The person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons. (Mental Health Act 1993 (SA) s12)

There are some situations when a person can be given medical treatment without consent:

- In an emergency
- If unconscious
- If someone is required by law to make decisions on the person's behalf
- If a guardian has been appointed to made decisions on the person's behalf.

EUTHANASIA

Health workers are generally acutely aware of the issues facing chronically ill people. In an important article, Stevens and Hassan (1994) focus on the juxtaposition between the intentions of the Hippocratic Oath – among other things the commitment to do no harm – and the increasing demand from clients and users of public health for greater control over medical decision making and life options. Their discussion distinguishes between active euthanasia (where a practitioner actively assists in terminating life), and the withdrawal of treatment (where a person is no longer given treatment that has thus far kept him or her alive).

While the legality of euthanasia or physician-assisted suicide may vary in different states (for example, it is illegal in South Australia), Stevens and Hassan state that a considerable percentage of practitioners report enabling euthanasia, either through active or withdrawal methods. While a number of practitioners in their study refuted the rights of health care professionals to do this, there were others who either supported or who had practised euthanasia, demonstrating the changing and contested views in this area.

Much of the debate over euthanasia focuses on the conflict between sustaining life and relieving suffering. These are important issues for General Practitioners who may be confronted by clients who either implicitly or explicitly seek assistance in accessing medications that may assist in suicide. While this paper does not attempt to take a definitive position on this dilemma, it canvasses these issues so that workers can consider their views and how they may respond to patients seeking their assistance in this way. Their responses may well shape whether and how a person goes on to contemplate suicide, and how this may relate to the end of life decisions that they make.

Practitioners also need to be aware of related issues such as those surrounding do-not-resuscitate (DNR) (Eliot & Olver, 2003). Clients may approach practitioners for information or advice in these areas, and it is important that they are able to offer informed, non-judgmental information. This of course does not mean that practitioners must uncritically accept information presented to them within the clinical setting, but it is nonetheless important that clients are able to access available information in order to make appropriate decisions. Withholding information on the basis of moral or personal judgments about euthanasia or DNR orders will not enable people to make informed decisions.

It is useful to highlight the difference between those who may contemplate suicide as a result of personal, cultural or emotional hardship, and those who may consider suicide as a necessary choice when life quality is severely reduced by extreme pain or illness (a category that may include those doctors treating clients in such pain, as Stevens and Hassan (1994) suggest). While the legal issues involved in euthanasia are very much the same as those for any health worker working with clients at risk of suicide, the issue of euthanasia is part of a debate about morality, life and death that will continue to be contested within health care. The information provided here may assist practitioners to reflect on the possible decisions they can make when confronted with these issues, and when making risk assessments.

4. SELF CARE

Self care is typically not given much emphasis in health training. Yet there are proactive ways in which practitioners may engage in self care which may prevent burnout or other long term negative effects or potentially, practitioners' suicide.

It is important to understand the cultural context in which Australian workers practice. Because the dominant (male) Australian culture does not condone public displays of grief, and because of notions of 'professionalism' and 'objectivity' within the health professions, practitioners may hide their feelings or not take sufficient time out to deal with loss and grief. Reflexive thinking is integral to self care.

BURNOUT

Health workers are at high risk of burnout which may be caused by: 1) emotional exhaustion, 2) lack of professional efficacy, 3) cynicism, or 4) lack of adequate social support (Barnett *et al.*, 1999; Fox & Cooper, 1998).

STRESSORS

Common stressors within the health professions, which may lead to burnout, are:

- Understaffing/high client load
- Constantly having to make critical decisions
- The litigious context within which health operates
- High levels of emotionality with clients
- Sleep deprivation
- Teaching and research demands (Gundersen, 2001).

VICARIOUS TRAUMATISATION

These stressors, particularly when associated with the loss of a client through suicide, may result in health workers feeling overwhelmed by their work. Working constantly with clients in crisis can also result in vicarious traumatisation, where the practitioner personally experiences the client's psychological traumas. This is most likely to occur if a practitioner does not have suitable opportunities to debrief after a critical incident or when they feel personally accountable for the incident itself.

It is important for practitioners to remember that while they can assess the risk of suicide, they cannot always prevent it. They should not feel guilt or shame if they have not been able to 'save' a client. Working with clients, and empowering them to develop the necessary skills to maintain a positive focus on life may be a more productive means to suicide prevention than attempting to 'rescue' clients who are at risk.

Effects of burnout may include:

- Negative work-related attitudes, including cynicism
- High levels of alcohol and drug use
- Relationship problems
- Mental health problems.

Negative or cynical attitudes may lead to practitioners making unethical decisions, or failing to adequately address issues of suicide risk (e.g. by minimising their time with clients).

Health workers who themselves do not take seriously their own health care, may have problems in promoting the importance of health care (and in particular preventative care) to their clients (Gross, *et al.*, 2000; Gundersen, 2001).

PRACTITIONER SUICIDE

The prevalence of practitioner suicide is a cause for concern and therefore an important aspect of any suicide prevention project aimed at primary health care workers. While suicide rates among health workers vary, there is some evidence that they may be higher than in the general population, possibly because of their greater access to lethal means. American research suggests that female medical practitioners may be at greater risk than male practitioners, possibly because of:

- Lack of female role models
- Institutional and individual sexism and other forms of discrimination
- Role conflict
- Inadequate female-specific support for women.

The impact of practitioner suicide is obviously enormous. Besides the impact that is experienced by the family of the practitioner who suicides, there is also an impact on:

- Colleagues
- Clients/patients

- Employers
- Service provision within place of employment
- Reputation of health system more broadly.

In particular, it may result in: disillusionment from colleagues; despair, or feelings of resentment from clients; pressures on the caseload to be filled in the short term; and the potential for litigation for the place of employment. It may also negatively impact upon clients already at risk for suicide.

THE CULTURE OF MEDICAL TRAINING AND PRACTICE

Medical training may create a culture that mitigates against self care, by teaching 'dysfunctional beliefs', such as:

- Altruism is good (even to the point of self-denial)
- Professionalism means keeping feelings, emotions, and uncertainty to oneself
- Ultimate responsibility for the patient is the physician's alone
- Lack of knowledge is a personal failure.

These types of beliefs may result in practitioners taking on unreasonable burdens, making decisions that may not be theirs to make, ignoring their own needs and wants, blaming themselves for mistakes based on poor knowledge, 'playing God', and failing to examine their own beliefs and roles. These may all obviously have very serious consequences, both for the client and practitioner.

If health care is to be fulfilling and sustaining for both clients and practitioners, we need a system that is both community building and individually supportive. It is important that primary health care workers, just like those at risk for suicide, focus on the protective, as well as the causative factors. This may involve paying attention to matters such as:

- Setting life priorities
- Understanding needs
- Learning to say 'No' or 'I don't know'
- Joining support groups for debriefing, trauma support and ongoing support.

REFERENCES

- Barnett, R.C., Brennan, R.T. & Gareis, K.C. (1999). A closer look at the measurement of burnout. *Journal of Applied Biobehavioral Research*, 4, pp. 65-78.
- Baume, P., Rolfe, A. & Clinton, M. (1998). Suicide on the internet: A focus for nursing intervention? *Australian and New Zealand Journal of Mental Health Nursing*, 7, pp. 134-141.
- Becker, K. & Schmidt, M.H. (2004). Internet chat rooms and suicide. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, pp. 246-247.
- Blood, R.W., Putnis, P., Pirkis, J., Payne, T. & Francis, C. (2001). Monitoring media coverage of suicide: Theory and methodology. *Australian Journalism Review*, 23, pp. 57-80.
- Breckenridge, J., Cunningham, J. & Jennings, K. (2005). *Respond SA, Adult Childhood Sexual Abuse Service, Evaluation Report*, NSW: Centre for Gender-Related Violence Studies, UNSW.
- Cottler, L. B., Campbell, W., Krishna, V.A.S., Cunningham-Williams, R.M. & Abdallah, A.B. (2005). Predictors of high rates of suicidal ideation among drug users. *Journal of Nervous and Mental Disorders*, 193, pp. 431-437.
- Conner, K.R., Cerulli, C., Caine, E.D. (2002). Threatened and attempted suicide by partner-violent male respondents petitioned to family violence court. *Violence and Victims*, 17, pp. 115-125.
- Durrington, L. (2005). Reform of Mental Health...A work in progress. PowerPoint presentation.
- Dawson, M. (2005). Intimate femicide followed by suicide: Examining the role of premeditation. *Suicide and Life-Threatening Behavior*, 35, pp. 76-89.
- Dhossche, D.M. (2003). Toxicology of suicide: Touchstone for suicide prevention? *Medical Science Monitor*, 9, pp. SR9-19.
- Elliott, J., & Olver, I. (2003). Legitimizing do-not-resuscitate orders: a discursive study of cancer patients' speech. *Journal of Palliative Care* 6, pp. 59-68.
- Fox, R. & Cooper, M. (1998). The effects of suicide on the private practitioner: A professional and personal perspective. *Clinical Social Work Journal*, 26, pp. 143-157.
- Goldney, R. (2002). A global view of suicidal behaviour. *Emergency Medicine*, 14, pp.24-34.
- Government of WA (2001). Report No 11 to Parliament, *Life Matters: Deliberate self harm in young people*. www.audit.wa.gov.au/reports/report2001_11.html

Gross, C.P., Mead, L.A., Ford, D.E. & Klag, M.J. (2000). Physician, heal thyself? Regular source of care and use of preventive health services among physicians. *Archives of Internal Medicine*, 160, pp. 3209-3214.

Gundersen, L. (2001). Physician burnout. *Annals of Internal Medicine*, 1135, pp. 145-148.

Hutson, H.R., Anglin, D., Yarbrough, J., Hardaway, K., Russell, M., Strote, J., Canter, M. & Blum, B. (1998). Suicide by Cop. [Annals of Emergency Medicine, 32, pp. 665-669. .](#)

Langhinrichsen-Rohling, J., Lewinsohn, P., Rohde, P., Seeley, J., Monson, C.M., Meyer, K.A. & Langford, R. (1998). Gender differences in the suicide-related behaviours of adolescents and young adults. *Sex Roles*, 39, pp. 839-854.

Layton, R. (QC) (2003). Our best investment: A State plan to protect and advance the interests of children. *Child Protection Review*, South Australia.

Olsson, T. and Chung, D. (2004). *Report of the Board of Inquiry into the handling of sexual abuse and misconduct within the Anglican Diocese of Adelaide.*

Packman, W.L., O'Connor Pennuto, J.D., Bongar, B. & Orthwein, J. (2004). Legal issues of professional negligence in suicide cases. *Behavioral Sciences and the Law*, 22, pp. 697-713.

PADV (2005). Family and Domestic Violence: An Overview. *Point of Contact, Book 4*. Canberra: Govt. of Australia.

Petrakis, M. (2004). Keeping the client safe: Complexities and clinician risk in working with the suicidal client. [antiTHESIS forum Volume Two](#)

Pratt, R., Burman, E. and Chantler, K. (2004). Towards understanding domestic violence: Reflections on research and the "domestic violence and minoritisation" project. *Journal of Community & Applied Social Psychology*, 14, pp. 33-43

Pirkis, J. & Blood, R.W. (2001). *Suicide and the media: A critical review*. Canberra: Commonwealth Department of Health and Aged Care.

Rajagopal, S. (2005). Suicide pacts and the internet. *British Medical Journal*, 329, pp. 1298-1299.

Rivara, F.P., Mueller, B.A., Somes, G., Mendoza, C.T., Rushforth, N. & Kellerman, A.L. (1996). Alcohol and illicit drug abuse and the risk of violence death in the home. *Journal of the American Medical Association*, 278, pp. 569-575.

Simon, R.I. (2000). Taking the 'sue' outside of suicide: A forensic psychiatrist's perspective. *Psychiatric Annals*, 30, pp. 399-407.

Stevens, C.A. & Hassan, R. (1994). Management of death, dying and euthanasia: Attitudes and practices of medical practitioners in South Australia. *Journal of Medical Ethics*, 20, pp. 41-46.

Stewart, S. (2004) Interpersonal violence, suicide & cultural diversity– what are the links?. *Australian Domestic and Family Violence Clearinghouse Newsletter*, 20, December 2004.

www.austdvclearinghouse.unsw.edu.au/PDF%20files/Newsletter_20.pdf

Ullman, S.E. (2004). Sexual assault victimization and suicidal behaviour in women: A review of the literature. [*Aggression and Violent Behavior*, 9, pp. 331-351.](#)

WA Ministerial Council for Suicide Prevention (MCSP) (no date). Youth Suicide in Western Australia Involving Cannabis and Other Drugs. Research sheet from the MCSP website, www.mcsp.org.au/files/user2/illicit_drugs_suicide.pdf

Wilcox, H.C., Conner, K.R. & Caine, E.D. (2004). Association of alcohol and drug use disorders and completed suicide: An empirical review of cohort studies. *Drug and Alcohol Dependence*, 76S, pp. s11-s19.