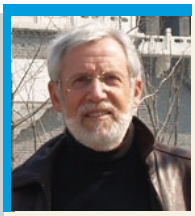
newsbulletin

International Association for Suicide Prevention

FEBRUARY/MARCH 2010



FROM THE PRESIDENT

The common law legal system originated in England in the Middle Ages and constitutes the basis of current legal systems in countries that were once colonies of the British Empire, ranging from the United States to New Zealand and Ghana.There are some exceptions, particularly in countries colonized by other nations, e.g., South Africa and Sri Lanka, which follow Roman Dutch law. Common law is equivalent to case law, as it rests on decisions of judges and courts to create a body of law and set precedents. In contrast, civil law is established essentially by legislative act or statutes; it does not rest on precedent. Civil law systems exist in most of Continental Europe, Brazil, and Japan. Yet other legal systems exist, for example, Socialist law in the former Soviet Bloc countries and Islamic law in Saudi Arabia, as do mixed systems. This much I garnered from the Internet.

The concept of negligence (a tort) exists in practically all legal systems, common, civil, mixed, or other. Typically, negligence is defined as a breach of a legal duty resulting in damages, e.g. injury or death, said breach being something a reasonable and prudent man would not cause to happen. Where a breach can be shown to have occurred and to be responsible for harm, the victim may be compensated. With regard to suicide (the damage), the question to be addressed is whether the caregiver (e.g. psychiatrist, hospital…) that has a duty towards the patient (to assess, to treat…), should have known the patient was at risk (were the consequences reasonably foreseeable?), and accordingly acted reasonably to prevent death or injury. If it is deemed that a death by suicide was caused by the caregiver's negligence, the decedent's estate may be compensated. Typically, the caregiver/institution is indemnified by liability insurance to cover such a possibility.

What becomes quite fascinating when looking at how this script plays out internationally, are its many variations. In the United States, any and all mental health professionals may be and are held liable for the death by suicide for a patient in their care. The most common malpractice complaint filed against psychiatrists is for suicide. For psychologists, suicide malpractice is the second most costly type of claim paid by liability insurers. Few, if any, countries appear to be as litigious as the United States, but several IASP members I asked reported disturbing trends.

Bob Goldney, for example, observed that "*Australia is not as litigious as the USA…we are catching up.*" Similarly, Lars Mehlum noted *"this has become an issue with increasing significance over time in Norway…*" Michael Phillips related that the seeking of compensation *"following an unexpected death has become much more common over the last 10-15 years as the middle class has risen in China."*

From Australia, Bryan Tanney further noted that *"The public health system provides malpractice insurance for all employees. If there are matters of care towards persons at risk of suicide, these are usually directed towards institutions and quickly towards the government who pays the bills."* In Norway, where most psychiatrists and psychologists treating patient populations are government employees, lawsuits are directed toward hospital trusts, rather than the individual practitioner. In China, where the vast majority of suicides, according to Michael Phillips, *"do not occur during mental health treatment, the identified 'responsible agency' is typically the institution where the individual works or studies,"* from which families will demand recompense. If the individual was in mental health care, *"it is always the institution (not the individual caregiver) [that] is the target,"* as "*individual physicians do not have insurance or money.*" In Australia, both Tanney and Goldney note that mental health professionals other than psychiatrists do not have indemnity insurance, thus are generally not sued.

Is there enough meat on the bones of these trends and variations for an IASP Task Force to explore these in depth and produce a white paper on the subject? Are there IASP members interested in pursuing this or related objectives based on the potential for this issue to be a more significant concern to mental health clinicians and treating institutions around the globe in the coming years?

Lanny Berman, Ph.D., ABPP

THE SUICIDE PREVENTION RESOURCE CENTER

Jerry Reed
Ph.D., MSW

The Suicide Prevention Resource Center (SPRC) is a national resource center in the United States to help stakeholders enhance their capacity to develop, implement, and evaluate suicide prevention programs, policies, and activities.

SPRC was funded in 2002 by the United States Department of Health and Human Services to fulfill Objective 4.8 of the National Strategy for Suicide Prevention which called for the development of one or more training and technical resource centers to build capacity for states and communities to implement and evaluate suicide prevention programs. In 2004, SPRC expanded its role to provide technical assistance services to states, tribes, and colleges and universities receiving Federal funds for suicide prevention activities under the Garrett Lee Smith Memorial Act, a legislative initiative that supports the planning, implementation, and evaluation of activities to prevent youth suicide in the United States.

SPRC's staff includes experts in suicide and suicide prevention, public health, mental health, communications, technology, education, training, program design, implementation, and evaluation, and library and information science. Prevention and information specialists offer technical support to state, tribal, territorial, and campus groups engaged in activities to prevent suicide. SPRC's Best Practices Registry for Suicide Prevention reviews and disseminates information about evidence-based programs, expert and consensus statements, and suicide prevention programs and practices. The SPRC Training Institute provides a wide array of face-to-face and online learning opportunities including *Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals, Strategic Planning for Suicide Prevention, and Research to Practice Webinars*. Resources available through the SPRC Online library includes suicide data fact sheets, program planning tools, information on suicide risk in specific populations, clinical guidelines, and SPRC publications such as *Suicide Risk and Prevention for Lesbian, Gay, Bisexual and Transgender Youth and The Role of Faith Communities in Preventing Suicide*. The Weekly Spark, SPRC's electronic newsletter, highlights news, announcements, events, research, and funding opportunities related to suicide and suicide prevention.

SPRC works closely with other suicide prevention organizations, including the American Association of Suicidology (AAS), the American Foundation for Suicide Prevention (AFSP), and the National Suicide Prevention Lifeline, a free, 24-hour telephone hotline for people in emotional distress or suicidal crisis. For more information about SPRC and direct access to many of its resources, visit the SPRC website (http://www.sprc.org). SPRC prevention and information specialists can be reached by telephone at +1-877-438-7772 or by email at info@sprc.org.

Contributions for the news bulletin are welcomed from other organizations.
Please send any contributions to Dr. Jerry Reed or contact him for advice about preparing your report
jreed330@comcast.net

SPRC SUICIDE PREVENTION RESOURCE CENTER

TASK FORCE:
National systems for certifying suicidal deaths

Suicide statistics are a central focus for all involved in suicide research and prevention, yet many of us have limited knowledge of the systems and procedures that generate these statistics. As a consequence, we may be unaware of issues that would affect our interpretation and use of suicide statistics. The primary goal of this task force is to establish a database that describes national systems for certifying suicidal deaths.

Anyone interested in contributing descriptions of their national system is invited to visit the relevant page of the IASP website (http://www.iasp.info/national_systems_for_certifying_suicidal_deaths.php) where a detailed description of the Irish system is provided as an example. Descriptions may be submitted by email to the Chair of the Task Force.

Dr Paul Corcoran, Task Force Chair, paul.nsrf@iol.ie

IASP

In official relations with the World Health Organization

President: Dr Lanny Berman
1st Vice President: Professor Heidi Hjelmeland
2nd Vice President: Professor Paul Yip
3rd Vice President: Dr Ella Arensman
Treasurer: Professor Michael Philips
General Secretary: Dr Tony Davis
National Rep: Dr Murad Khan
Organisational Rep: Dr Jerry Reed

REPORT FROM A NATIONAL REPRESENTATIVE

SUICIDE IN NEW ZEALAND

Sunny Collings
Ass. Prof.

In 2007, the most recent year for which statistics are available, the age-standardised suicide rate was 11.0 per 100,000 (483 people). This continues the downward trend since the peak years 1994-98 when rates ranged between 14.1 and 15.1 per 100,000. The 27.3% drop since 1998 when the rate was at its highest masks more dramatic changes for specific groups. Rates for men aged under 30 have dropped by over 40% and for 15-24 year-olds they have dropped by over 45% over the last 12-15 years. However, there are still areas of concern: Maori (NZ's indigenous people) had a 60% excess risk of suicide in 2007, with rates showing no obvious sign of converging towards non-Maori rates.

In 2006 NZ adopted an all-ages suicide prevention strategy followed by a multi-sectoral action plan for 2008-2012. In 2007, NZ$23 million was allocated to suicide prevention activities over 4 years. We were fortunate to have this commitment before the economic crisis and will need to work hard to ensure that suicide prevention remains on the government agenda after 2012. Government spending is likely to be lean over the next decade so future emphasis will necessarily be even more focused on evidence. Retaining some balance between research and intervention programs will be important.

Current research includes investigations of family factors in the development and management of suicidal behaviours in young people, geospatial mapping of suicide and suicide attempt clusters, content analysis of suicide reporting in the our media, and media influences on suicidal behaviour. Research on specific interventions includes trials of Dialectical Behaviour Therapy for adolescents, and problem-solving therapy and a community intervention for reducing suicidal behaviours across the age span. Current intervention programmes include the ASIST suicide prevention first-aid training, specialist counseling for those bereaved by suicide, community postvention response, and a clinical and monitoring intervention for young people in care and protection.

Outside suicide prevention programmes there is scope for activity that can contribute to reductions in suicidal behaviours. For example, NZ society has major problems with its binge-drinking culture and alcohol consumption and there is community acknowledgement that the associated health and social consequences are not acceptable. In 2009 our Law Commission reviewed policy and practice relating to liquor availability. If evidence-led, politically courageous choices follow from this, one consequence may be further reductions in suicidal behaviours in the short as well as the longer term.

Sunny Collings, Associate Professor, University of Otago, Wellington

THEME

Effectiveness of restricting access to means and methods of suicide and deliberate self harm - An update

The review of effectiveness of suicide prevention programmes by Mann et al (2005) showed that restricting access to (potentially) lethal means appears to be one of the most effective measures to prevent suicide.

Since publication of the review, the outcomes of numerous new studies have been published reporting on various measures to restrict access to lethal means for suicide and deliberate self harm Overall, the outcomes of the research published in recent years further consolidate the findings of Mann and colleagues published in 2005.

Studies in which the effects of barriers on bridges or limited access to bridges which had become so-called 'hotspots' were examined, all showed significant reductions in suicide with no indications for substitution effects (Bennewith et al, 2007; Reisch et al, 2007; Skegg & Herbison, 2009). Remarkably, Beautrais et al (2009) reported a fivefold increase in the number and rate of suicides from a bridge in New Zealand after barriers that had been in place for 60 years were removed, which further underlines the importance of restricting access to means as a suicide prevention strategy.

A study investigating the impact of the withdrawal of prescription painkiller co-proxamol in the UK consistently showed significant reductions in suicide involving co-proxamol, with little evidence for substitution effects (Hawton et al, 2009).

Even though legislation restricting paracetamol pack size initially showed promising results in terms of reduced rates of suicide and deliberate self harm, this was not confirmed by outcomes of a study by Bateman et al (2006) conducted in Scotland. However, in a second Scottish study reduced rates of deliberate self harm were observed immediately following the 1998 legislation restricting the paracetamol pack size, but this effect was not maintained in the long term (Gorman et al, 2007). In this regard it would be recommended to further restrict the paracetamol pack size and restrict the number of outlets where paracetamol can be obtained.

In most studies the impact of restricting access to lethal means was evaluated over a relatively short period. Therefore, it would be recommended to verify the effectiveness including possible substitution effects over a longer period of time.

Dr Ella Arensman

AWARD

Professor Paul Yip has been awarded the *Outstanding Researcher Award* from the University of Hong Kong for his contribution to suicide prevention research in Hong Kong and the region. The Outstanding Researcher Award is given annually by the University to recognize individuals who have made a significant contribution in an area that has made impact locally and internationally. Professor Yip is working with his team in advocating a public health approach In relation to suicide prevention and has promoted evidence-based and innovative suicide prevention programs in Hong Kong. One of his latest studies is on the restriction of means of charcoal burning which will appear in British Journal of Psychiatry in March. The exploratory study in removing charcoal from supermarket open shelves has shown to be effective in reducing the number of suicides by charcoal burning.

CONFERENCES AND SYMPOSIUM ANNOUNCEMENTS

43rd American Association of Suicidology Annual Conference Families, Community Systems and Suicide

April 21st - 24th, 2010

For further information, see www.suicidology.org

American Association of Suicidology (AAS)

4th Asia Pacific Regional Conference of the International Association for Suicide Prevention

17th-20th November, 2010

The 4th Asia Pacific Regional Conference of the International Association for Suicide Prevention (IASP) is to be jointly hosted by Suicide Prevention Australia (SPA) and The Australian Institute for Suicide Research and Prevention (AISRAP). For further information, see **www.suicideprevention2010brisbane.org**

Submission of Abstracts for Parallel Sessions: DEADLINE OF SUBMISSION: February 10, 2010; **Submission of Proposals for Parallel Symposia, Courses and Workshop:** DEADLINE OF SUBMISSION: March 26, 2010. For further information, see www.esssb13.org

XXVI IASP World Congress

21-24 September 2011, Beijing, China