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Evidence-based psychological treatments to reduce Suicide in New Zealand

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We need more specialist, secondary, evidence-based psychological treatments to reduce suicide in New Zealand

What is left out of the current debate on suicide

The recent public debates and awareness around suicide in New Zealand have highlighted substantial unmet needs across our many communities.[1] To date, the main focus has been on unmet need in primary care and community agencies.

What is overlooked in the debate is the large number of people presenting across health, emergency, social services and the justice sector (primarily Corrections and Police) with chronic problems of suicidal and self-injurious behaviour who do not have access to suitable care, despite evidence-based treatments existing.

Currently, these people are often seen briefly by emergency services and then either discharged (without treatment of the problems causing the suicidal and self-harming behaviour), or referred to secondary services, where the waitlist for an evidence-based treatment can be up to a year.

Complex presentations account for significant deaths

For instance, international studies note:

- Suicide occurs in up to 10% of people with the complex presentation of borderline personality disorder (BPD), often after considerable healthcare and emergency service usage.[2] In New Zealand, the rates of hospital admission for self-harm are about 50- to 100-fold greater than those for suicide,[3] and rates are higher for Māori than non-Māori.[4]
- Psychological autopsy methods suggest that personality disorders were present in about half of completed suicides under the age of 35, with BPD being the most common category.[5]
- Nearly a third of youth suicides, most of whom are male, can be diagnosed with BPD by psychological autopsy.[6] [7]
- Both international[8] and longitudinal New Zealand[9] research shows the risk of both suicide attempts and suicide is significantly higher in those who have engaged in repeated self-injury. These problems are not restricted to those formally diagnosed with BPD[10] but point to the significance of emotional and interpersonal dysregulation in driving suicide in New Zealand.

'Standard' treatments don't work

Standard and brief treatments do not help people with these problems:

- There is no evidence-based medication-based treatment for BPD.[11]
- Standard care models and psychiatric hospitalisation (especially repeated hospitalisation) for suicidal threats and attempts can be counter-productive and increase long term risks (for example, an increase in support immediately following repeated attempts can inadvertently reinforce such behaviour). [12]

Specialist evidence-based treatments are available

Currently, evidence-based treatments (EBTs) for BPD (and related problems) are specific, well-articulated forms of psychological treatment.[13] To date:

- Dialectical Behaviour Therapy (DBT)[14] is the only evidence-based treatment recommended for BPD by the Cochrane library.[13] DBT is typically associated with reduced suicidal and self-injurious behaviour, reduced inpatient days, reduced anger expression and increased social adaptation.[15] DBT has been successfully applied to a range of more complex and less complex populations such as those in forensic and correctional settings,[16] eating disorders,[17] alcohol & drug use,[18] suicidal adolescents[19] (and their families[20]), and even 'normal' school populations.[21]
- Mentalization based therapy (MBT) is a promising EBT for BPD and has been applied successfully with clients across a range of personality disorder categories.[22]
- Other treatments with some evidence include transference-focused psychotherapy,[23] schema-focused therapy[24] and adaptations of standard cognitive therapy.[25]

We need more access to evidence-based treatments for suicidal people

In New Zealand, there is very limited access to EBTs for chronic suicidal and self-harm behaviour including BPD and related problems. These services need strengthening.[4]

- A number of DHBs provide limited access to DBT or MBT, but waitlists are long due to limited implementation and low staffing.
- More training in EBTs for health and justice-sector staff (e.g., via DBTNZ, an accredited training affiliate, and MBT-NZ, via Te Pou) is needed. Local research to evaluate effectiveness, including kaupapa Māori research[26] and Māori leadership[4], is vital.[27]
- Public mental health treatments are structured to favour a reliance on medication, despite the limited evidence for this group, as the majority of the cost of prescribing is met outside of clinical provider. Conversely, all the costs of psychological treatments are met by the clinical service. This is a disincentive to provide evidence-based care.

The risks if we don't

If the current increased focus overlooks specialist, secondary treatments for people with complex problems and suicidal behaviour, then the risks are:

- Standard-care models may increase the occurrence of suicidal behaviours in people with more complex problems.[12, 28]
- Treatment-as-usual costs more than evidence-based psychological treatment.[29, 30]
- Increased primary care assessments are likely to increase the referral rates to secondary services which are already overstretched with long wait lists.[31]
- Staff currently involved in stretched secondary services may be attracted to the new funding and elect to work for growing primary services. We may unwittingly degrade existing speciality services.
- We fail to provide sufficient access to effective evidence-based treatments, and more untreated people commit suicide.

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