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# Position Paper – suicide prevention

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# Suicide prevention

## the issue

**headspace** recognises that suicide is the leading cause of death among young people—higher than road traffic accidents. In 2008, the year for which the most recent data are available, suicide accounted for one in four deaths among young people aged 12-24 years [1]. Whilst it is acknowledged that suicide is complex and has multiple causes, research consistently indicates that most young people who die by suicide or make a serious attempt are suffering from a recognisable psychiatric disorder at the time of their attempt [2], but that few are receiving mental health care [3-4].

Early intervention is warranted for young people experiencing, or at-risk of experiencing, suicidal behaviour [5], however, it remains the exception rather than the rule. This situation is unacceptable given the prevalence of suicidal behaviour among young people in Australia.

There is much more to be done and much more that we can do.

## Evidence

**Rates and risk factors:**

- Suicide is the leading cause of death among young people—higher than road traffic accidents. In 2008, the year for which most recent data are available, suicide accounted for 281 deaths, representing one in four deaths among those aged 12-24 years [1]. Despite a reduction in the youth suicide rate in Australia since 1997 [6], it remains the leading cause of death.
- Research consistently indicates that suicidal behaviour in young people is complex and has multiple causes [7].
- Young women are more likely to attempt suicide than young men, but young men are three times more likely to complete suicide as they often use more fatal means [6] and are less likely to seek help for personal and emotional problems.
- Suicide attempts are more common than completed suicides. A suicide attempt is an important warning sign or 'red flag', as a past suicide attempt is one of the strongest risk factors of later dying by suicide [8], among both general and clinical populations [9-12].
- It is estimated that 30% of adolescents aged 12-20 have thought about suicide at some point in their lives and 24% do so in any year [13]. While the vast majority will not go on to take their lives, suicidal ideation is a strong indicator of significant psychological distress and possible clinical depression [14].
- Research on youth suicide consistently indicates that most (but not all) young people who die by suicide or make a serious attempt are suffering from a recognisable mental illness at the time of their attempt (e.g. depression, anxiety or a substance use disorder). Most are not receiving mental health care at the time of their death [3].
- At-risk youth are often reluctant to seek help, in particular from professionals [15].
- High risk periods for youth suicide include early in the period of specialist care and immediately following discharge from services [16-18].
- Several marginalised groups of young people have been identified as being at particularly high risk of attempting or completing suicide, including:
  - Indigenous young people: the rates of completed suicide among Aboriginal and Torres Strait Islander males and females are over twice the rate for other Australian males and almost twice the rate for other Australian females [19].
  - Same sex attracted young people [20]
  - Young people living in rural areas [21-22], and
  - Young people experiencing a mental illness [23-24].

**Interventions**:

- There are opportunities to intervene when a young person is at risk of suicide, as a suicide attempt is often (although not always) preceded by warning signs [24]. Parents, health professionals and others working with

young people (e.g. teachers, youth workers, sport coaches) need to be aware of these warning signs as they are well-placed to detect risk. See Mental Health First Aid Guidelines on Suicidal Thoughts and Behaviours at www.mhfa.com.au/documents/guidelines/8191_MHFA_suicide_guidelines.pdf

- The most effective way to assess suicide risk is to ask a young person directly whether they are experiencing suicidal thoughts or engaging in suicidal behaviours. If the topic is approached sensitively, only a small minority of people will deny suicidal intent when asked about it directly [25].
- Asking a young person directly about suicidal thoughts and feelings, if risk is suspected, is not harmful [26-27]. This is particularly important if the young person is self-harming, as the combination of self-harm and suicidal intent carries a high risk of completing suicide (see www.headspace.org.au/what-works/resources/-mythbusters) [28].

The evidence regarding effective interventions is limited, however, it is building in the following areas:

- *Population-based prevention programs*: These programs usually take the form of curriculum-based approaches to suicide prevention. They aim to deliver interventions to whole school populations via the school curriculum, with the aim of reducing risk factors and enhancing protective factors across the entire student population regardless of risk. Their focus is generally to enhance awareness regarding suicide among students; to educate students to recognise possible signs of suicidal behaviour for one's own safety and that of others, and to provide students with information about available school and community resources [29].
- Overall these types of interventions can lead to benefits in terms of increased levels of knowledge of the risk factors and warning signs for suicide, with all those that measured knowledge as a study outcome reporting positive effects. Some benefits regarding self reported likelihood of help-seeking, and improved attitudes towards suicidal behaviour and suicidal peers were reported, and some reduction in suicide related outcomes, including self-reported risk of suicide, suicide-related thoughts and suicide attempt (maybe reference our headspace report).

- However, there are disadvantages. Firstly, concerns exist regarding the potential for unintentional adverse effects. Indeed, suicidality is complex and talking with young people about suicide is often not a benign process, leading some to argue that when working with large groups, there may be no way of knowing which young people in the group are already vulnerable and, therefore, may be adversely affected by the content of the program. Thus some young people may be left more vulnerable than before [30].
- They have also been criticised for normalising suicidal behaviour, for underplaying the relationship between suicidal behaviour and mental illness, and because they are not always evidence-based and can be hard to subject to rigorous evaluation [31-33].
- "There is a tension between a need for increased awareness and knowledge about suicidal behaviour, and a need to maintain duty of care in the way suicide is reported, discussed and communicated to minimize risk to vulnerable individuals" [34].
- Conceptually, it is argued that improving mental health literacy and help-seeking, and reducing stigma should contribute to reduced suicide risk, to date the effectiveness of programs targeting such factors on reducing suicide risk is unknown [35].
- *Gatekeeper training:* The term 'gatekeeper' refers to professionals who are likely to come in to contact with at-risk youth, and may include religious leaders, youth workers, sports coaches and school staff. The rationale behind gatekeeper training is to better equip these professionals to identify young people at risk and better enable them to provide front-line support while referring the young person on for thorough assessment and treatment. Training programs among General Practitioners have been shown to be effective in reducing suicide rates [36-37]. Research has also demonstrated increased knowledge, improved attitudes and increased levels of confidence and perceived skill among school welfare staff following specific training in managing at-risk youth [5, 38]. Other commonly used programs include Applied Suicide Intervention Skills Training (ASIST) (www.livingworks.org.au) and Mental Health First Aid (www.mhfa.com.au). However, the effects of such programs upon actual suicide-related behaviour or help-seeking in secondary school students or for young people remain unknown.
- *Early detection programs:* These programs aim to identify people who may be at risk, but who have not sought help or been identified by professionals as needing support. Such programs may focus purely on identifying people already showing suicide risk, although they may also seek to identify people at risk of other difficulties that place them at elevated risk of suicide, such as depression, anxiety or substance misuse. Schools are an ideal and accepted setting for implementing screening programs, and these can be

implemented using paper or computerised assessment tools [39-40] Screening programs have been shown to be both acceptable [26] and effective in identifying young people at risk and engaging them in treatment [27].

- *Psychological therapy:* A range of psychological approaches have been tested among suicidal young people, including: dialectical behavioural therapy [41]; group therapy [42-43]; problem-solving therapy [44-46]; attachment based family therapy and cognitive behavioural therapy (CBT) [47-48]. A recent review found CBT to be the most effective therapy among adolescents and young adults [49].

## position statements

- **headspace** recognises that although there has been a reduction in youth suicide rates in Australia since 1997, these rates remain unacceptably high.
- Reducing suicide is everybody's business. As such, a broad response is required at every level of the community from social (e.g. addressing social exclusion and inequalities) and health policies (e.g. ensuring access to care), to the education system (e.g. school-based prevention programs, support for schools affected by suicide).
- Young people experiencing mental illness, particularly mood disorders and substance abuse, are at high risk of attempting or completing suicide. It is vital that young people who are experiencing mental ill-health are better supported to access timely support from youth-appropriate services.
- There is an urgent need to address the high suicide rates among marginalised youth, in particular, Indigenous youth, young people who are same-sex attracted, or living in rural areas.
- The high suicide rate among Indigenous people requires urgent attention.
- There must be continued efforts to reduce the stigma associated with mental illness and suicide to encourage early help-seeking.
- Integrated early intervention models such as **headspace** are required to provide appropriate services when and where they are needed.
- **headspace** advocates for responsible media reporting of suicide, consistent with Mindframe's evidence review which concludes that irresponsible presentations of suicide in the media can influence 'copycat' acts [50].

## headspace recommends

- Improved education and training for those in frequent contact with young people (including teachers, youth workers, coaches and health professionals, as well as parents and friends) to improve identification of and responsiveness to suicidal young people.
- Continued efforts to reassure parents and those working with young people that asking a young person directly about suicidal thoughts and feelings, if risk is suspected, is not harmful.
- Increased awareness of available support, resources and services to effectively address the issue of youth suicide. These include community-based support services, crisis intervention services, and mental health services. Service availability, awareness and responsiveness is particularly important if community awareness is raised regarding suicide risk.
- Further investment into understanding the risk factors and help seeking pathways of Indigenous young people and testing the usefulness of interventions to effectively reduce the suicide rate.
- Development of online and e-health options to extend the reach and timeliness of mental health services to young people, particularly those who have more difficulty accessing face-to-face services, such as young people in rural areas.
- A comprehensive evaluation of current suicide prevention programs, to inform the development of a coordinated national response to the issue, including interventions provided within schools.
- Development of guidelines around the impact of social networking in following a completed suicide (e.g. how to minimise the risks associated with developing 'tribute pages').
- Streamlining of State and Territory-based suicide data collection systems to more accurately assess Australia's suicide rates.

## headspace will

advocate strongly for the development of evidence-based suicide prevention interventions at all levels of the community, and ensure that its services are responsive and effective for young people at risk of suicide.

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