

Best Practice Strategies for the Prevention of Youth Suicide 2014

Abstract

Suicide is a tragedy and a concerning global issue. The impact of a young person's suicide on their whanau, friends and wider community is devastating, and can have serious emotional, financial and economic consequences. Many young people are at high risk, with New Zealand youth suicide rates ranking in the top 2 OECD countries.

Research shows mixed results about the effectiveness of suicide prevention strategies. This reflects the complexity of the issue itself and of the issues young people face when they contemplate suicide. This paper sets out best practice strategies for people working with young people who may be considering suicide. For youth workers and helpline volunteers, best practice involves recognising warning signs of suicide, encouraging help seeking and referring young people to appropriate services. For clinical workers and health promoters, the most effective prevention strategies appear to be those which utilise a multifactor approach to create targeted 'wrap-around' support for young people at risk.

Population stats

- Worldwide, close to 1 million lives are lost to suicide each year^[1]
- In New Zealand, this number is around 500 lives per year, with particular concern surrounding youth (124 lives in 2011)^[2]
- Compared with other OECD countries, New Zealand has the 2nd highest rates of both male and female youth suicide deaths^[2]
- New Zealand youth suicide deaths have declined since their peak in 1995 (from 156 deaths in 1995 to 124 deaths in 2011)^[2]
- However, suicide still accounted for a quarter of all youth deaths in 2011 and was the leading cause of death for youth for that year^[2]

Overview

What is suicide? Recognising the warning signs

Suicide is generally defined as "the act of intentionally killing oneself"^[3], though it can be used to cover a number of behaviours. These range from thinking about death to deliberate action resulting in death^[2]. Young people who display low-level behaviours tend to be at greater risk of later deliberate death^[4].

High priority warning signs require immediate help. These include someone^[5]:

- threatening to hurt or kill themselves
- actively looking for ways to kill themselves (e.g. seeking access to pills, poisons, weapons or other means)
- talking or writing about death, dying or suicide

Lower priority warning signs warrant the need for professional assessment^[5] and are listed below. Many reflect the diagnostic criteria for depression and anxiety (see Youthline's best practice papers for depression and anxiety):

- hopelessness
- anger, revenge seeking
- risky behaviours
- feeling trapped
- increased drug/alcohol use
- social withdrawal
- anxiety, agitation, sleep disturbances
- significant changes in mood
- no reason for living, no life-purpose

However, many young people may not be completely open about their contemplation of suicide^[6].

Young people may:

- not have thought about suicide before they actually attempt it (i.e. they act on impulse)
- be serious about dying and may not wish to be stopped
- feel ashamed about it
- feel talking about suicide to be tapu or taboo
- worry they will be thought of as 'crazy'
- be afraid they will be locked up, or detained by police
- worry about confidentiality
- not believe anyone can help
- have trouble labelling or naming their pain

However, there appear to be many ways for gently inviting conversation about suicide that may be helpful. The Mayo clinic (a non-for-profit medical practice and research group) suggests asking some of the following questions^[7]:

- How are you coping with what's been happening in your life?
- Do you ever feel like just giving up?
- Are you thinking about dying?
- Are you thinking about hurting yourself?
- Are you thinking about suicide?
- Have you thought about how you would do it?
- Do you have the means to do it?

Researchers have also suggested that using techniques such as normalising suicidal thoughts (emphasising that other young people also consider suicide) could reduce some of the shame or taboo that young people may associate with having suicidal thoughts and talking about it^[8].

Vulnerability and risk

Risk factors (such as background, family, psychological and personality factors) increase a young person's likelihood of experiencing difficult circumstances, stressful life events and mental illness which, in turn, make them vulnerable to considering suicide^[9].

This model may be helpful in understanding the 'big picture' of a young person's life. It may also be helpful to consider that factors influencing suicide are not the same for everyone, but rather fluctuate over time and differ across demographics of age, sex and ethnicity^[4].

Knowledge of risk factors will be helpful in the assessment and treatment of a young person. These include^[4; 10; 11]:

- mental health issues and psychopathology (particularly mood and substance abuse disorders, and antisocial behaviours)
- biological predispositions and factors (including genetic, medical and neurological factors)
- family histories of suicide
- childhood and family adversity
- social deprivation
- family disadvantage and dysfunction
- economic hardship or disadvantage
- substance abuse
- stressful life events or adverse circumstances
- shared social meanings of suicide (including cultural, religious and familial beliefs, and media normalisation)
- access to lethal means and opportunities to use them
- previous suicide attempts
- circumstances which have led to involvement with Child, Youth and Family Services

Depression has been found to be a consistent risk factor for suicide^[12], with suicidal ideation being part of its diagnostic criteria^[13]. It is recommended that this best practice paper be considered alongside Youthline's 'best practice intervention strategies for depression' paper.

High risk groups

Young men

Male youth suicides have been consistently higher than female youth suicides since 1967, with three times the number of male youth deaths in 2011 (93 compared to 31 female youth deaths)^[2].

Young Maori

Maori youth are at high risk of suicide, with suicides rates over twice that of the declining rates of non-Maori youth^[2]. This reflects global trends, where indigenous mortality trends show suicide rates two to three times higher than the general population^[4; 11; 14]. This is not surprising given the many risk factors that Maori face. Compared to non-Maori, Maori are more likely to experience anxiety, mood, eating and substance disorders,^[11; 15] as well as social disadvantage and stressful life events (such as homelessness, unemployment, incarceration, family problems, violence and abuse)^[11; 16]. Maori are also more likely to experience negative effects associated with historical events of colonisation, particularly trans-generational trauma, loss of land, loss of culture, racism and social exclusion^[4; 11]. These experiences overlap risk factors for depression and suicide, and put Maori at increased risk^[11].

Such high exposure to risk factors highlights the pressing need for effective prevention for Maori young people. The most common prevention strategies targeted toward overseas indigenous populations are community prevention, gate-keeper training and education initiatives^[11]. However, assessing interventions aimed at indigenous populations is both complex and difficult, thus few evaluations of acceptable methodological quality exist^[11]. There appears to be a need for greater partnership and collaboration between government bodies, research organisations, health-care providers and indigenous services to develop and evaluate effective indigenous-specific interventions^[11].

Contagion

Contagion refers to the spread of suicide to vulnerable young people through imitation^[17]. Research suggests that young people who are already vulnerable to considering suicide are more likely to attempt suicide following media portrayals of suicide^[17] or in response to the suicide of someone close to them^[18]. This trend appears to be highest for young people aged between 15 and 19, with minimal effects on those above the age of 24^[17].

Resilience

The following resilience factors may act as buffers for young people, which could weaken the influence of vulnerability and risk^[16; 19; 20].

- perceived fairness of teachers
- feeling safe at school
- Individual attributes
 - cognitive ability
 - temperament and personality
 - self-regulation skills
 - positive outlook
- relationships
 - family connection
 - caring family relationships
 - connection to pro-social peers
- community resources and opportunities
 - good schools
 - connection to pro-social organizations
 - neighbourhood quality
 - social service quality
 - health care quality

Despite increased academic interest in protective factors to suicide in young people, there is little systematic research directly linking resiliency factors to reductions in suicide^[20].

Best practice

Before a discussion around best practice takes place, it may be useful to consider the language used when talking about suicide. Particular language may maintain stigma and shame around suicide, and can make it harder for grieving communities to cope with a death by suicide^[21; 22; 23].

It is common to speak of 'committing' suicide, 'completing' suicide, a 'successful' suicide, or a 'failed' or 'unsuccessful' suicide attempt. However, it has been argued that the word 'commit' has negative meanings associated with criminal offences. On the other hand, to say that someone successfully completed suicide or failed a suicide attempt may position suicide as something positive to strive for^[21; 22; 23]. Researchers and health services have recommended the use of 'suicide', 'death by suicide', 'died by suicide', 'ended/took their life own' or

'attempted to end/take their life' to avoid negative associations and accusations^[21; 23].

Evidence suggests that 'wrap-around' prevention strategies may be effective in preventing youth suicide. These strategies incorporate multiple methods (e.g. training gatekeepers as well as increasing access to pharmacotherapy and psychotherapy) and involve multiple levels of healthcare systems (e.g. public health care as well as primary health services)^[24].

What follows is a review of individual suicide prevention strategies and their supporting evidence. Each could be used as part of a larger, comprehensive wrap-around approach.

Recognition and referral (gatekeeper training)

Recognition and referral initiatives train people who have regular contact with young people to act as 'gatekeepers'. Being a gatekeeper means looking out for warning signs of suicide (recognition) and then to refer young people to help services that specialise in intervention with suicide (referral).

Recognition and referral has been found to be both popular and effective in preventing possible suicides^[25]. As a result of recognition and referral training programs, adults who work with young people have reported improvements in their knowledge, skills, attitudes and access to services. Research also shows that between approximately one to two thirds of trained recognition and referral gatekeepers report intervening with a suicidal young person within 6 months following training^[25].

Peer recognition and referral gatekeepers are young people who are trained to watch out for warning signs in their peers, and then to refer at-risk peers to help services. Peer training has shown increases in skills, knowledge and attitudes toward suicide prevention^[25]. There is also some evidence to suggest that peer gatekeeper training may be effective with particular indigenous populations; increasing gatekeeper knowledge, their intentions to help and their confidence in identifying risk^[25].

However, research also suggests that some gatekeepers may attempt to manage at-risk young people on their own rather than referring them on^[26]. This suggests that in recognition and referral training, the risk to gatekeepers of the burden of support should be emphasised, as well as the importance of referring at-risk young people to appropriate care.

Particularly effective recognition and referral prevention initiatives tend to be deployed as part of larger programs, aimed at specific populations and carried out within organisations such as schools or military services^[24; 25].

Telephone helplines and text services

Although there is no robust systematic evidence behind the effectiveness of helplines and text services in preventing suicide, the body of supportive research appears to be growing. Recent research suggests that telephone helplines can be effective in preventing a caller from harming or killing themselves, while also increasing their feelings of being supported^[27] and reducing their suicide risk status, psychological pain and feelings of hopelessness over the course of a call^[28].

Around 8% of young people contacting Youthline's text counselling service talk about suicide. In research on their experiences of this service, young people report a preference for texting, rather than contacting a close adult or face-to-face counsellor. Their reasons included using a service that seemed anonymous and private, and gave them the ability to control their interaction with the service^[29]. Although Youthline does have procedures around tracing texters in the event of an emergency, the text counselling service appears to reduce young peoples' perception of possible negative interference by an adult^[29]. This research suggests that young people value anonymity and control in help-seeking; characteristics which helplines and text services use to provide young people with spaces to talk through suicidal thoughts freely and openly.

Helpline callers have positively rated a number of call and counsellor characteristics, and may respond well to^[27; 28]:

- feeling listened to
- feeling understood
- being allowed to talk
- warmth and empathy
- options for coping
- availability and patience of their counsellor
- a space to calm down
- clear thinking/seeing a new perspective

This suggests that helplines may be an effective prevention strategy by providing respite and human connection within a call. On the other hand, callers gave negative feedback in regards to counsellors^[28]:

- providing unhelpful referrals
- being uncaring or abrupt
- making unhelpful suggestions or advice
- not identifying problems

Overall, there is evidence that helplines provide callers with the opportunity to establish a warm and caring relationship with phone counsellors, which may play a role in preventing a caller's immediate suicide. Callers also appear to appreciate a person-centred, strengths-based approach rather than a solution-based approach.

Some research suggests that a caller's intent to die may remain high at the end of their conversation with a helpline counsellor^[28]. Therefore, respite appears to be temporary, which highlights the need for referral to appropriate services.

Advising health care providers

Health care providers are people who work with young people in primary health care roles such as school nurses, family physicians, general practitioners and staff in emergency departments. Health care providers play an important role in preventing suicide given that they may be a first point of contact in response to a young person feeling unwell. Health care providers thus play a vital role in recognising suicide risk and also in treating and managing at-risk youth. However, systematic reviews have shown that many health care providers may not recognise suicide risk. At-risk young people may thus miss out on treatment^[24; 30].

What appears to be missing is training and support that equips health care providers with the knowledge, skills and tools to recognise and address suicide risk^[24; 30]. Organisations such as Youthline that provide seminars and training are in a good position to advise health care providers in the recognition, referral and ongoing care of young people considering suicide. Staff and volunteers are also in a good position to create links between such organisations and health care workers to ensure continued training and support.

Some education programs have shown increases in the recognition of symptoms of mental disorders as well as increases in antidepressant prescription rates^[24; 30]. Increases in antidepressant prescriptions have, in turn, been linked with decreased suicide risk^[24], though the evidence has been mixed^[30].

Helping young people to overcome barriers

Limited health literacy, help-seeking reluctance and not sticking to treatment regimens may present barriers between young people and suicide prevention^[24]. This may be particularly true of young people experiencing depression, due to behaviours that are associated with depression such as social withdrawal (which could prevent help-seeking) or reduced motivation (which could prevent treatment adherence).

Those working with young people are in a good position to educate young people, encourage help-seeking from appropriate services and support young people in following through with prescribed treatments.

Public awareness and education programs

Public awareness and education campaigns have been popular in trying to increase the general population's awareness of issues such as depression and suicide. They also aim to reduce negative associations people may have with these issues. However, there is no robust evidence to support the effectiveness of public education campaigns in increasing public awareness or treatment seeking^[30]. There have also been criticisms that this approach may tend to exaggerate the prevalence of suicide in young people and so risk portraying suicide as a common and therefore acceptable course of action^[31].

Psychotherapy

Several reviews have found promising results with various cognitive-behavioural therapies, *with adults*^[30; 32]. In particular,

- cognitive therapy has shown promise in reducing suicidal behaviours and reattempt rates
- dialectical behavioural therapy in improving treatment adherence and reduced suicidal

behaviour in those with borderline personality disorder

- problem-solving therapy in improving hopelessness and depressive symptoms
- interpersonal psychotherapy, cognitive behavioural therapy and dialectical therapy in decreasing suicidal ideation

However, cognitive-behavioural prevention strategies have so far been found ineffective in reducing risk in young people^[32].

Suicidal behaviour appears to be difficult to treat in young people and may require treatment approaches that differ from those that are effective in adults^[32]. There is some evidence to suggest that problem solving, coping with stress and improving resilience may strengthen a young person's protective factors, though none exists to confirm the prevention of suicide^[20; 30].

Pharmacotherapy

Recent research has found the use of antidepressants to be effective in treating the symptoms of depression and anxiety^[33]. However, warnings have been issued overseas, advising carers to monitor pharmacotherapy use in young people due to concerns around possible adverse suicidal effects of medications, particularly selective serotonin reuptake inhibitors (SSRIs)^[30]. Careful consideration is advised when considering pharmacotherapy for young people.

Means restriction

Tougher governmental regulation around access to lethal means (such as tighter regulation of firearm ownership, pesticides, barriers at jumping sites and lower toxicity antidepressants) is linked with reduced suicide rates by these means [24; 30]. Restricting access to lethal means may thus be an effective way to prevent suicide.

However, it is important to bear in mind that the most common means of suicide in New Zealand in 2011 were hanging, strangulation and suffocation^[2]. These means may be harder to monitor than firearms or poisons, which should be taken into account if considering means restriction.

Screening and assessment

Screening and assessment methods have been found to be effective in identifying at-risk youth^[30], while presenting them with little risk^[24]. However, screening is not a treatment in itself and should be followed up with appropriate care^[24].

Summary

While the literature on suicide prevention does not provide definitive direction for treating suicidal behaviours in young people, there appears to be much that can be done to prevent suicide. This mainly involves training people to recognise and act on warning signs of suicide. For those working closely with young people, particularly youth workers, helpline volunteers and health care providers, best practice means being able to recognise warning signs of suicide and being able to refer young people to appropriate services. Recommended referrals are listed on the following page. Given the links between depression and anxiety to suicide, knowledge of the symptoms of depression and anxiety is also advised, especially since not all young people that struggle with depression and/or anxiety will be officially diagnosed (see Youthline's depression and anxiety best practice papers).

Of particular relevance to those working in clinical services, there appears to be no single 'magic bullet' prevention strategy for youth suicide. Instead, young people may benefit most from a combination of simultaneous, intertwined and overarching prevention strategies. Young people may also respond well when prevention strategies are individually and culturally tailored.

Strategies that work

- ✓ Training those who work with young people to recognise warning signs of suicide
- ✓ Actively screening/checking for warning signs
- ✓ Training those who work with young people to refer at-risk youth to appropriate services
- ✓ Actively following risk screening with appropriate referrals or care
- ✓ Organising risk recognition programs within schools or community groups
- ✓ A consideration of the complexity involved in a young person's contemplation of suicide
- ✓ Using a variety of strategies at multiple levels of a young person's life
- ✓ Restricting access to, or encouraging the disposal of, a variety of lethal means
- ✓ There may be some promise in problem solving, coping with stress and improving resilience

Strategies that don't work

- × Assuming a one-size-fits-all approach
- × Screening young people for risk without following up with appropriate referral or treatment
- × Assuming positive outcomes from treatments that may work with adults
- × Campaigns/programs that do not teach people about warning signs or available services
- × Ill-consideration of the costs versus benefits of pharmacotherapy to a young person

Recommended referrals

In an emergency

Police/ambulance services 111

Youthline counselling services

Helpline 0800 37 66 33
Free text counselling 234
email counselling talk@youthline.co.nz
face-to-face counselling (09) 361 4168

Local mental health service providers

211 information line 0800 211 211
Family services directory www.familyservices.govt.nz/directory

Training and seminars

Youthline www.youthline.co.nz

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