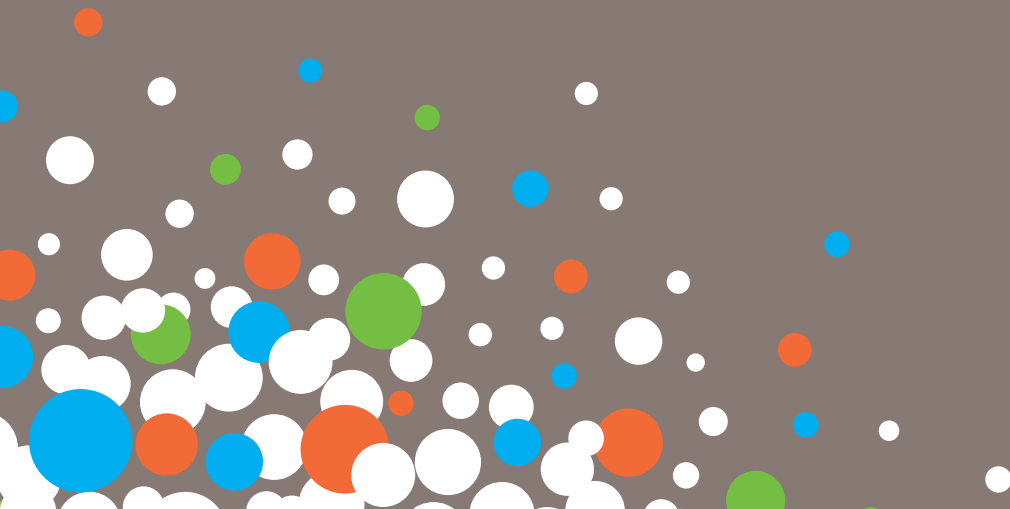




The National Centre of Excellence
in Youth Mental Health

**Raising the bar for
youth suicide prevention**



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youth suicide prevention**



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Introduction

Much has already been achieved in youth suicide prevention. This has been due to the collective resources, skills and expertise developed over many decades in both the suicide prevention and youth mental health sectors. To recognise and build on their work, the advice provided in this report has been developed in consultation with representatives from these sectors and in partnership with young people. This process has involved an online consultation with sector leaders, two workshops with young people from Orygen's National Youth Advisory and Youth Research Councils and a roundtable event held on 2 June 2016 with sector representatives and young people.

This consultation has been underpinned by a comprehensive review of the national and international literature on youth suicide prevention undertaken by Orygen's Suicide Prevention Research Team (current as at April 2016) and an analysis of suicide clusters among both young people and the general population prepared by Orygen and the University of Melbourne's School of Population Health.

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Report development process



Executive summary

In 2015 more young people aged 15–24 years died by suicide than any other means (including transport accidents and accidental poisonings). Over the past 10 years, rather than making inroads into reducing the number of young lives lost to suicide in Australia, there have instead been small but gradual increases in suicide rates. Twice as many young women aged 15–19 years died by suicide in 2015 than in 2005 and rates have also increased among young people under the age of 14 years.

This has mirrored high rates of self-harm among young people. Recent reports indicate that approximately one in four young women aged 16–17 years have self-harmed in their lifetime and hospitalisations for self-poisoning, again among young women, have spiked in recent years.

In 1995 Australia was one of the first countries in the world to develop a suicide prevention strategy, focused initially on young people. Successive national and state/territory suicide prevention strategies have been released although available evaluations are unable to link these to reductions in suicide or suicide-related behaviours at a national or community level. Further, an analysis of current suicide prevention policies across the country has identified gaps in evidence-based and young person appropriate, accessible and acceptable programs and services. We cannot afford to continue to focus on policies, programs and activities for which limited evidence exists; the cost of these tragic and preventable deaths is too great.

There are a number of reasons why a youth-specific response to suicide prevention is required. First is the increased susceptibility to the onset

of mental ill-health during this period of life, and the well-documented elevated risk of suicide among those experiencing mental ill-health. Young people with serious and complex experiences of mental ill-health, for example affective disorders, personality disorders and psychosis, are most at risk of suicide and yet many are unable to access the youth focused specialist support services they need. We need to urgently respond to this critical gap in care.

Secondly rates of self-harm are unacceptably high in this age group, which in itself should act as an early indication for service providers and policy makers that many young people are distressed and crying out for help.

Finally, a recent analysis of suicide cluster data has shown that a youth suicide is more likely to be part of a cluster than an adult suicide. As such researchers, sector experts and young people themselves have suggested that responding to suicide among young people requires a different approach than for other age groups. Responding early to both suicide risk and mental ill-health in young people could provide one of the 'best-bets' for suicide prevention moving forward.

At the time of publishing this report, the Australian Government is reinvigorating its suicide prevention strategy. This will include a significant role for the 31 Primary Health Networks (PHNs) across Australia who will now plan and commission regionally focused suicide prevention responses. It has also committed to the development of an equitable and integrated youth mental health system, a digital gateway into mental health care and a new end-to-end school-based mental health program.

Thanks to strong advocacy from the suicide prevention and mental health sector, most recently in the lead up to the 2016 Australian election, the Australian Government has identified further funding for suicide prevention research and evaluation and additional regional suicide prevention trial sites.

As such, there are now timely opportunities to ensure that evidence-based youth suicide prevention responses are embedded in new arrangements and activities. It will be critical that future government funded suicide prevention

strategies and activities are robustly evaluated, using methods and instruments to ensure they measure youth acceptability and appropriateness as well as their impact on suicide-related outcomes.

Through the review of available research evidence and input from both suicide prevention and mental health sector experts and young people themselves, this report presents a number of recommendations for future youth suicide prevention efforts in Australia (summarised below).

- 1. National leadership and coordination is needed.** In reinvigorating the national suicide prevention strategy, the Australian Government should:
 - Develop a separate National Youth Suicide Prevention Implementation Plan and embed youth advisory mechanisms and processes to support the Australian Government and PHNs to design and evaluate suicide prevention activities.
 - Facilitate and lead integration of suicide prevention policy and programs across other levels of government and outside of health (for example education, justice, and family services).
 - Develop and improve access to the evidence base through the development of a better practice register and a national evaluation framework which ensures youth-related outcomes are collected.
- 2. A system of youth mental health care should be built that responds early and effectively to suicide risk among young people.** Given evidence for the impact of contact with headspace and other specialist youth mental health services on reported self-harm and suicidal ideation, this should:
 - Provide national coverage of headspace so that all young people in Australia have access.
 - Enhance the youth mental health service model and provide seamless care through both the Australian and state/territory governments' mental health funding and service systems. This includes: a) resourcing and reshaping the provision of specialist mental health care to ensure it is integrated with early intervention services for young people (i.e. headspace); and b) ensure step-down access into the youth mental health system on discharge from hospital or emergency care.
- 3. Regional responses should be developed that meet the needs of young people.** There is a strong role for the PHNs and community leaders to:
 - Work with state/territory based local health networks to explore co-commissioning of post-discharge responses for young people.
 - Ensure that regional systems based models: a) include activities and programs that are evidence-based, appropriate, accessible and acceptable to young people and b) provide an adequate proportion of the PHNs suicide prevention funding to youth-specific activities.

4. **Government and service commissioners should prioritise a commitment to using technology in a proactive way.** For example:
 - Governments should continue to support and resource critical national crisis services and infrastructure such as Lifeline, Kids Helpline and beyondblue. eheadspace should also be brought to scale, to ensure young people can access this service at the times when they need it most.
 - Future online platforms should 'add value' for young people through age appropriate interface and functionality; bridging service gaps of face-to-face care; addressing barriers to access (including connectivity and privacy concerns); and ensure online platforms are co-designed with young people.
5. **Responses in education settings need to reflect emerging evidence that suicide prevention programs can be delivered safely to students.** It is recommended that:
 - School-based mental health programs include evidence-based suicide prevention programs that can be delivered directly to students.
 - Government funded mental health and suicide prevention education should be extended into tertiary education settings.
7. **Postvention programs are important and should be included in both community-based and school-based youth suicide prevention responses.**
8. **Gaps and barriers in youth suicide prevention research and data collection need to be addressed.** The research funding promised by the Australian Government in the 2016 election, as well as future National Health and Medical Research Council (NHMRC)/Australian Research Council (ARC) research priorities, should focus on addressing gaps that exist in the conduct of youth focused and youth friendly suicide prevention research.

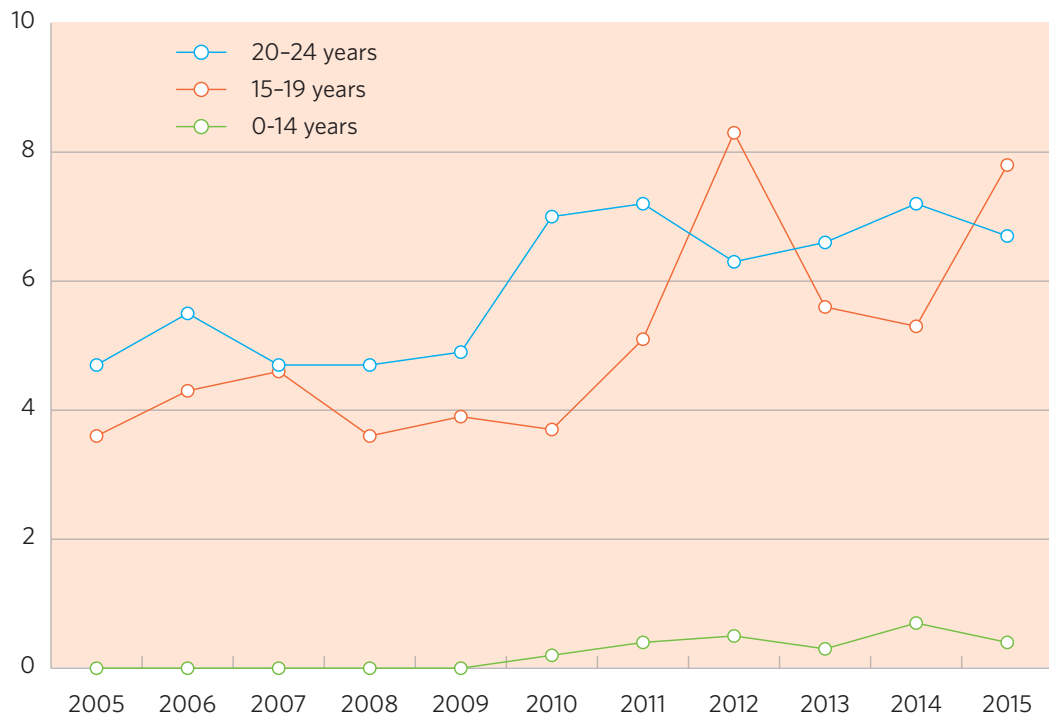
Section 1

The situation

In 2015 more Australian young people aged between 15 and 24 years died by suicide than by any other cause, including transport accidents and accidental poisonings, with suicide accounting for almost a third of all deaths in this age group (ABS, 2016).

For both young men and women aged between 15 and 24 years the rates are at their highest in 10 years. In particular, there has been a gradual annual increase in suicide rates among young women between 2008 and 2015 (Figure 1), and twice as many young women aged 15-19 years died by suicide in 2015 than in 2005. While still a rare event, rates among young people and children under 14 years of age have also increased (ABS, 2016).

FIGURE 1: SUICIDE RATES AMONG YOUNG WOMEN 2005-2015 (RATE PER 100,000)



Source: ABS, 2016

FIGURE X: TWICE AS MANY YOUNG WOMEN AGED 15-19 YEARS DIED BY SUICIDE IN 2015 THAN IN 2005

2x
as many young women
aged 15-19 years
died by suicide in
2015 than in 2005



Many more young people think about or attempt suicide, although the numbers are difficult to estimate as many attempts and thoughts go unreported. In the recent Australian Child and Adolescent Health and Wellbeing Survey, 7.5 per cent of 12-17 year olds reported having considered suicide in the past year and 2.4 per cent had made an attempt; this equates to approximately 41,000 Australian adolescents (Lawrence et al., 2015). Among young people aged 16-24 years the 2007 National Mental Health and Wellbeing Survey reported 5.1 per cent of young females and around 1.5 per cent of young males had experienced suicidality (thoughts, plans or suicide attempts) (Slade et al., 2009).

While most self-harming behaviour is not an attempt at suicide, a history of repetitious self-harm is a risk factor for future suicide-related behaviours (Robinson et al., 2016d) and the rates of self-harm among young people in Australia are concerning. 24.4 per cent of young women and 18.1 per cent of young males (aged 20-24 years) reported they had self-injured in their lifetime (Martin et al., 2010) and there has been a spike in hospital admissions for young women aged 15-19 years who have self-harmed (Australian Institute of Health and Welfare, 2014).

Overrepresented

Particular groups of young people are at greater risk of suicide.

Young men continue to suicide at much higher rates than young women. In 2015, 72 per cent of the deaths among young people aged 15-24 years attributable to suicide were male (ABS, 2016).

Young people with an experience of mental ill-health: One of the strongest risk factors for suicide-related behaviour is the experience of mental ill-health which has been found to be present in around 90 per cent of young people who die by suicide (De Silva et al., 2013, Fleischmann et al., 2005). This includes:

- Affective disorders - Cash and Bridge (2009) cited a number of studies which found 60 per cent of young people had diagnosable depression at the time of a suicide attempt. There is also a high lifetime prevalence of suicide attempts in people with bipolar affective disorder, 15 times that of the general population (Harris and Barraclough, 1997).

- Schizophrenia and borderline personality disorders – There is an 8-10 per cent lifetime risk of suicide among people with these conditions (Harris and Barraclough, 1997, Pompili et al., 2007, Pompili et al., 2005). For these conditions there also appears to be evidence that risk is greatest around the time of first diagnosis.
- Eating disorders – Risk is greater than the general population, particularly for anorexia nervosa but studies have also found increased risk in populations with bulimia nervosa (Guillaume et al., 2011).
- Young people with a history of self-harm are at increased risk of suicide (Hawton et al., 2003). Self-harm is a behaviour which frequently emerges during adolescence and young adulthood. As these young people are

at risk of a whole range of negative outcomes, in addition to suicide, the early detection of these behaviours and effective interventions for any underlying mental ill-health should be an important component of suicide prevention for this age group (Moran et al., 2012).

Comorbidity, with substance misuse appears to increase the risk further (Pompili, 2010).

Rates of suicide among **Aboriginal and Torres Strait Islander children and young people** (aged 5-17 years) are five times that of non-Aboriginal and Torres Strait Islander young people (ABS, 2016). Table 1 shows that the rates have been consistently higher for well over a decade. Suicide, and anxiety and depression have all increased among Aboriginal and Torres Strait Islander young people in recent years (Dudgeon et al., 2014b).

TABLE 1: SUICIDE RATES (NSW, QLD, SA, WA AND NT) PER 100,000 POPULATION (2001-2010)

Age	Male		Female	
	Aboriginal and Torres Strait Islander	Non- Aboriginal and Torres Strait Islander	Aboriginal and Torres Strait Islander	Non-Aboriginal and Torres Strait Islander
15-19	43.4	18.7	9.9	3.2
20-24	74.7	21.8	19.2	4.0
Average	59.1	20.3	14.6	3.6

Source: ABS data reported in the 2013 *National Aboriginal and Torres Strait Suicide Prevention Strategy*.

Other groups of young people identified as being at elevated risk include:

- **Young people recently in contact with the justice system:** Suicide was associated with having been involved in a forensic event (e.g. being arrested, charged or sentenced) in the previous three months and in particular the last week (Cooper et al., 2002).
- **Young people who live in rural and remote areas:** Suicide rates among males, including young males, living in regional, rural and very remote areas are higher than those in major cities, increasing with remoteness (ABS, 2016; Australian Institute of Health and Welfare, 2007).
- **Young people in contact, or recently left, statutory care:** Twelve months after leaving care, more than one in two young people reported that they had experienced suicidal thoughts, and more than one in three had attempted suicide (Cashmore and Paxman, 2007, Cashmore and Paxman, 1996).
- **Young people who have been exposed to suicide or suicide-related behaviour:** These young people were eight times more likely to report engaging in self-harm than those who hadn't been exposed (McMahon et al., 2013).

Spotlight - LGBTIQ young people

Rates of suicide and self-harm are up to six times higher among LGBTIQ young people than the general population (Dyson et al., 2003) with an association between homophobic abuse and suicide and self-harm reported in an Australian national study of LGBTIQ young people (Hillier et al, 2010).

Most Australian state and federal government suicide prevention policies recognise LGBTIQ populations are at increased risk and identify strategies to respond.

A recent report exploring self-harm, suicidal feelings and help-seeking among LGBT youth in the UK found that of the young people in the study:

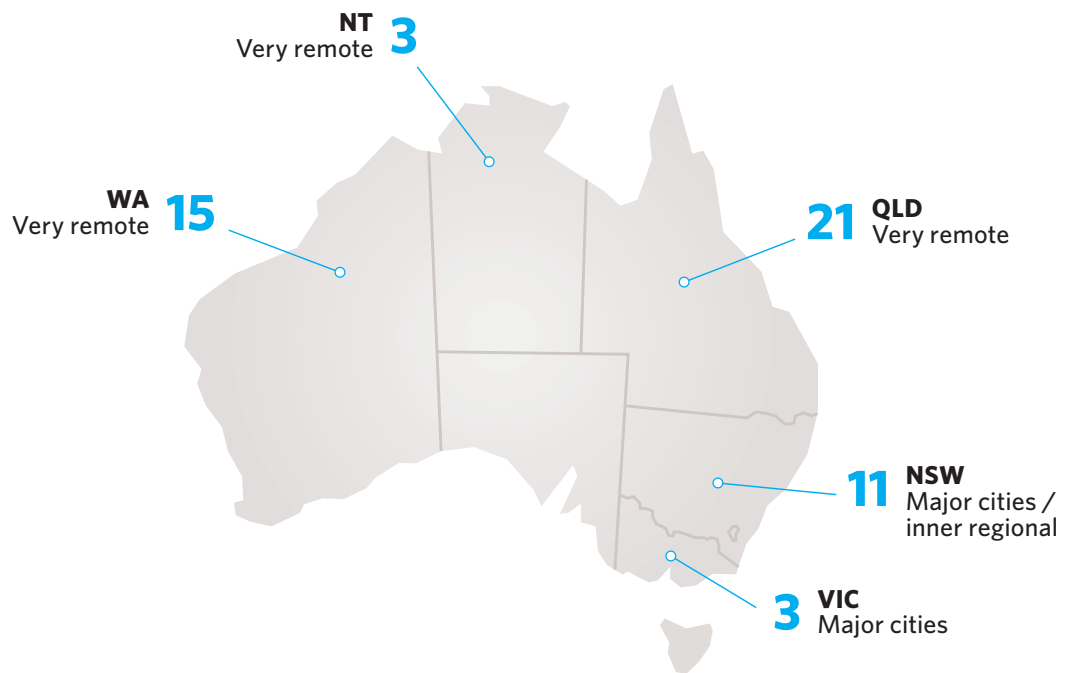
- Over 70 per cent experienced discrimination, bullying, rejection, physical and verbal violence, threats and/or other forms of marginalisation related to their sexual orientation and gender identity. Those who felt affected by this abuse were 2.18 times more likely to plan or attempt suicide than those unaffected.
- 82.9 per cent had not told everyone they needed to about their sexuality and gender and almost 75 per cent indicated that not being able to talk about their feelings or emotions influenced their self-harm and suicidal feelings either 'very much' or 'completely' (Queer Futures, 2016).

Suicide clusters

Suicide clusters, defined by O'Carroll et al. (1988) as 'a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected on the basis of either statistical prediction or community expectation' are a rare event. However suicides among young people more commonly occur as part of a cluster than suicides among adults (Cox et al., 2012, Haw et al., 2013, Robinson et al., [in press]). This is also the case among Aboriginal and Torres Strait Islander communities (Hanssens and Hanssens, 2007), people with mental illness (McKenzie et al., 2005), and prisoners (Hawton et al., 2014).

A recent analysis of Australian data has confirmed that suicide deaths among young people are more likely to occur in clusters than is the case among adult populations (Robinson et al., [in press]). This analysis identified 12 spatial clusters (with a total of 190 suicide deaths) over a three-year period between 2010 and 2012. Five clusters were identified among young people, which accounted for 5.6 per cent of all youth suicides and seven were identified among adults, accounting for half as many adult suicides (2.3 per cent).

FIGURE 2: NUMBER OF SUICIDES PER CLUSTER



As shown in Figure 2, the five youth suicide clusters were distributed across four states and one territory, Victoria, New South Wales, Western Australia, Queensland and the Northern Territory, with the largest clusters in Queensland (n=21) and Western Australia (n=15). Unlike adult clusters, three of the five youth clusters occurred in remote areas, suggesting that geographical isolation and remoteness may be a risk factor for youth suicide clusters in particular. The analysis also found suicide clusters were significantly more likely to occur among Aboriginal and Torres Strait Islander young people than non-Aboriginal and Torres Strait Islander young people.

Economic impact

Along with the devastating personal and community impact of suicide and suicide-related behaviours, there is likely to be a significant economic impact. The recent report, *Australian Burden of Disease Study: Impact and causes of illness and deaths in Australia*, found that suicide and self-inflicted injuries accounted for the leading burden of disease for young males in Australia aged 15-24 years (Australian Institute of Health and Welfare, 2016).

While a 2009 report by ConNetica Consulting estimated the cost of suicide in Australia to be \$17.58 billion (equated to \$795 per person per year), no report on the economic cost of suicide-related behaviour specifically among Australian young people is available, nor have robust economic evaluations of national suicide prevention activities been conducted, despite previous recommendations to this effect (Australian Healthcare Associates, 2014). As such, economic evaluations and modelling for suicide prevention remains a priority.

IMPLICATIONS

The situation

In 2015 more Australian young people aged between 15 and 24 years died by suicide than by any other cause, including transport accidents and accidental poisonings, and there has been a small but gradual increase over the past ten years.

Approximately 41,000 young people aged 12-17 years had made a suicide attempt and by 24 years of age, one in four young women reported self-harming in their lifetime.

There are high rates of suicide in particular among young people with an experience of mental ill-health, Aboriginal and Torres Strait Islander young people, LGBTIQ young people, young people living in rural and remote areas, young people in contact with statutory care systems and young people who have been exposed to the suicide of another.

Suicides among young people more commonly occur as part of a cluster than suicides among adults.

No report on the economic cost of suicide-related behaviour specifically among Australian young people is available, nor have robust economic evaluations of national suicide prevention activities been conducted. This remains a research priority.

Section 2

Why specific youth suicide prevention responses are needed

While youth suicide rates may not be as high as other age groups, the proportion of deaths among young people attributed to suicide are greater than any other cause of death.

Feedback from consultations with sector experts and young people strongly suggested that responding to suicide among young people requires a different approach than for other age groups. For example, some individual risk factors, 'tipping points' (as described in the LIFE Framework) and help-seeking behaviours are particular and unique to this stage of life. As stated by the Australian Institute for Suicide Research and Prevention: 'Children and adolescents differ in terms of physical, sexual, cognitive and social development and warrant separate consideration' (Australian Human Rights Commission, 2014, p82). This separate consideration also includes the particular social, cultural and community contexts which may influence suicide risk for young people, a number of which are discussed in this section.

Individual factors for young people

Developmental changes

Adolescence is a period of significant functional and structural changes in the brain. This can compromise cognitive and emotional functioning and result in impulsivity, impaired problem solving and coping skills, and poor decision making (Balogh et al., 2013). All of this means that suicidal thoughts can quickly escalate and adolescents may have difficulty communicating their distress, particularly with those people they are close to (or in close proximity to) such as family members. This can make timely intervention for young people particularly difficult and points to the need to equip family and close friends with the skills to identify risk and lead helpful conversations.

Youth as a time of onset of mental ill-health

Youth is a period of susceptibility to the onset of mental illness (McGorry et al., 2014). Not surprisingly then, we see mental ill-health first emerge for 75 per cent of people before the age of 24 years (Kessler et al., 2007) while approximately one in four young people aged 12-25 years will experience mental ill-health each year (ABS, 2008). Given that an experience of mental ill-health is a significant risk factor for suicide, access to high quality youth mental health care, early in onset should be a cornerstone of youth suicide prevention.

Drug and alcohol use

Overuse of alcohol contributes to the three leading causes of death among adolescents one of which is suicide, the others being unintentional injury and homicide (Australian Drug Foundation, 2013). Research has established a strong relationship between alcohol and other drug use and suicide-related behaviours, particularly in older age groups (Petit et al., 2013). Although for adolescents the role of alcohol in a suicide is more difficult to attribute (Pompili et al., 2010) it can be involved in the immediate circumstances of suicidal thoughts or suicide attempts. In consultation for this report, stakeholders emphasised the importance of recognising the role and impact of drug and alcohol use/misuse and the importance of providing early intervention and access to drug and alcohol treatment services within suicide prevention policy, program and service development.

“ Embedded in a national strategy should be a strong practical and policy-setting approach to alcohol and substance use in young people.

Stakeholder

Social and contextual factors for young people

Social determinants

As in the general population, there are a number of social and cultural determinants that are thought to contribute to rates of youth suicide including criminality, family dysfunction, poor educational outcomes and other consequences of social and economic disadvantage.

A recent analysis of regional suicide data by ConNetica Consulting identified that many communities with high rates of suicide were also experiencing economic change and uncertainty, brought about by the loss of local industry, housing affordability and high costs of education and training (Consulting, 2016). In such economic down-turns, young people are particularly disadvantaged. They face significant barriers entering the workforce or accessing the training they need to skill-up for jobs.

Applying a public health framework, which address these underlying causes of suicide and involve sectors outside of health, such as

education, business and industry, is therefore an important component in any effective suicide prevention response (World Health Organization, 2012).

Increasing pressures

The environment in which young people are maturing is also experiencing rapid social, technological and economic changes (McGorry et al., 2014). The bar is rising for entry into the workforce (VicHealth & CSRISO, 2015) with many young people now looking at prolonged and competitive postsecondary education to compete in the job market, resulting in prolonged dependence and increasing levels of debt early in adult life. Strategies which support young people to respond to these types of external stresses and pressures need to be considered in future youth suicide prevention efforts and mitigate potential ‘tipping points’.

Spotlight – risk factors for Aboriginal and Torres Strait Islander young people

Direct and secondary exposure to trauma have been identified in the high rates of youth suicide seen in the Kimberley region (Ralph et al., 2006). Suicide and anxiety and depression has increased among Aboriginal and Torres Strait Islander young people in recent years (Dudgeon et al., 2014). The association with alcohol and other drug use and chronic mental illness makes these appropriate targets for interventions (Closing the Gap Clearinghouse, 2013).

It has been suggested that many mainstream risk factors do not apply to Aboriginal and Torres Strait Islander people and communities. Instead, community factors such as: a lack of sense of purpose and role models; family disintegration and lost community support; personal abuse alcohol and other drug use; community politics; grief and the effects of poor literacy need to be addressed (Tatz, 2005).

Help-seeking

Mental ill-health and suicide-related behaviours are increasingly recognised, discussed and responded to by government and the community. Efforts to destigmatise these experiences and provide effective evidence-based services as early as possible in the emergence of psychological distress and mental ill-health are embedded in most recent mental health policies and strategies.

“ We need to start the conversations that really matter and empower young people to reach out for support early, before it gets to crisis point.

Young Person

Importance of help-seeking

The impact of help-seeking can be considerable. A national Kids Helpline Survey of young people who reported experiencing suicidal thoughts (yourtown, 2016) found a greater proportion of young people who had sought help reported a subsequent reduction in suicidal thoughts compared to those who had not. This is consistent with research demonstrating that even brief contact with services can result in a reduction in suicidality (Cosgrave et al., 2007, Bergen et al., 2010). Key features of a positive help-seeking experience was that the helper should 'listen, not judge and demonstrate that they care' (yourtown, 2016).

However, help-seeking rates are low among all young people experiencing suicidal thoughts or behaviours, in particular for young men (Rickwood, 2006), with many citing stigma, fear and embarrassment as barriers to seeking support. A systematic review of help-seeking barriers for suicidal thoughts and self-harm found that the most common barriers were a fear of being forced to talk about their personal problems, confidentiality concerns and fears of being admitted into hospital. Other barriers included practical access to services, time and personal resources (Michelmore and Hindley, 2012).

Role of family and friends

When young people do seek help they often turn to informal sources of support such as their parents and peers as opposed to professionals (Ivancic et al., 2014). Yet the efficacy of these sources is questionable. The Kids Helpline (KHL) survey respondents indicated that, while they would be likely to seek help from a parent, more often they found them to be not as helpful as they could be (yourtown, 2016). Michelmore and Hindley (2012) also found limited studies into peer responses and those available indicated that less than a quarter of young people who supported a suicidal peer told an adult or encouraged their friend to seek adult help.

While many people mean well, they are often not equipped with the tools and resources to respond effectively to such a confronting and complex experience in someone they care about. Therefore, youth suicide prevention activities that focus on the role of family members and peers are required. This could involve the delivery of resources, supports and training so that they can better identify, respond and refer their child/sibling.

Role of youth mental health services

It has been identified that suicide prevention policy should include a core component for the provision of accessible, timely, evidence-based mental health care (Jones and Cipriani, 2016). For young people, this involves access to youth-specific mental health care.

In Australia, headspace centres and eheadspace have been reaching an increasing number of young people with over 75,000 young people in Australia accessing the services in 2014-15 (headspace, 2015). A recent evaluation of headspace found there were significant decreases in suicidal ideation and reported self-harm following treatment in particular among young people who demonstrated clinical improvements in other symptoms. This may highlight the important role headspace can play in protecting young people from extreme consequences of mental ill-health (Hilferty et al., 2015).

Spotlight – youth mental health services

There is evidence (presented in detail in Section 4) that providing effective youth mental health care early following the onset of mental ill-health, in particular in first episode psychosis, leads to better outcomes for young people, including a reduction in suicide-related behaviours (Harris, 2008). Given that suicide-related behaviours are linked to a range of diagnoses, mental health services that provide early intervention support for depression, anxiety and borderline personality disorder could also be effective suicide prevention responses. Further, we know that even brief contact, if provided early enough, can have an impact on suicidal ideation (Cosgrave, 2007).

Therefore the roll-out of early intervention youth mental health services is not just an important youth mental health initiative but an important component of any suicide prevention strategy, addressing risk before it becomes chronic (Orygen, 2014).

headspace provides a platform within which young people can access youth-friendly, evidence-based mental health care. What is needed now is the further roll-out of this initiative to ensure every young person in Australia has access. The recent evaluation of headspace found that under the current allocation process, national coverage would be achieved with a total of 196 headspace centres across Australia (Hilferty et al., 2015).

However, many of the young people who are most at risk of suicide are also those currently considered too complex for headspace services. Therefore further augmentation of this model is urgently required in order to provide: seamless care across all stages of mental ill-health (including those more severe presentations); national coverage; and clear pathways into services for young people who have presented to hospital or emergency departments after self-harm or a suicide attempt.

Role of technology

Many young people seek information and support for their health and mental health from the internet. It also provides a platform for services to engage with groups who may not seek help through face-to-face services, including young people with disabilities, young people with severe mental illness, Aboriginal and Torres Strait Islander young people and young men (Burns et al., 2014). LGBTIQ young people also appear to preference help-seeking online, with the UK-based Queer Futures study reporting that 82.3% of participants indicated that they would be 'likely' or 'very likely' to choose online help (Queer Futures, 2016). A recently released report by Reachout highlighted the extent to which young people use the internet as a source of information and resources to support and manage their mental health. It also identified the particular role digital self-help (delivered through services like Reachout) can play for young people who may lack access to appropriate face to face services (Vogl et al., 2016).

Those at risk of, or considering, suicide often have a wish to remain anonymous, hence the value and importance of online prevention programs (Black Dog Institute and CRESO, 2014). As such many mental health and suicide prevention services are now reaching young people through TeleWeb services, web-based information, directed online self-help, mobile apps, online counselling and by using social media platforms.

headspace provides clinical support to young people at all stages of mental ill-health and at all times of the day, including at night when they are often vulnerable and experiencing suicidal ideation. Support includes information, self-help resources and online clinical care. A recent review of headspace also found that it was reaching a unique group of young people who may not have otherwise accessed help, including those with higher levels of psychological distress, but at earlier stages of illness (Rickwood et al., 2016). Given suicidal ideation may escalate quickly among young people it is important that this population has access to qualified and effective support 24/7.

Systematic review's conducted by Daine et al. (2013) and Robinson et al. (2016b) found there was evidence of the internet's positive influences on self-harm and suicide. For example, it provides anonymous, easy to access 24/7 and non-judgmental support. However, concerns exist regarding privacy, confidentiality and contagion. Links between cyberbullying and suicide among children and adolescents have been found (van Geel et al., 2014) although conclusions at this stage are limited by the number of current studies. The evidence and opportunities for the use of technology in youth suicide prevention is discussed in more detail in Section 4 of this report.

IMPLICATIONS

Why specific responses are needed for young people?

There are a number of distinct considerations for suicide risk among young people, including a susceptibility to the onset of mental ill-health (one of the most significant risk factors for suicide) during this period.

There are still significant numbers of young people who do not seek help for suicide-related feelings or behaviours. This is particularly true for younger age groups and young men.

Accessible youth mental health care is crucial. Augmenting and providing national coverage for early intervention youth mental health services such as headspace and eheadsace is needed.

Family and friends appear to be an important first point of call for a young person who is seeking help, yet often they are reported to be unhelpful. Strategies which build the skills of family and peers to respond effectively are needed.

Given the acceptability among young people of seeking out health information online, in part due to the anonymity, accessibility and 24/7 nature of support, online technologies have an important role to play. There is a need to urgently build a better understanding of how these platforms can be best utilised in youth suicide prevention.

Section 3

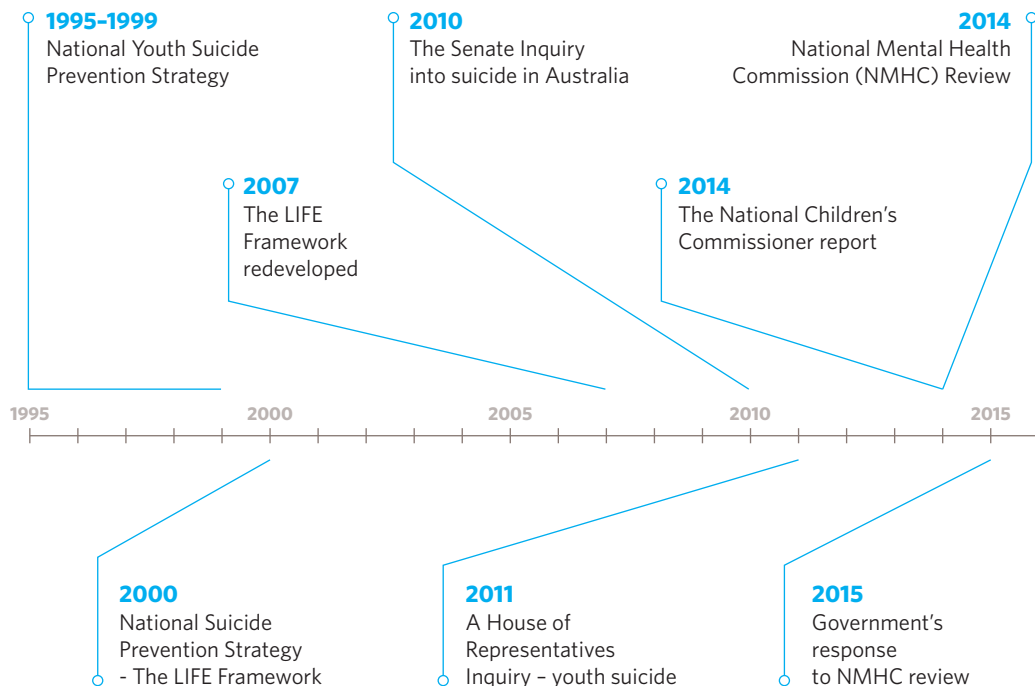
Government responses to youth suicide in Australia

For over 20 years successive suicide prevention policies, strategies and frameworks have been developed by the Commonwealth and state/territory governments in Australia. Most states and territories have a suicide prevention strategy that is current and active and the Australian Government has committed to reinvigorating a National Suicide Prevention Strategy.

National suicide prevention policies

A strong focus has been placed on suicide prevention in Australia (Figure 3). Commonwealth Government leadership in the 1990s saw Australia become one of the first countries to develop a national suicide prevention strategy, focused initially on responding to youth suicide.

FIGURE 3: A TIMELINE OF NATIONAL SUICIDE PREVENTION ACTION



From 1995-1999, the **National Youth Suicide Prevention Strategy** was a world leading response from the Commonwealth Government aimed at coordinating an approach to youth suicide prevention throughout Australia. The goals of the National Youth Suicide Prevention Strategy were to:

1. Prevent premature death from suicide among young people
2. Reduce rates of injury and self-harm
3. Reduce the incidence and prevalence of suicidal ideation and behaviour, and
4. Enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

In 2000 the Government released the **National Suicide Prevention Strategy (NSPS)** to address suicide across the whole lifespan. The NSPS includes the LIFE Framework, which provides a strategic plan for national action to prevent suicide and promote mental health. The framework was last reviewed in 2007 and while limited in detail regarding specific youth focused suicide prevention activities, there are some activities particularly relevant to young people including:

- Develop and promote programs to enhance help-seeking among high risk groups including young people
- Expand and resource the capacity of schools to identify and provide support to those at risk
- Research the influence and impact on suicidal behaviours of new technologies.

Spotlight - ATAPS Tier 2 suicide prevention

Another important Australian Government policy and program response to suicide prevention has been the ATAPs Tier 2 - suicide prevention program. This program provides psychological services as needed over two months for people who present to a GP with suicide-related behaviours, including ideation, who have self-harmed or who are at increased risk due to the impact of another's suicide. It isn't a crisis service, nor is it intended to supplement or replace the existing state and territory mental health service system treating people with a long history of suicide related behaviours related to mental illness.

Generally the ATAPs suicide prevention service has been deemed an appropriate and effective suicide prevention intervention (including for young people) particularly in terms of uptake and clinical outcomes in the short term (Fletcher et al., 2012). However it has not been tested for economic efficiency nor for data on suicide related outcomes in the long term. Its specific impact upon young people is also not clear from evaluations to date (Australian Healthcare Associates, 2014).

Other elements of the NSPS included the National Suicide Prevention Programme (NSPP) and mechanisms to promote alignment with state and territory suicide prevention activities. Between 2005 and 2011 the Australian Government more than doubled its investment in the NSPP from \$8.56 million to \$23.8 million (Commonwealth of Australia, 2010).

Further Australian Government inquiries on both suicide and youth suicide specifically been conducted including:

The Senate Inquiry into Suicide in Australia, The Hidden Toll (2010): resulted in the Taking Action to Tackle Suicide (TATS) package, including \$61.3 million over four years from 2010-11 to promote good mental health and resilience in young people to prevent suicide later in life (Commonwealth of Australia, 2010). The package also funded a boost in frontline services (such as the expansion of

ATAPs Tier 2 see Spotlight) for those most at risk. For young people this resulted in more avenues to mental health support including through headspace and improved telephone and web-based services.

The House of Representatives Inquiry into Youth Suicide, Before it's too Late Report (2011): recommended more frontline services including psychological and psychiatric services; promoting better mental health and wellbeing among young people; the development of additional youth headspace sites and additional early psychosis prevention and intervention centres. The Government responded to this report in 2013 supporting the recommendations in principle and restating its commitments to many of the actions and initiatives underway through the TATS.

The National Children's Commissioner Report on Suicide and Self-harm among Children and Young People (2014): emphasised the need to include young people who self-harm or who engage in suicide-related behaviours in research, program development and training development and delivery. Significant gaps in data and the need for assertive follow-up care were also identified to better support young people discharged from hospitals and emergency departments. Further the report called for a national research agenda to respond to the many gaps and barriers for research on these issues.

The National Mental Health Commission Review of Programmes and Services: took a notable stance in calling for a target of a 50 per cent reduction in suicide and suicide attempts over the next decade. The commission also highlighted the need for improved online approaches to stepped care for people who do not access face-to-face services (including young people) and provide follow-up care from emergency departments and hospitals upon discharge. The commission review proposed trialling a locally-led systems based approach to suicide prevention across 12 pilot sites in Australia (with urban, rural, regional and remote sites included).

State/territory responses

Every state and territory in Australia has a suicide prevention strategy or policy, aligned to the LIFE Framework.

Most strategies identify particular priority populations who should be the focus of suicide prevention activities, including young people. Most also identify a multi-faceted approach to suicide prevention including inter-sector collaboration, community-based approaches and health system actions for those with imminent and urgent needs. Only Tasmania includes a separate Youth Suicide Prevention Plan (Department of Health and Human Services, 2016). Table 2 presents an analysis of the different activities **targeted specifically** to young people described in state/territory suicide prevention policies (current as at March 2016).

TABLE 2: ANALYSIS OF SPECIFIC YOUTH SUICIDE PREVENTION ACTIONS AND ACTIVITIES IN STATE AND TERRITORY STRATEGIES

Number of state/ territories	Area of action identified
Almost all	Identified high risk groups within the 12-25 year old bracket, although these differed across the policies. Many jurisdictional policies identified action for groups engaged in systems they administered e.g. family services, child protection, juvenile justice.
	Identified delivery of gatekeeper training/mental health literacy training for professionals working with young people who might be at risk including schools.
	Identified the need to ensure a whole school student health and wellbeing approach was taken to build protective factors among students such as self-esteem, social skills, looking after each other, anti-bullying and creating safe and supportive educational environments.
Many	Identified the need for integrated and coordinated approaches to suicide prevention particularly for high risk groups (some placed the action in justice, others between schools and local mental health systems, another with a focus on homeless young people).
Half	Described action on postvention support for young people impacted by suicide and self-harm. This was often in the context of responding to the risk of contagion. All were to be delivered through schools.
	Described action to improve service access including youth friendly and appropriate, flexible models for young people at risk with a particular focus on early intervention services that are provided in a youth friendly way, at times (including after hours) and places they need it. One strategy identified the need for delivery of suicide prevention activities in vocational and tertiary education providers, as well as schools.
Some	Identified social media, online, technologies within their policy. NSW and WA identified that these could be useful tools for suicide prevention responses, but also identified the risks social media and technology pose e.g. cyber bullying.
	Described youth participation and engagement as a component of their suicide prevention response. WA committed to the development of a youth engagement strategy to support their policy. One described action for peer support programs.
	Even though most strategies identified drug and alcohol misuse as a risk factor only one policy (NT) described drug and alcohol interventions specifically in response to suicide risk among young people.
	Only one (TAS) Identified clear action and priorities in regards to the role of families, parents and carers of young people.

Aboriginal and Torres Strait Islander suicide prevention strategies

The 2013 National Aboriginal and Torres Strait Suicide Prevention Strategy has six action areas. Young people are specifically mentioned in the first two: with early interventions for young people identified as a part of building community strength and capacity (Action 1); and the importance of universal information to dispel myths around suicide and promote the use of services and support – in particular through community cultural activities for young people (Action 2).

Many state and territory prevention strategies have focused on ensuring mainstream programs are culturally appropriate. However, culturally appropriate suicide prevention needs to recognise the specific factors behind suicide among Aboriginal and Torres Strait Islander people not just modify existing programs for this group. For example, suicide prevention policies for Aboriginal and Torres Strait Islander people have been largely independent of strategies to restore social and emotional wellbeing (Dudgeon et al., 2014a). This is despite a focus on elements of social and emotional wellbeing being described as ‘suicide proofing’ individuals, families and communities (Powell et al., 2014). A focus on addressing the social determinants of suicide for Aboriginal and Torres Strait Islander young people should also be a priority moving forward, along with using appropriate methodological approaches to better evaluate outcomes.

Impact of policy responses

Successive evaluations of national suicide prevention efforts over the past decade (Table 3) have been unable to link the range of policy and program actions to any reductions in suicide-related behaviours, including self-harm, at a national level or within communities. In general, evaluations of national suicide prevention activities and programs funded under the NSPP have been patchy and problematic.

If we draw conclusions from suicide rates then the impact of 20 years of successive and concerted suicide prevention efforts has been, at best, negligible. Suicide rates across the general population haven’t decreased. Indeed, the ABS data released in 2016 indicated that in the past 10 years (to 2014) the suicide rate has risen nearly 20 per cent. While suicide rates among young people dropped in the decade after the release of the Youth Suicide Prevention Policy in 1995, there has been slight but gradual increase in suicides since.

However, it is acknowledged that outcome measurement in suicide prevention is more nuanced than recording changes in rates, and includes variations in risk and protective factors for suicide, as well as changes in other suicide-related behaviours.

TABLE 3 – NATIONAL SUICIDE PREVENTION EVALUATIONS

Evaluation	Findings
Youth Suicide Prevention Strategy Evaluation (Mitchell, 1999).	While a range of appropriate activities based on international suicide prevention literature were initiated, there were no data to indicate whether or not these activities had reduced suicide-related behaviours or associated risk factors. This was in part due to the short-time frame from implementation, and also the difficulty in measuring suicide prevention outcomes. Found that the strategy had resulted in improvements in the perceived of services to respond and prevent suicide among young people and a small number of projects demonstrated evidence of positive outcomes for young people.
NSPS Evaluation (Department of Health and Ageing, 2006).	Found that there were some improvements in understanding, capacity building of individuals and services, help-seeking and referrals. However, assessing the effectiveness of these activities was hampered by the lack of quantifiable outcome data collected by projects. The evaluation concluded that it was not possible to say whether any NSPS Project appeared to have led to reductions in suicide or self-harm
Evaluation of Suicide Prevention Activities (AHA, 2014).	Reported that ‘while several projects reported improvements in knowledge, attitude and behaviours relating to suicide prevention, and others showed decreased levels of suicidal ideation, distress, anxiety and depression... data on the incidence of suicide and suicidal behaviour before or after the interventions were not collected.’(p126)

State and Territory evaluations

Published evaluations of state and territory suicide prevention efforts were also difficult to come by even though each policy identified the need for ongoing evaluation and monitoring. The ACT's 'Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014' has been the first in Australia to attempt a longitudinal evaluation of the implementation of a suicide prevention strategy (Sheehan et al., 2015). The study reported that it is possible to evaluate a complex, multi-component and multi-sectoral suicide prevention strategy, with agencies providing data for approximately 64 per cent of their funded activities, of which 42 per cent had been fully implemented in the four-year period under evaluation. Again, the impact of these activities on suicide rates or suicide-related behaviours was not evaluated.

Aboriginal and Torres Strait Islander Suicide Prevention evaluation

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) report (2016) was recently made available and summarises the evidence of what works in Indigenous community-based suicide prevention, including what is available from evaluations of national and jurisdictional funded suicide prevention activities. The report found for Aboriginal and Torres Strait Islander young people activities such as peer-to-peer mentoring; engagement and diversion programs such as sport; connection to culture/country and elders; and providing education and employment pathways to build hope in the future were successful program factors.

The new agenda - 2016 and beyond

In November 2015 the Australian Government announced its response to the National Mental Health Commission's Review of Mental Health Programmes and Services, a review that called for 'urgent and significant' reform.

In particular the Government committed to a renewed suicide prevention strategy with a focus on an evidence-based and regionally focused approach that is both planned and systematic. This will include:

- 'National leadership and infrastructure including evidence-based population level activity and crisis support services
- A systematic and planned regional approach to community-based suicide prevention ... will be led by PHNs who will commission regionally appropriate activities
- Refocusing efforts to prevent indigenous suicide
- Working with state and territory governments to ensure effective post-discharge follow-up for people who have self-harmed or attempted suicide in the context of the Fifth National Mental Health Plan.' (Commonwealth of Australia, 2015, p17).

In the lead up to the 2016 Federal Election, a 'call to action' was launched by leaders in suicide and mental health, asking all major parties and candidates in the 2 July election to spell out what they will do in the next Parliament to address the rising toll of suicide and self-harm across Australia (ConNetica, 2016).

By the time of the election, all of the major parties had detailed specific initiatives in suicide prevention. The Coalition, who were returned to Government committed to provide additional funding for a Suicide Prevention Research Fund, supporting targeted research and the development of a 'better practice hub' of resources to support those in the community involved in commissioning, developing, implementing and evaluating community-based suicide prevention activities (The Liberal and National Parties of Australia, 2016).

The roll out of these reforms provide a timely opportunity to ensure that evidence-based youth suicide prevention responses are embedded in their implementation.

Other areas of reform

The Government has also outlined a number of other areas of reform relevant to improving the response to youth suicide. These include the development of:

- An integrated and equitable approach to youth mental health. This includes integrating headspace and other youth mental health services with primary care, thus providing early intervention for a larger group of at risk or unwell young people.
- A new digital mental health gateway, which will provide people with the tools and information to better navigate the mental health system. The role of crisis support services will be protected, ensuring that they can be accessed quickly and simply.
- An 'end-to-end school-based mental health programme', to support promotion and prevention activities and build resilience and will be delivered from early childhood education to end of secondary school (Commonwealth of Australia, 2015).



IMPLICATIONS

Government responses

Australia was one of the first countries to develop a national suicide prevention strategy, focused initially on responding to youth suicide.

Much has been delivered through successive policy, program and activities at both the national and state/territory level over the past 20 years.

Successive evaluations of national suicide prevention efforts over the past decade have been unable to link the range of policy and program actions to any reductions in suicide-related behaviours, including self-harm, at a national level or within communities.

The Government recently announced a suite of mental health reforms, including a reinvigorated suicide prevention strategy and a role for the 31 PHNs to plan and commission regionally focused youth mental health services and suicide prevention responses.

This provides a significant opportunity to ensure that evidence-based youth suicide prevention responses are embedded in their implementation and that the strategy is evaluated robustly to build the future evidence base regarding what works.

Section 4

Areas and settings for action

This section describes the current evidence for effective youth suicide prevention interventions across a range of areas and settings. This has been based on the peer-reviewed literature of which a selection of the most recent evidence is presented here (a full summary of evidence is included in **Appendix 1**). Studies were included if they implemented an intervention aimed at preventing or treating suicidal behaviour in young people up to the age of 25 years, and included a suicide-related outcome.

This section also captures reflections from suicide prevention experts, youth mental health experts and young people themselves (the youth consultation report is included in **Appendix 2**) about what they believe would be effective responses and interventions for young people across a number of settings and situations.

National leadership and coordination

As described in Section 3, the Australian Government has committed to develop and implement a new suicide prevention strategy, which will involve national leadership and infrastructure including evidence-based population level activity and crisis support services. In August 2016 the Government released the tender guidelines for a National Suicide Prevention Leadership and Support Program. This outlined a number of national activities to be funded, including a national leadership role, leadership in suicide prevention research and national support services for individuals at risk (Australian Government, 2016).

What the evidence says

There is limited research evidence on what are the key elements of an effective suicide prevention strategy. A systematic review by Mann et al. (2005) on suicide prevention strategies found the impact of different strategies on national suicide rates is important for planning but difficult to estimate.

One report by Australian authors Martin and Page (2009) compared a number of suicide prevention strategies across several countries (including Australia) and identified a suite of key elements of successful and effective strategies, each of which requires national leadership. These included (but aren't limited to):

- A clear framework
- Measurable targets
- Improving the capacity of services and access/ links between them and the community
- Strong evaluation components.

What people told us

During consultation for this report, stakeholders and young people were asked to identify what they believe is needed in government leadership and coordination to respond specifically to suicide among young people (albeit recognising the needs of this group at a national level could not be completely isolated from the broader population response). The findings are presented in Table 4 below.

One of the strongest themes to emerge was the need for a separate and dedicated response to youth suicide prevention, which should be developed in partnership with young people. To date young people have not been involved in: a) the development of suicide prevention policies, b) the design of suicide prevention activities that would meet their needs; or c) to evaluate these efforts or provide ongoing governance.

“ Young people should have a strong voice in the design and delivery of youth suicide prevention policy and programs...young people are well placed to shape a successful strategy or strategies.

Young person

TABLE 4: AN EFFECTIVE NATIONAL YOUTH SUICIDE PREVENTION POLICY RESPONSE - CONSULTATION SUMMARY.

The National Suicide Prevention Strategy requires:	A youth suicide prevention response would also require:
A national plan with clear objectives, priorities for activities to be delivered: a) nationally, b) at a state/territory level and c) regionally.	A separate youth suicide prevention implementation plan which describes activities and partnerships in settings where young people are engaged and likely to seek help e.g. education settings (primary, secondary, community and tertiary) and families. This is an age group who may not have had contact with the health system yet.
Communication and clarity of roles to ensure that suicide prevention activities (including the role for step-down care following discharge from services) are integrated.	Actions, roles and responsibilities are identified across all portfolios (in all levels of government) relevant to young people and the social determinants of suicide risk including: education, health, justice, social and community services.
An advisory mechanism with genuine capacity to direct suicide prevention action, such as Australian Suicide Prevention Advisory Council.	Young people represented on, or consulted by, this advisory mechanism with a commitment to genuine partnerships with young people in the process of developing and providing advice to government.
A strategic approach and adequate funding in order to conduct relevant research and build the evidence base in suicide prevention.	New and innovative youth suicide prevention activities are funded and researched.
Ready access to existing evidence through the development of a 'Better Practice Register'.	Ensure that the evidence base clearly identifies youth appropriate, acceptable and effective strategies and that this information is made available to commissioners and providers.
A robust and nationally consistent evaluation framework developed and resourced from the outset.	Evaluations that seek out young people's views to a) ensure youth-related outcomes are collected and b) determine the program's acceptability and appropriateness.
Improved national data collection and monitoring to understand the prevalence and impact of suicide-related behaviours.	Building on existing (and create new) national data collection instruments to ensure that the right questions are asked in the right way to collect information from young people.
A parallel national suicide prevention workforce development strategy.	Building competency in a workforce that a) young people are most likely to seek help from (including peers and family) and b) are in regular contact with young people and in a position to identify risk (including teachers, youth workers, sports administrators, music clubs).

IMPLICATIONS

National leadership

Suicide prevention for young people is different than other age groups and a separate Youth Suicide Prevention Implementation Plan is needed.

Young people want to be engaged in suicide prevention leadership and coordination and have a place at the table with the decision makers, policy developers, funders, program managers and evaluators.

It is important that elements of a successful suicide prevention strategy, such as a strong evaluation framework, robust data collection and research are developed in such a way that they collect the right information from young people in the right way.

It is important to develop partnerships with sectors and systems outside of health to target support and suicide prevention activities to people and settings where young people are most likely to seek help.

Youth mental health services and clinical care

One of the strongest risk factors for suicide-related behaviour in people, including young people, is the experience of mental ill-health. As identified earlier in this paper, it has been suggested that up to 90 per cent of people who make suicide attempts are believed to have a mental health condition. A significant proportion (80 per cent) of these people will have not received early, or indeed any, treatment for their mental illness (Mann et al., 2005).

In particular, rates of suicide attempts among young people with depression are significant, with one study reporting that 22.9 per cent had made a suicide attempt in the early stages of depression and with 32.6 per cent making an attempt at some stage in their life (Fombonne et al., 2001). Similarly, suicide-related behaviours are prevalent among young people with psychotic disorders, with risk highest early in the course of illness (Palmer et al., 2005) and increasing if the individual experiences multiple mental illnesses (Slade et al., 2009).

Currently in Australia we do not have a youth mental health service system which provides the full spectrum of integrated and evidence-based stepped-care from early intervention through to specialised services for those experiencing severe mental ill-health. For young people at risk of suicide, not being able to access the appropriate level of care, where and when needed, potentially falling through the chasms within the system, can have tragic consequences. This is most evident in the period following discharge from an emergency department or hospital following a suicide attempt or self-harm.

It has also been suggested that better targeting and tailoring of youth mental health services to those at higher risk of suicide and suicide-related behaviours (even in the absence of a diagnosis) is required. These groups include young men, rurally isolated young people, young people not engaged in school, young people in out-of-home care, homeless young people and Aboriginal and Torres Strait Islander young people (headspace, 2014, National Mental Health Commission, 2014).

“ I feel that the issue of suicide needs to be broadened to look at help-seeking or early intervention more generally. At our early point of care we find that young people just describe having a ‘tough time’.

Stakeholder

What the evidence says

Interventions for clinical populations

There is some evidence available for effective clinical interventions for young people who have an experience of mental ill-health and who may also be experiencing suicidal ideation/behaviours, in particular Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy (CBT) and Family-based interventions (see Table 5).

Specialised youth focused treatment (for early psychosis) as well as contact with headspace services has also been found to result in significant decreases in suicidal ideation and reported self-harm (Hilferty et al., 2015).

TABLE 5: EVIDENCE FOR CLINICAL THERAPY FOR YOUNG PEOPLE ENGAGING IN SUICIDE-RELATED BEHAVIOURS

Intervention type	Evidence support
Early access to mental health treatment	Studies have also shown that young people who had contact with specialised treatment (for early psychosis) had lower suicide risk over the following two years than those who didn't have contact (Harris et al., 2008). For many young people presenting with suicide risk their symptoms will remit with only minimal contact with mental health treatment services (Cosgrave et al., 2007).
DBT	Delivered to young people with a diagnosis (or symptoms) of borderline personality disorder (BPD) was found to be associated with significant decreases in suicidal ideation and/or behaviour (Fleischhaker et al., 2011, Geddes et al., 2013, Mehlum et al., 2014, Turner, 2000).
CBT	Significantly reduced suicidal ideation and behaviour (Brent et al., 2009a, Esposito-Smythers et al., 2006, Esposito-Smythers et al., 2011, Slee et al., 2008, Alavi et al., 2013).
CBT combined with medication	Mixed findings. In one study Venlafaxine treatment was actually associated with a higher rate of self-harm events in participants with higher suicidal ideation (Brent et al., 2009b).
Multimodal interventions	A comprehensive program (involving psychoeducation, CBT, psychosocial interventions and pharmacotherapy) targeted to persons at the onset and/or at high risk of psychosis was associated with a significant reduction in suicidal ideation after one year (Preti et al., 2009).
Family-based interventions	Positive effect on suicide-related behaviours including suicidal ideation in both young people and, in some studies, their parents. These effects often continued at follow up (Asarnow et al., 2015, Diamond et al., 2010, Pineda and Dadds, 2013, Spirito et al., 2015).

In hospital, and post-discharge care from hospital or emergency department

There is considerable evidence that the post-discharge period from hospital services (including psychiatric inpatient care and emergency departments) is one of elevated risk of suicide (Fedyszyn et al., 2016, Bickley et al., 2013). The Australian Government has recognised this and flagged urgent improvements to the post-discharge response as one of the key focuses for

the renewed suicide prevention strategy and fifth National Mental Health Plan (Commonwealth of Australia, 2015). It has also become increasingly a focus for state/territory suicide prevention plans.

There have been a number of studies into the effectiveness of interventions delivered in the period following discharge from hospitalisation due to suicide-related behaviours. The findings are presented in Table 6 below:

TABLE 6: EVIDENCE FOR POST-DISCHARGE CARE IN YOUNG PEOPLE

Intervention type	Evidence support
Brief Intervention and Contact in hospital (with follow-up)	Significantly fewer deaths from suicide occurred among those who had attempted suicide and been delivered Brief Intervention and Contact involving a psychoeducation session close to the time of discharge followed by regular follow-up phone calls or visits over a 6-month period, than those who received usual care (Fleischmann et al., 2008).
Psychosocial assessment	Psychosocial assessment provided in hospital after an episode of self-harm was associated with a 40% lower risk of repetition of self-harm, in an all-ages cohort (Kapur et al., 2013).
Rapid-response follow-up	Suicidal adolescents who received rapid-response outpatient follow-up after presenting to an emergency department had a lower hospitalisation rate than those who did not (Greenfield et al., 2002).
Family-based interventions	Mixed results for family-based interventions following discharge from hospital. With two studies reporting positive effects (Wharff et al., 2012, Huey et al., 2004). However another two found no effect on suicide-related outcomes (Asarnow et al., 2011, Harrington et al., 1998).
Postcard interventions	Mixed results for the effect of postcard interventions on suicidal ideation. One reporting a reduction in suicidal ideation and reattempts (Hassanian-Moghaddam et al., 2011) another reporting no effect on suicidal ideation or attempts, or deliberate self-harm (Robinson et al., 2012). Similarly no effect on repeat suicide attempts was found for the provision of readmission tokens upon discharge (Cotgrove et al., 1995).

What people told us

The sector has flagged a number of areas where the youth mental health service system could be improved to better respond to the needs of those young people experiencing mental ill-health who are also at risk of, or engaging in, suicide-related behaviours. These include:

Build an integrated system of youth mental health care, which includes national coverage of headspace and restructured and resourced specialist mental health care for young people.

This system of care should provide young people aged between 12 and 25 years with seamless pathways between primary and specialist services (as well as other youth-specific settings such

as schools) across a full range of mental health needs including more severe and complex mental presentations. It should also deliver the evidence-based dosage and duration of care (as would be provided other experiences of ill-health such as heart disease, cancer or diabetes). For example, Harris et al. (2008) found that once young people were discharged from the early psychosis services the declining rate of suicide evened out. This suggests there is still a need for providing longer-term care that exceeds the publicly funded care available.

Better targeting and tailoring of youth mental health services and early intervention to those at higher risk of suicide and suicide-related behaviours (such as young men and Aboriginal and Torres Strait Islander young people) even in the absence of a diagnosis (headspace, 2014, National Mental Health Commission, 2014).

“ I consider the current programs do not engage with many high risk groups. It has to do with language, style, environment (and) “clinical” approach.’

Stakeholder

Urgently improve follow-up care after a suicide attempt or after discharge from inpatient hospital care and/or emergency departments:

State/territory systems and federally funded community-based services (including youth mental health services) need to work together and ensure what is provided is seamless, accessible and acceptable to young people. A liaison role in each PHN to support transitions between service settings could facilitate this. There is some evidence for brief interventions, and rapid follow-up (described above), however there is also need to explore the role technology can play in providing 24/7 accessible follow-up care for young people after a suicide attempt or self-harm (both those instances that have resulted in hospitalisation and those which are identified by others in the community).

“ Once someone is discharged from a service, guidance for how to access another service if they need one or what services are good is so necessary for ensuring their ongoing help and support.’

Young person

Respond to the barriers to service access particularly for young people under 18 years, including costs of services, difficulties getting to appointments independently (particularly if they don't want their parents to know), confidentiality, and long waiting lists (beyondblue, 2014).

Incorporate youth suicide prevention and postvention activities within the suite of existing youth mental health prevention and early intervention programs. This will involve providing tools, resources and workforce development opportunities to staff managing and delivering these programs (beyondblue, 2014), the delivery of evidence-based treatments in suicide prevention, as well as training future staff prior to service (The Hunter Institute of Mental Health, 2014).

Address inequity in youth mental health service and suicide prevention service delivery, particularly in rural and remote areas. These are the areas with high rates of youth suicide and self-harm hospitalisations (National Mental Health Commission, 2014). There is a need to direct more resources to the delivery of mental health services which are acceptable to young people in these areas. While online delivery is an option, many rural and remote areas still experience poor network connectivity, therefore access to direct contact with youth mental health professionals is still needed.

IMPLICATIONS

Youth mental health services

There is a strong link between mental ill-health and suicide among young people, as well as evidence that early intervention can decrease suicide risk, including among those with more severe and complex presentations. The provision of integrated and specialised youth mental health care is critical to prevent future deaths.

Contact with youth mental health services is vital (Hilferty et al., 2015). However, there is still a need to respond to mental health service barriers, particularly for high risk groups of young people including Aboriginal and Torres Strait Islander young people and those living in rural and remote areas who do not currently have access to headspace or specialist youth mental health services.

Efforts to improve follow-up care post discharge is needed across all settings including emergency departments, primary and tertiary care, however pathways must be youth appropriate and accessible (this includes consideration for the role of technology).

There are interventions for clinical populations, which show promise, particularly DBT and CBT.

Along with the acceptability of family members as a source of support for young people experiencing suicidal ideation or related behaviours, the involvement of family members in interventions also appears to be generally effective.

More needs to be understood about the suicide-related outcomes of a range of treatment interventions across diagnoses and stages of mental ill-health, including those delivered online (e.g. online self-help, particularly in the earlier stages of ill-health).

Technology and the internet

The growing evidence for the efficacy, reach and potential impact of harnessing technology to deliver youth suicide prevention activities and programs has been identified in the literature and by the suicide prevention sector. As described in Section 2, the 24/7 accessibility of online support services provides significant opportunities to deliver effective interventions to young people at times of the day when suicidal ideation or thoughts may escalate quickly. A number of services which make use of technology to deliver mental health interventions have emerged over recent years. These services included:

- TeleWeb services (including hotlines, telephone counselling or online counselling, e.g. Kids Helpline, eheadspace, Lifeline, beyondblue and Qlife;).
- Web-based information and digital self-help programs (for example Reachout).
- Mobile apps (including those for specific high-risk groups such as Black Dog's iBobbly app for Aboriginal and Torres Strait Islander young people).
- Social media platforms, both those designed and built for purpose and those utilising existing platforms where young people are already active such as Facebook.
- Project Synergy (which has received continued funding from the Australian Government in 2016) as a platform which will enable technologies to interact with and provide a seamless journey through mental health support and services, including facilitation of links to clinical services both on and offline.

The Government's new digital gateway into mental health care will preserve current crisis services, however there are implications for how this gateway and/or other government funded online mental health platforms could provide effective youth suicide prevention interventions. Bringing to scale existing youth acceptable platforms, such as eheadspace, could complement both a new digital interface to care and enhance the stepped models of mental health care to be developed across the PHNs.

What the evidence says

Online programs and TeleWeb counselling

To date limited research evidence has been published on youth specific online suicide prevention interventions. While we know that young people are using these services in large numbers, evidence regarding their impact on suicide-related outcomes is limited. Of the studies identified, most were delivered in educational settings. Findings include:

- Use of online suicide prevention programs which include brief interventions and online motivational interviewing can increase help-seeking attitudes, intentions and readiness to seek help among young people (King et al., 2015, Taylor-Rodgers and Batterham, 2014).
- CBT delivered online and other interventions promoting behavioural change appear to decrease suicidal ideation (Robinson et al., 2014, Hooven et al., 2012).
- An online suicide prevention 'first aid program' delivered on its own, and when combined with a skills training intervention for parents resulted in reductions in suicide risk factors and increases in protective factors throughout adolescence and into young adulthood (Hooven et al., 2010, Hooven et al., 2012).

Mobile apps

Given the affordable and accessible nature of their delivery, government and the mental health sector has been increasingly interested in the generation of evidence to guide the development of high quality and clinically effective apps.

These types of interventions are also acceptable to young people and align with recent findings that young people use smartphones and download mobile apps for numerous purposes (including supporting their health and wellbeing) at a greater rate than any other age group (ACMA, 2013). Unfortunately at this stage:

- There is limited research evidence available on the impact of these types of mental health focused apps and programs on suicide-related outcomes; and
- The authors of this report were unable to find research published on apps specifically targeting suicidal young people. Black Dog is currently rolling out a national evaluation of iBobbly, the world's first suicide prevention app designed especially for use by young Aboriginal

and Torres Strait Islanders (aged 16-30 years). According to Black Dog the results of an initial pilot study were promising (Black Dog Institute, 2015).

There are also reports of the proliferation of mobile app mental health interventions with concerns that the technology is moving faster than research can keep up. As a result, the majority of these apps remain unsupported by evidence (Martínez-Pérez et al., 2013, Donker et al., 2013). Further research is therefore a priority, as is consideration of ways in which evidence-based apps could be both 'accredited' and promoted.

Social media

There is limited evidence available on the safety and efficacy of utilising social media for suicide prevention. A call for more research into both the opportunities and risks associated with social media use in suicide prevention has been made by many in the sector (Robinson et al., 2015). Work has recently been undertaken by the Young and Well CRC and Orygen to develop safety protocols and ethical guidelines to ensure that social media interventions are developed and are delivered safely.

Spotlight - Partnerships with technology

Social media companies, such as Facebook and Twitter, have responded to calls to keep their platforms safe and supportive (Young and Well, 2015). In partnership with the suicide prevention sector in the US (Forefront, Lifeline and Save.org), Facebook released a Suicide Prevention Tool in June 2016 which provides users with the option to identify a concerning post and are subsequently provided with a range of options on how to respond.

However, other social media sites have run into challenges. For example, Samaritans Radar, an app designed to connect to Twitter, was launched and then withdrawn due to concerns that the app was sharing information about people's mental health without permission.

On Tumblr, a blogging site predominantly used by young people, a number of unofficial suicide prevention bloggers known collectively as Tumblr Suicide Watch (TSWatch), trawl the site for trigger hashtags such as #selfharm or #suicide and reach out to offer support and help. While well intentioned, there is the potential that untrained and unregulated individuals could provide potentially unhelpful, or even harmful, advice.

Regardless of these challenges, young people consulted for this report described the need for help to be easily accessible online and that support needs to be better integrated into the technology they are already using - this included popular search engines such as Google, and social media platforms.

What people told us

Many existing TeleWeb and online services provide youth friendly and acceptable access points trusted by the service sector and young people alike and there is significant support for their protection in an environment where government is exploring new opportunities to deliver mental health care online.

“ Young people are already engaging so much with Instagram, Facebook, Snapchat, What’s app etc and so I think the solution lies within the current platforms as opposed to creating something completely new.

Young person

Young people we spoke to believe there are opportunities for the mental health sector, including clinical services and programs, to utilise these existing platforms and services to better engage and support suicidal young people. Any future suicide prevention programs or interventions delivered online should then add value to what is currently available. This could include:

- Increasing access to and availability of e-mental health clinics where young people can access counselling online 24/7.
- Addressing gaps in access to online services such as cultural and language barriers and connectivity issues in rural and remote areas of Australia.
- Consideration of youth-specific and age appropriate interfaces, language and functionalities.
- Peer-to-peer communication and networking through social media ensuring significant care and resources are required so that these platforms are carefully moderated and well connected into TeleWeb and other clinical assisted services.

“ Peer-to-peer support is incredibly valuable, but would need to be regularly monitored to ensure that conversations are not harmful to others.

Young person

- Engaging young people (both those with a lived experience of mental ill-health and those with expertise in technology) in co-design of current and future online mental health and suicide prevention service delivery platforms.
- Building a bridge between the online and offline supports for young people by integrating online mental health and suicide prevention service delivery platforms with primary care, community and crisis services to enable:
 - Access to early intervention services through screening referrals and care coordination
 - Clinical care and support 24/7, particularly important in the early hours, days and weeks after discharge from inpatient, hospital and emergency departments after self-harm or a suicide attempt.

IMPLICATIONS

Technology

Most suicide prevention policies to date have not identified adequate opportunities to use technology effectively and safely with young people.

Kids Helpline, Lifeline and beyondblue are all considered by the sector and by young people as providing a critical national service and important TeleWeb interventions for young people who are at risk of suicide.

24/7 online youth mental health counselling (such as eheadspace) could also provide an effective intervention for young people at times of heightened risk. Ensuring that these services are resourced to respond to demand should be a priority.

There is evidence that some e-mental health and suicide prevention interventions could be effective but more research is needed.

Technology-based interventions developed in the future will need to 'add value' to what young people are already using.

Partnership with young people and technology companies is essential.

Education settings

Schools, TAFEs and Universities provide an appropriate and effective setting within which to deliver evidence-based suicide prevention activities to young people.

The reach and impact of delivering school-based programs early and at a point of life when mental ill-health is likely to onset is now widely recognised and is included in most suicide prevention policies. School-based suicide prevention activities in Australia have consisted of gatekeeper training for staff, mental health awareness raising among students and teachers, whole-of-school student wellbeing policies to address risk factors, and postvention programs.

However, they have typically not featured components that facilitate discussions about suicide or suicide-related behaviours directly with students (although examples do exist, e.g. SafeMinds in Victoria).

For instance, the Australian Government's *MindMatters* has not historically dealt directly with suicide, a position that has been described as prudent given the limited evidence 'that school-based programs that focus on raising awareness about suicide are beneficial and not harmful.' (Australian Healthcare Associates, 2014, p165-66).

What the evidence says

Suicide prevention education and awareness raising:

Recent studies have begun to demonstrate that suicide prevention programs can be safely and effectively delivered directly to students (Table 7) and there is good evidence for peer support

and social connectedness programs in schools, if implemented carefully (Wyman et al., 2010, Calear et al., 2016). For example one study compared three different strategies (education, screening and gatekeeper training) and found that psychoeducation was the only component to significantly reduce suicide attempts and severe suicidal ideation (Wasserman et al., 2015).

TABLE 7: EVIDENCE SUMMARY SUICIDE PREVENTION EDUCATION PROGRAMS

Finding	Reference
Suicide prevention education programs have been delivered safely to students in secondary schools with good outcomes, including in Australia.	(Robinson et al., 2016a) (Wyman et al., 2010)
Psychoeducation has been found to significantly reduce suicide attempts and severe suicidal ideation.	(Wasserman et al., 2015)
Suicide prevention education programs have been found to improve knowledge, confidence, attitudes, and help-seeking intentions AND can improve outcomes in regards to suicidal ideation or other suicide-related behaviours	(Gravesteyn et al., 2011, King et al., 2011, Le and Gobert, 2015, Robinson et al., 2016a)

Gatekeeper training

A feature of most suicide prevention policies, both nationally and across states/territories, gatekeeper training in schools is supported by the sector who recognise that it improves the knowledge and confidence of those trained. These 'gatekeepers' then report feeling, in the short-term, better able to respond to a young person who is experiencing suicidal ideation or engaging in suicide-related behaviours. However, the outcomes for young people (e.g. changes in help-seeking, or suicide-related behaviour) remain

untested and unknown. Similarly the effectiveness of gatekeeper training delivered in tertiary education settings is also unknown. A summary of available evidence is presented in Table 8.

“ Gatekeeper training is one of interventions that is considered to be effective. It should be as widely available as possible and should, of course, be a part of how schools deal with suicide risks in students and staff.”

Stakeholder

TABLE 8: EVIDENCE SUMMARY: GATEKEEPER TRAINING

Finding	Reference
Gatekeeper training was associated with increases in knowledge, confidence, perceived competence, and attitudes. However, these changes did not always correspond to actual changes in behaviour	(Pearce et al., 2003, Taub et al., 2013, Tompkins and Witt, 2009, Stanley et al., 2015, Yousuf et al., 2013)
Mixed findings that training positively impacted gatekeepers' behaviour in terms of skill acquisition, identifying and referring young people at risk of suicide	(Cross et al., 2011, Wyman et al., 2008, Robinson et al., 2016c)

Screening programs:

Screening programs aim to identify people at risk of suicide early, including those who have not yet sought help and are not already in contact with mental health services and support systems. In schools, screening is usually conducted by external professionals, often in partnership with school staff. Overall screening interventions appear to be safe, acceptable and effective at identifying students at risk who may otherwise have gone unidentified (Robinson et al., 2011, Gould et al., 2005). However, most of the research studies noted difficulties including:

- Screening large groups is time-consuming, expensive and requires the commitment of school staff and/or mental health professionals.
- There is the potential for screening instruments to identify students as 'at risk' when they may not be (false positives) or, more worryingly, fail to identify some people from getting help who may need it (false negatives).

For these reasons screening programs have not had widespread uptake in Australia.

Multimodal programs

These refer to school-based suicide prevention programs that have delivered a number of the elements already described, simultaneously (multimodal). These programs have been found to improve the knowledge and attitudes of staff and students (Schmidt et al., 2015, Wyman et al., 2010) but have not necessarily resulted in improved help-seeking or changes in suicide-related behaviours (Aseltine et al., 2007, Schilling et al., 2014, Freedenthal, 2010).

What people told us

Young people and stakeholders consulted for this report identified that suicide prevention in education needs:

A consistent approach, with coordination and communication between mental health and education portfolios: This is required across all levels of government to build an accurate picture of current activities and gaps.

Parents and the broader school community (including surrounding youth mental health services) to monitor and support students at risk: Many young people also said there was a need to connect these mental health awareness activities closely to the mental health services in the immediate school community.

“ (there) definitely needs to be a whole school holistic approach in which young people, teachers, parents and friends are all educated and supported.”

Young person

More gatekeeper training: Those consulted in the development of this report called for more gatekeeper training for teachers, parents and students themselves, although it was widely agreed that only evidence-based approaches should be delivered and that they should be carefully monitored.

Spotlight – Postvention in education settings

Postvention services or activities are designed to reduce the distress and trauma experienced by a school community following the death of a student, and to reduce the risk of subsequent deaths. Given that youth suicides more commonly occur in clusters than adult suicides, and that schools are a common setting in which clusters can occur, postvention activities in school settings are important to reduce the risk of subsequent deaths.

Currently the Australian Government funds [headspace School Support](#) to provide this service across Australian secondary schools. The need for postvention programs is also identified as important in over half of the state/territory suicide prevention policies. However there are currently gaps in what's funded including: a lack of services in tertiary education settings or primary schools; a lack of support provided following a suicide attempt; and limited evaluation. Given the Australian Government has released funding for future postvention activities, it is important that these gaps are addressed.

Unfortunately at present, evidence for school-based postvention studies is limited (creating some contention in the sector about their inclusion in suicide prevention strategies). As such, further research is urgently required. The studies that are available were limited in terms of study design (a common limitation for postvention research) and differed in terms of sample size, type of intervention tested and outcomes assessed, thereby making it difficult to draw conclusions regarding the overall impact. For this reason, several sets of best practice guidelines have been published to guide postvention responses, both in Australia and overseas. Most of these are designed to be used in schools, such as those published by [headspace School Support](#) in Australia following an expert consensus study (Cox et al., 2015).

Direct conversations with students about suicide and/or suicide-related behaviours: Young people in particular asked for schools and education systems to stop 'being afraid' to talk about these issues directly with them.

“ We can't pretend there's an established age where people experience or are affected by these issues, and they need to be discussed and the conversation normalised earlier.

Stakeholder

Tertiary education settings: The absence of government funded suicide prevention activities and programs in tertiary education institutions was identified by many stakeholders and in the peer-reviewed literature (Burns et al., 2014). Young people felt particularly strongly that there was a need to increase suicide prevention activities in these settings and not expect students to 'grow up and just deal with it' as soon as they leave school. In contrast, in the United States there have been concerted efforts within colleges to reduce rates of student suicide, including through organisations such as the [Jed Foundation](#).

IMPLICATIONS

Education programs

Young people have identified the need for a more direct approach to talking about suicide, and they are calling for programs that provide them with the skills and resources to respond if they know someone who might be struggling or at risk.

Talking to young people about suicide appears to be safe, if done with care. Suicide prevention programs where young people are trained to act as peer support workers also appear to have good outcomes.

Gatekeeper training is effective in schools in terms of building knowledge and confidence among those trained.

Given that suicides among young people are more likely to occur as part of a suicide cluster than adult suicides it is important that postvention programs for young people continue to be delivered in both schools and communities. What is needed is robust evaluation and research in order to build the evidence base.

More needs to be done in tertiary education settings, which are currently ignored in state and federal mental health and suicide prevention program funding and delivery.

Community-based responses

'Mental health and suicide prevention activities need to be highly localised in their delivery as well as fundamentally coordinated at the regional level' (Hickie, 2015, p516). This sentiment was at the centre of the recommendations made in the National Mental Health Commission Review of Programmes and Services and was echoed by key stakeholders in consultation for this report. It places a strong focus on delivering evidence-based community-based suicide prevention responses tailored to the local community's need.

“ Whilst a national commitment is important, the capacity to tailor responses and strategies to the needs of local communities is essential.

Stakeholder

What the evidence says

Studies have shown that multimodal programs, where a range of community-based activities (including awareness raising, screening, gatekeeper training, improved community partnerships and provision of crisis hotlines) were delivered as part of a single program, there were significantly lower rates of suicide attempts and suicide deaths among young people (Walrath et al., 2015, Garraza et al., 2015, CDC, 1998, Hacker et al., 2008, May et al., 2005). These programs have also been found to increase adults' perceived competence and confidence in responding to at-risk young people, and the likelihood of young people seeking help from an adult and helping a peer (Baber and Bean, 2009, Bean and Baber, 2011).

On their own, individual elements of community-based suicide prevention have generally strong evidence for their effectiveness with young people, as presented in Table 9.

TABLE 9 – EVIDENCE FOR COMMUNITY SUICIDE PREVENTION ACTIVITIES WITH YOUNG PEOPLE

Element	Evidence
GP skills training	Improving GP skills in screening and referral of young people at risk was found to increase the numbers of young people who access help before they consider or engage in suicide-related thoughts or behaviours (Jones and Cipriani, 2016, Krysinska et al., 2016, Pfaff et al., 2001). Training primary care providers to understand youth suicide risk and feel comfortable making outpatient referrals has also been associated with a reduction in referrals to the emergency department (Wintersteen and Diamond, 2013).
Gatekeeper training	Gatekeeper training in an Aboriginal community in NSW was associated with decreased intentions to refer to mental health services; attributed to increased confidence in participants' ability to respond to and manage suicide risk (Capp et al., 2001). Longer training and training that involved young people was also associated with identifying more at risk young people (Condron et al., 2015).
Awareness raising	A youth focused media campaign advertising a suicide prevention hotline resulted in a sustained increase in calls to the hotline over time, although the actual age of callers was unknown (Jenner et al., 2010). Television advertisements appear to be more acceptable to young people compared to billboards (Klimes-Dougan and Lee, 2010, Klimes-Dougan et al., 2009).
Means restriction	Three studies that examined the impact of policies limiting access to firearms in three different countries reported conflicting results. The first was set in Australia and found that the policy had no impact on youth suicide rates (McPhedran and Baker, 2012), the second, set in Austria, found that the change in policy resulted in a decrease in suicide rates (Niederkröthenthaler et al., 2009), and the third was set in Israel and found that the change in policy was associated with an increase in suicide rates (Lubin et al., 2010).
Postvention	While not specific to young people, an evaluation of an all-ages postvention service 'Standby' found it was an effective (including cost-effective) way to support people bereaved by suicide (United Synergies, 2011).

Spotlight – the systems approach and young people

Internationally there is strong support for an evidence-based systems model of suicide prevention to be delivered across multilevel systems including governments, health, education, research, community organisations and business. Both the National Mental Health Commission Review (2014) and the World Health Organization in *Preventing Suicide: A Global Imperative* (World Health Organization, 2014), identified evidence that a systems response is most likely to significantly impact on suicide rates.

In the 2016 election, the returned Australian Government committed to funding 12 trial sites of community-based suicide prevention, applying evidence-based models in an integrated, regionally-based approach (The Liberal and National Parties of Australia, 2016). States and territories (such as Victoria) are also committing to regional systems pilots (Victorian Government, 2016).

One model in Australia has been developed by the CRESP and Black Dog Institute (2015) and is currently being trialled in a number of locations. The model consists of nine elements implemented simultaneously across a region or community and includes targeted approaches to high-risk groups (CRESP and Black Dog Institute, 2015).

It is important to ensure that a systems approach includes evidence-based activities that are appropriate, accessible and acceptable to young people. It will also be important that this model is properly evaluated for its impact on youth suicide specifically.

To provide an example, an analysis of the nine elements of the Black Dog model is presented below.

Key: Green = meets these requirements; yellow = partially; red = gaps exist.

Appropriate and continuing care once people leave Emergency Departments (ED)		Urgently required and as important for young people as the general population.
High quality treatment (CBT and DBT) including online		Providing opportunities for young people to access this treatment online is important.
School-based peer support and mental health literacy programs		Strongly supported, as long as evidence-based and delivered to students as well as staff.
Training of frontline staff.		Need for compassionate responses often described by young people, and is particularly important in emergency departments and hospitals after self-harm or a suicide attempt (Robinson et.al., 2016d).
Gatekeeper training in workplaces and community organisations		Must include key gatekeepers for young people e.g. parents, peers and assess student-related outcomes such as help-seeking.
Community suicide prevention awareness programs		Must be delivered through mediums acceptable to and accessed by young people (e.g. social networking sites).
Reducing access to lethal means		Many of these deaths are by hanging which is hard to restrict in community settings; however restricting access to other commonly means of suicide - e.g. railway lines, jumping sites is still needed.
Training of GPs		Activities that address barriers to primary care for young people are also required as well as education for GPs in what depression and suicide risk looks like in young people specifically..
Responsible suicide reporting by media		Young people don't use traditional media, need to consider skilling young people as content creators and consumers online Guidelines for responsible communication are needed for social media platforms and bloggers..

Missing from the model for young people

- Postvention
- Provision of specialist mental health services
- Strong emphasis on the role of technology
- Co-design with young people

What people told us

In our consultation, a number of important elements of a community-based youth suicide prevention response were identified. They were:

Integrating technology into the activities is important both as a youth friendly access point to suicide prevention activities and as an enabler of primary care coordination and 24/7 support.

Including young people and stakeholders in the design, development, implementation and evaluation of all community-based suicide prevention activities from the outset. This should include the steerage and governance arrangements for implementing the model as a whole.

Need for postvention to be included in a regional community-based suicide prevention response.

There was also some feedback regarding the acceptability of some evidence-based community suicide prevention activities to young people. These included:

To be an effective intervention for young people gatekeeper training needs to be targeted to those professionals and individuals from whom young people are most likely to seek help. These include parents, peers, sporting clubs, youth, art and music services and communities, school and tertiary education staff and even online moderators and social media administrators.

“ Support, education and targeted prevention strategies should be aimed at families who are the front line in supporting a young person.

Young person

Many young people don't seek help from GPs.

A report by the Australian Institute of Health and Welfare found that young people are less likely to seek help from a GP for their mental health than any other age group (Australian Institute of Health and Welfare, 2013). Similarly the beyondblue depression monitor suggests that more young people aged 18-24 years sought information about depression from the internet than from a GP (beyondblue, 2014). Addressing the barriers that prevent young people seeking help from GPs should complement GP skills training.

Understanding of the relationship between suicide and social media is an area that requires work (The Royal Australian and New Zealand College of Psychiatrists, 2015). For young people, as regular users and creators of social media, this work is required urgently. Community-based activities, which skill young people to manage and respond to potentially harmful content on these sites, could have a role to play in building this evidence base.

“ There will be a multitude of areas the PHN's will need to focus on and while all are important, youth mental health will be pushed to the wayside if nobody has it at the front of their minds. A youth partner would remind the PHNs of prevalent issues and impacts that they may have otherwise been unaware of.

Young person

IMPLICATIONS

Community-based suicide prevention

A systems approach to community-based suicide prevention has the potential to deliver significant outcomes young people and many elements of the model have been shown to be effective with this age group.

However, any regionally-based systems model should ensure all elements are appropriate, acceptable and effective with young people. For example:

- Address barriers for young people to seek help from a GP (including awareness, confidentiality concerns, costs) and/or provide them with an alternative screening and referral options (for example online or through schools).
- Gatekeeper training should be delivered to people and in settings where young people are in regular contact and are points of early help-seeking e.g. parents and peers.
- Postvention activities should be included and evaluated.
- The model and associated activities should be co-designed with young people.
- Consideration to the role of technology in delivering community-based suicide prevention activities to young people (and in providing 24/7 support to young people at risk).

Research priorities

There remain significant opportunities to increase the evidence base in youth suicide prevention. The Australian Government has recently committed additional funding for suicide prevention research and evaluation of the PHN trial sites, while in 2014, the NHMRC announced funding for four grants for targeted research for Suicide Prevention in Aboriginal and Torres Strait Islander Youth.

A number of leading research institutes in Australia, including the Hunter Institute, the Young and Well Cooperative Research Centre, CRESP and Black Dog, as well youth suicide researchers at Orygen have identified that more research is needed into:

- High-risk groups of young people. For example, research with Aboriginal and Torres Strait Islander young people, those with a history of self-harm, those with psychiatric disorders and those who have had contact with statutory services including the justice system and human services to identify what interventions are most effective.
- The effectiveness of Aboriginal and Torres Strait Islander specific programs, the extent crisis lines and online counselling services are used and whether screening and gatekeeper programs can be culturally adapted. A systematic review of evaluated suicide prevention programs targeting Aboriginal and Torres Strait Islander young people in Australia, Canada, New Zealand and the United States found that more controlled study designs using valid outcome measures were needed (Clifford et al., 2013).
- The role of social media in both the development, and prevention, of contagion and suicide clusters among young people.
- Effective online/mobile interventions in suicide prevention including novel interventions that make use of social media.
- Large scale testing of the effects of interventions that show promise. This includes CBT with at risk young people and extending the impact of gatekeeper training beyond the effect of increased knowledge and feelings of capability among those trained.
- Cost effectiveness of suicide prevention interventions and economic modelling of the costs of suicide and related behaviour.
- The impact on suicide-related outcomes of interventions targeting other mental health concerns (e.g. anxiety, depression, BPD).

Suicide prevention researchers consulted for this report also identified a range of structural and procedural barriers within research funding streams that add to the challenges of conducting youth suicide research. These include: addressing ethical considerations in regards to both the sensitivities and fears of iatrogenic effects; and in using non-traditional youth friendly methods (for example using social media channels rather than traditional survey tools).

There is also growing evidence to support the involvement of young people directly in suicide prevention research (Orygen Youth Health Research Centre, 2014). While, for some young people, discussing suicide can be distressing, they indicate they would still prefer to be involved and receive personal benefit from participating. It is important therefore to continue to build the evidence base regarding the ways in which young people engaging in suicide-related behaviours or with a history of a previous suicide attempt can be safely engaged in research. One way to do this is to engage young people in research and include outcome measures to test for both the benefits and potential iatrogenic effects of their participation. This evidence base could support both the appropriateness and efficacy of future research and address ethical committee concerns.

Section 5

A way forward

There has been a considerable amount achieved in suicide prevention at a national and state/territory level, including among young people. While rates of suicide have not dropped to reflect this (and are, among some groups and locations, increasing) that does not mean previous work shouldn't be maintained or adjusted to respond to the changing needs and experiences of young people.

There are opportunities to build on the work already delivered and develop new and innovative approaches to youth suicide prevention, particularly engaging young people themselves as agents of change.

National leadership and coordination

Starting with the opportunity provided through a reinvigorated National Suicide Prevention Strategy there are a number of activities recommended which would ensure that the needs and experiences of young people are responded to effectively.

1. The Australian Government should lead the development of a separate Youth Suicide Prevention Plan that sits under the new National Suicide Prevention Strategy. This should address the unique needs of young people, with particular consideration given to:
 - Specific groups of young people who may be at elevated risk (including young people with serious and complex experiences of mental ill-health; Aboriginal and Torres Strait Islander young people and LGBTIQ young people);
 - The help-seeking patterns and preferences of young people;
 - The role of families and peers; and
 - The settings for youth engagement and service delivery.
2. The Australian Government should develop and embed youth advisory mechanisms to support the Youth Suicide Prevention Plan and the PHNs role in its commissioning of suicide prevention activities. It should:
 - Commission sector leaders with experience in youth engagement, youth mental health and suicide prevention to produce a framework for young people's engagement in suicide prevention to support the planning and implementation of national and regional suicide prevention.
 - Actively establish connections with networks of young people to help inform the implementation of suicide prevention responses at a national and regional level.
3. The Australian Government, along with the states and territories, should facilitate and lead integration of suicide prevention policies with other sectors. This would include:
 - Establishing interdepartmental and cross-portfolio mechanisms that support the Youth Suicide Prevention Plan at both a national and state/territory level.
 - Identifying activities and actions in the implementation plan for other departments across all levels of government.
 - Developing stakeholder engagement frameworks that support PHNs and state/territory Local Health or Hospital Networks (LHNs) to establish suicide prevention networks and/or link into networks where they exist. Networks should include youth

mental health organisations, schools and tertiary education providers, primary care, police, community services, Aboriginal and Torres Strait Islander organisations, parents and young people.

4. The Australian Government should commission a consortia of suicide prevention and youth mental health leaders to develop:
 - A better practice register, which would provide access to evidence-based suicide prevention interventions, including those that are acceptable, accessible and effective for young people.
 - An evaluation framework/toolkit for PHNs and the sector (linked to the better practice register). The framework should be developed in partnership with young people to a) ensure youth-related outcomes are collected and b) determine the program's acceptability and appropriateness.

Build a system of youth mental health care that responds early and effectively to suicide risk and behaviours among young people

As part of the Australian Government's commitment to build an integrated and equitable youth mental health system, and the implementation of future COAG action on mental health through the Fifth National Mental Health Plan, it is important that a model of youth mental health care is available to every young person in Australia which responds to suicide risk among this age group. This could be achieved by:

5. Providing full national coverage of headspace, 196 centres as described in the 2016 headspace evaluation report.
6. Resourcing specialist youth mental health services within enhanced regional primary care systems. These should integrate with local headspace centres to better support those young people who present with more severe and complex mental ill-health in order to provide seamless pathways of care.
7. Trialing an approach in 10 headspace centres for high quality, responses specifically for young people who self-harm or have attempted suicide (including outreach to high risk groups). This should include the development of youth appropriate and accessible post-discharge and step-down care responses following hospitalisation or an emergency department presentation.

Regional responses that meet the needs of young people

Since 1 July 2016, the PHNs have been responsible for commissioning community-based suicide prevention services, which includes effective post-discharge care and a refocusing of suicide prevention efforts for Aboriginal and Torres Strait Islanders. 12 of the 31 PHNs will also be involved in trials which will test and evaluate evidence-based suicide prevention models and strategies. Within this new role for the PHNs, this paper recommends:

8. Opportunities for co-commissioning of services by PHNs and LHNs should be explored (particularly to provide assertive regionally tailored follow-up care for young people post-discharge from hospital).
9. PHNs and leaders in community-based suicide prevention responses should work closely together (and with young people) to ensure that regionally-based systems responses are developed and evaluated to ensure they meet the needs of young people.
10. Adequate proportion of the PHNs community-based suicide prevention funding should be allocated to youth-specific activities such as:
 - extensive gatekeeper training for youth-related workforces (as well as GPs);
 - approaches to supporting and evaluating online suicide prevention activities (including guidance for safe discussions online/social media); and
 - community-based postvention activities.

A stronger role for technology

Governments and service commissioners should prioritise a commitment to using technology in a more proactive way. This should be done through identifying technology-specific actions within suicide prevention strategies, and suicide prevention activities within digital service platforms such as the digital gateway and project Synergy currently under development.

11. Governments should continue to support and resource critical national crisis services infrastructure such as Lifeline, Kids Helpline and beyondblue and invest in eheadspace to bring it to a scale that will more effectively meet demand.
12. Online platforms should add value to young people in their engagement with support and

services and not be an additional barrier to accessing support. This could be provided through:

- Age appropriate youth interface and functionality.
- Connectivity to the suicide prevention responses of the PHNs and facilitating access to face-to-face support in their area.
- Addressing existing gaps in online mental health services (including cultural and language barriers).
- Co-designing with young people.
- Providing access to clinically 'accredited' and recognised apps to create a bridge between online and offline service provision.

Educational responses that meet the needs of young people

Historically, education about suicide or suicide-related behaviours has not been a feature of MindMatters or KidsMatter due to concerns about the efficacy and safety of suicide-specific school programs. However, there is now emerging evidence to suggest suicide prevention can be safely delivered in schools. As such, the following is recommended.

13. All government funded mental health education programs (including the new Australian Government's 'end-to-end school-based mental health programme') should include the delivery of evidence-based suicide prevention activities. A register of these activities should then be developed and administrated across both Australian and state/territory governments to build a picture of current activities and gaps.
14. Schools, TAFEs and universities are an important settings for postvention activities and as such the Australian Government should continue to fund postvention program(s) for young people. This should be tied to a robust evaluation of the program(s) to build the evidence base.
15. The Australian Government (given its responsibilities for higher education) should extend education-based mental health and suicide prevention programs into tertiary education settings.

Responding to research gaps

16. The research funding allocated by the Australian Government to suicide prevention, as well as NHMRC/ARC and state/territory government research strategies should prioritise the funding and evaluation of current gaps in research on youth suicide prevention. This would include, but isn't limited to:
 - Innovative online suicide prevention interventions, including those targeting young people.
 - Cost effectiveness of suicide prevention interventions.
 - Suicide-related outcomes in interventions targeting other mental health concerns (e.g. anxiety, depression, BPD).
17. Address barriers to timely, large-scale research and cost-effective youth suicide prevention research. This includes:
 - Addressing ethical considerations in regards to both the sensitivities and fears of iatrogenic effects.
 - Using non-traditional youth friendly methods (for example using social media channels rather than traditional survey tools) and other automated research techniques.

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