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Lifeline Australia

Submission to the Inquiry into Youth Suicide Prevention
House Standing Committee on Health and Ageing

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1. Introduction

Lifeline welcomes the opportunity to provide input to the Standing Committee on Health and Ageing's *Inquiry into Youth Suicide Prevention.*

Lifeline has recently made a submission to the *Senate Inquiry into Suicide in Australia*[1] as well as Queensland's Commission for Youth and Young People and Child Guardian *Reducing Youth Suicide* Discussion Paper[2] and gathered input from Lifeline Centres as well as stories from the general public relating to the impact of suicide in their life. Many of the stories coming from Lifeline Centres as well as stories submitted via our website relate to youth suicide attempts and completed suicide.

Lifeline is the largest suicide prevention not-for-profit service provider in Australia. Suicide prevention requires a holistic approach which incorporates emotional, psychological, physical, spiritual and practical components to build the resiliency of the whole population.

Early identification of suicidal cues, and responding to those at risk of suicide to provide ongoing support should be a primary focus in youth suicide prevention.

Lifeline highlights important considerations in the development of initiatives for youth suicide prevention as;

- Improvement in effectiveness and accessibility of crisis support services catering to Australian youth.
- Provision of suicide awareness and prevention training to parents, teachers, sport coaches, and health and community workers; highlighting how to identify suicidal cues and approach youth in ways that increase their immediate safety and link them to further help.
- Provision of youth friendly services, resources and information and training for services providers in youth friendly strategies and approaches.
- Provision of age appropriate suicide awareness and prevention training to youth, to recognise the signs of suicidality, promote help-seeking, and strengthen peer support capacity and safety of youth, including peer support programs.
- Provision of alcohol and drug education for youth, and its link to suicide.
- Identifying and addressing broad social factors that may contribute to suicide risk for Australian youth, including child abuse, alcohol and drug abuse, mental health and wellbeing, family breakdown, homelessness, behaviour and disciplinary problems, and adjustment issues etc.
- Nurturing a suicidal child or adolescent's protective factors such as a cohesive family environment, peer support network, problem solving and help-seeking behaviours for mental health and wellbeing.
- Universal screening for early onset of mental health issues

[1] Lifeline's submission to the *Senate Inquiry into Suicide in Australia* www.aph.gov.au/Senate/committee/clac_ctte/suicide/submissions/sub129.pdf
[2] Discussion Paper - Reducing Youth Suicide in Queensland. www.ccypcg.qld.gov.au/pdf/monitoring/RYSQ-Discussion-Paper.pdf

- Destigmatising of accessing of health and mental health support
- Reduction in access to means of suicide, including modifying ‘hotspots’ to make them suicide safer.
- Best practice postvention strategies for whole of school community in place when a suicide or suicide attempt occurs within a school community
- Specific targeted support and services for those impacted by suicidal behaviour (attempt and completed)
- Increase in information, resources and awareness for the issue of deliberate self injury for the whole community
- Supporting good practice in media reporting around suicide.

1.1 Lifeline’s Experience with Youth Suicide

Many of our Lifeline Centres have had experience in dealing with youth suicide. Centres are located in areas where multiple youth suicides have occurred in local schools. These circumstances have resulted in Centres increasing their involvement with students at these schools, as well as parents and teachers around how to talk to youth about suicide.

Lifeline’s recent experience with young people who are exhibiting suicidal ideation (particularly in circumstances where another peer has died by suicide at their school), that has proven successful is working with them to develop a safety plan, and checking in on them on daily basis until the immediate risk of suicide has abated.

Given the growing evidence that youth prefer to SMS rather than make a phone call, Lifeline has trialled the use of SMS messaging and found it to be very successful in checking on young people at risk of suicide. Lifeline is also developing online services, which we anticipate will be utilised by youth in particular. Lifeline acknowledges that services that are located in buildings with offices do not always reach those that are most at risk of suicide and need immediate help. This is particularly the case with youth, who have grown up in a generation where technology has become the primary means for communication.

Lifeline’s experience has shown that those programs and services that go to where the people are have the best chance of being able to intervene when needed, and to connect that person at risk to further care. People in need will not always (or ever) walk into a doctor’s office, or mental health professional’s clinic. It is Lifeline’s hope that in addition to our confidential telephone crisis support service 13 11 14, online services will also provide another mode of support to those who are more comfortable with writing their feelings down, rather than talking over the phone or face to face. It is anticipated that this option will be attractive for youth requiring some support, and in a sense is ‘going to where they are’ by being so freely accessible.

Some Lifeline Centres have also developed resource kits which are distributed on a regular basis to schools. These resource kits are often suicide prevention specific in the information they provide to recipients, with age appropriate material being produced.

1.1.1 Postvention Support

Debriefing and support services are offered by some Lifeline Centres to family, friends, bystanders, witnesses and the wider community who need information, support & referral following involvement, or being witness to, traumatic events such as a suicide.

An example of such debriefing aimed at youth has been when a local Lifeline Centre attended a sporting club to provide a postvention service, following the suicide of one of their team members. Lifeline Centre staff engaged with twenty two players and other club members who were impacted. During this intervention two further people were identified as thinking about suicide themselves as a result of the initial suicide. These young people were provided with safe space to talk, information about support services and referrals.

These types of postvention support services work well because the youth involved are supported in a familiar environment and in a safe space with their peers. They also appear to share a bond following such postvention services, and are able to support each other following the postvention support session because they are all familiar with what may have occurred within the session.

2. Collaborative Responses- Access to Age Appropriate Support and Care

It is Lifeline's experience that a number of steps need to be taken to improve effectiveness and accessibility of crisis support services to youth who have attempted suicide, and friends and family who are bereaved by the suicide of a young person.

An improvement in emergency department procedures and referral of those who have attempted suicide is required. More consistent and comprehensive follow-up support for those who have attempted suicide and are sent home is required. For youth, this is particularly the case for their parents or carers as well. Lifeline has seen examples where a lack of coordinated care between services such as drug and alcohol, mental health, and hospitals can mean that youth at risk of suicide do not receive appropriate and holistic care and intervention.

Such a lack of cohesion in the health sector can mean that youth requiring help 'fall through the gaps' and the onus of responsibility and care is left to friends, family, or carers. Carers have reported feeling a sense of hopelessness and lack of support. They often feel frustrated by the inability to access age appropriate services for their child, as well as appropriate support for themselves.

In a hospital setting, often there is no non-medical way of supporting youth through a suicidal crises and no capacity to follow-up. There needs to be provision for acute non-medical intervention and follow-up support for suicidal youth. Youth suicidality is a complex issue and is not necessarily attributed to mental illness or a medical condition that is treatable through medical intervention alone.

2.1 Mental Health Care

Expansion of youth mental health services is also essential in order to provide age appropriate suicide interventions and follow-up support. An improvement in the co-ordination between services would allow for more comprehensive care and support for youth. The best approach to youth suicide prevention activities is a co-ordinated and

inclusive response which includes parents, carers, teachers and school counsellors, working closely with local community services available.

In relation to mental health facilities, Lifeline has heard reports of suicides occurring after young people have left a mental health care facility. It was thought by the loved ones of these people that if they had received appropriate and timely follow-up care, the suicides could have been prevented.

Specific examples which have been the experience of one Lifeline Centre have occurred when more than one parent has contacted the Centre looking for help, because they were worried about the safety of their son or daughter, or because a suicide attempt had been made, and there was no follow-up after an initial intervention by a mental health care facility.

One parent reported that his son died by suicide after many previous attempts. They did not know how to intervene, and did not know who to ask for help after he was released from the mental health hospital. Their son was suffering from a mental illness and was difficult to manage. The impact on this family has left them with feelings of loss, guilt, and shame for not being able to find the right kind of help to prevent the suicide.

Regular screening for early onset mental health issues should become common place in educational settings. Such screenings could identify young people potentially at risk in the early stages and provide them with the necessary care and support to ameliorate the impact to their health and well being and equip them with skills to deal with life's stressors.

2.2 Deliberate self injury

Deliberate self injury is a behaviour exhibited by many young people, more particularly young women. It is a complex behaviour and not well understood by health professional or the general community. Deliberate self injury can be very distressing for the young person and for their friends and family and it needs to be better understood in its own right and because of its association with suicidal behaviour. In a recent study by Professor Graham Martin et al 33% of people who self injure admitted to also having attempted suicide, and 54% experienced suicidal ideation[3]. Community resources such as *From Harm to Calm*[4] and training of 'front-line' workers, needs to be more widely available so that young people exhibiting deliberate self injury can be supported to find other ways to address their emotional distress.

3. Community Awareness and Education

Lifeline's experience in service provision has clearly demonstrated that suicidal people will reach out for help, if it is available. This is reflected in youth-specific suicide research, with the finding that 60% of children and young people who died by suicide had previously stated or implied their intent[5].

[3] Final Report - Australian National Epidemiological Study of Self Injury (ANESSI). www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/ANESSI%20Final%20Report.pdf
[4] From Harm to Calm: promoting help-seeking in young people who self-harm www.livingisforeveryone.com.au/From-harm-to-calm-promoting-help-seeking-in-young-people-who-self-harm.html
[5] Discussion Paper - Reducing Youth Suicide in Queensland. www.ccypcg.qld.gov.au/pdf/monitoring/RYSQ-Discussion-Paper.pdf

This raises the important issue of community awareness and education being required about suicide; what the signs are, and what to do if a child or adolescent is exhibiting suicidal cues.

Research has found that 50% of children and young people who displayed suicidal behaviours had contact with a health professional in relation to their suicidality or mental health issues[6]. This confirms Lifeline's belief that more suicide awareness and prevention training is required for 'front-line' workers. Too often, suicide cues are not being picked up on by health professionals, and sometimes, even if they are, are not being dealt with appropriately.

Competence in role appropriate suicide intervention knowledge and skills is a foundational requirement for front-line health and community workers providing services to persons at risk of suicide. Some effective training initiatives have been implemented in Australia over the past decade. However, systematic suicide intervention training to agreed standards across sectors, among emergency services personnel, and within professions has yet to be realised. Given the large proportion of the young people associated with educational settings and/or organised sports, opportunities to train front-line workers in these areas which deal primarily with youth is yet to be fully realised.

The importance of peer support in suicide prevention needs to be emphasised. Young people are often more open with their peers than their parents, carers, teachers or health professionals. Equipping young people with the knowledge and skills required to offer support to a friend if they express that they are thinking about suicide is vital to achieving a suicide safer community for our youth. As part of this education, alternatives to peer collusion around suicidality when suicide pacts are made also needs to be addressed. Research has found that suicide clusters are much more likely to occur among young people[7].

As a nation, we have a duty of care to make it easier for future generations to discuss and address suicide, providing them with the tools to recognise, acknowledge, and prevent suicide. Lifeline believes that if suicide awareness courses were provided as part of the school curriculum in an age-appropriate, safe way, that the youth of Australia would be better equipped to understand and read the signs of suicidality; both for themselves and their peers.

3.1 Using awareness campaigns to reach Australian youth

From Lifeline's experience, peers and role models (such as sports identities) speaking out about the need to seek help if feeling suicidal can be very powerful.

Lifeline has developed and implemented the *Help a Mate* suicide awareness and prevention campaign in 2007/2008 in partnership with the National Rugby League and Triple Eight Racing. This campaign used themes, imagery and Ambassadors from popular sporting codes to appeal to a predominantly male audience, and to promote subtle messages about suicide awareness and help seeking.

The campaign slogans of *"Help a mate stay in the game" (rugby league)* and *"Help a*

[6] Discussion Paper- Reducing Youth Suicide in Queensland. www.ccypcg.qld.gov.au/pdf/monitoring/RYSQ-Discussion-Paper.pdf

[7] Gould, M.S. Wallenstein, S., Kleinman, M.H., O'Carroll, P., & Mercy, J. (1990). Suicide clusters: An examination of age-specific effects. *American Journal of Public Health.* 80(2), 211-212.

mate stay in the race" (V8 motor racing), allowed Lifeline to lead into important key messages about a serious issue, in a way that was more socially and personally acceptable to the audience.

The campaign allowed Lifeline to somewhat normalise the practice of safely talking about suicide and mental health with friends, family, a GP, or support services such as Lifeline's 24 hour telephone crisis line.

Lifeline's Help a Mate has received a great deal of positive feedback and has won multiple state and national not-for-profit marketing awards.

4. Accuracy and Care in Suicide Reporting

There is a need for under-reporting of child suicide in Australia to be addressed and rectified. Accurate statistics on suicide are crucial to national, state and regional suicide prevention strategies and to the development of service priorities.

It is also vital that this data be available in a timely and accessible fashion. As a service provider, Lifeline understands the importance of data to inform service operations, service development and to identify service gaps and take responsive action. Better access to accurate information on suicide and suicidal behaviour could enable more effective local responses to communities and regions in Australia – notably in cases where several deaths by suicide occur in a short space of time, such as cluster suicides within schools. The early identification of 'clusters' of suicide in localities or particular social/demographic groups will support more effective suicide prevention responses.

Research has demonstrated that young people are particularly vulnerable to media reporting of suicide which glamorises or romanticises the suicide. Adherence to the Media Mindframe guidelines[8] and training of journalists (*ResponseAbility* training[9]) can ensure that care is taken when reporting on suicide to reduce the risk to vulnerable young people.

5. Cultural Connections- Indigenous Communities

Lifeline Centres have found that when young Indigenous people die by suicide, copycat suicides can follow. Indigenous communities are focused inward and it is very difficult to gain an entry point for workers outside if the community. There is an acknowledgement by Lifeline that more Indigenous community workers need to be trained in suicide awareness and prevention, so that they can be the ones to disseminate this information to Indigenous youth. Utilisation of existing and trusted community workers in Indigenous communities is vital for any suicide prevention work to occur, and for Indigenous youth to be approached and supported.

[8] Mindframe guidelines for Reporting on Suicide & Mental Illness. www.mindframe-media.info/client_images/826718.pdf
[9] ResponseAbility for Journalism Education. www.responseability.org/site/index.cfm?display=134559

A main point to be made in the development of suicide awareness programs aimed at Indigenous youth is that each Indigenous community is unique, and their needs will differ significantly in terms of the context of support that they may require. Each community and their existing health/community service organisations should be consulted regarding what they may require, and what would help them, to determine the most beneficial combination of programs for the community's youth (taking into account any existing services being run and how these may be supported by youth-oriented programs).

6. Psychosocial Factors

Lifeline would encourage psychosocial factors to be addressed in all efforts to reduce youth suicide. A number of factors may contribute to the despair of youth, which can affect their vulnerability to suicide. For example, the unemployment associated with the economic downturn has impacted on young men in particular. Also, regions such as Darwin have a disproportionate number of young men and Indigenous Australians, both factors contributing to elevated suicide rates.

7. Acting without Thinking

Suicide among young people can sometimes be an impulsive act which is not always thought through or planned. Impulsivity can be a symptom of a number of mental illnesses, such as borderline personality disorder, conduct disorder, and attention deficit hyperactivity disorder, and has been linked to suicidal behaviour. Impulsivity, risk taking and lack of consideration for consequences can also be a normal function of an adolescent brain. This point is aptly made by Professor Madelyn Gould in an interview discussing suicide clusters and media reporting:[10]

"Another characteristic typical of teenagers that puts them at increased risk of suicide is their tendency to act impulsively. This behavioral inclination is a function of a still-maturing brain. Neuroscientists have found that complex cognitive functions — such as inhibiting impulsive behaviors, planning ahead, and problem solving — occur in the prefrontal cortex, a brain area that continues to develop throughout adolescence and well into young adulthood.
So until an adolescent's brain is more fully mature, he or she will tend to behave impulsively, neglect future consequences, and perhaps view suicide as an immediate solution to problems, especially if a friend or acquaintance has taken that route".

Alcohol and substance abuse can also contribute to youth acting without fully thinking, and given that adolescence is usually a time of experimentation with mood altering alcohol and substances, the risk of suicide for youth is heightened. When dealing with often difficult and challenging problems in living their overriding goal is often to numb or end their pain. But this does not usually mean that they want to die to do that. There is a tendency for young people to act without thinking and sometimes without considering the potential seriousness or permanence of their behaviour. Sometimes such intermediate acts (like drinking too much) used to achieve numbness of pain can lead to lowered inhibition and therefore reduced resistance to steps like suicidal acts.

An important point though, is that most children and adolescents do give clues of their distress, and often their suicidality when present. In this context, it is true that children and adolescents often act without thinking when in distress, but they also provide clues regarding their distress so that there are opportunities for parents, family members, peers, sports coaches and teachers to recognise these cues and offer support.

The goal for someone noticing these clues would be to help create a safe environment. This may include talking with the young person and hearing their pain, finding mental health care, promoting help-seeking, organising peer-support, reducing their access to means of suicide (e.g. taking car keys), and ensuring safe use of alcohol. These steps can provide a safety net around the tendency sometimes to act without thinking.

[10] "Media should tread carefully in covering suicide" – National Public Radio (US), Nov 2009 www.npr.org/templates/story/story.php?storyId=120755264

8. Closing Statement

Lifeline believes that suicide is a whole of community issue. By starting from the ground up, suicide can be reduced in Australia. By this, we mean that when targeting youth to provide information and resources around suicide awareness and prevention, in effect, we are promoting suicide safer communities which will carry on into future generations, which will aid the prevention of youth suicide both in the future, and present. Meanwhile, if today's young people learn more about how to manage stressful events in their life and identify mental health issues, build coping skills and resilience, their risk and their friend's is more likely to be lower in future years.

Lifeline's vision is imagining communities where everyone can give and receive care. As a nation we have a duty of care to make it easier for youth, and in effect future generations as current knowledge is passed down, to discuss and address suicide in healthy conversation, providing them with the tools to recognise, acknowledge, and prevent suicide.

To reduce the number of children and young people taking their own lives, individuals, communities, professional services, government and non-government organisations must work together to provide a coordinated whole-of-community response to suicide prevention.

Lifeline would fully support a collaborative program where information and services could be shared between a number of agencies to help better identify, monitor and support children and young people at risk of suicide.