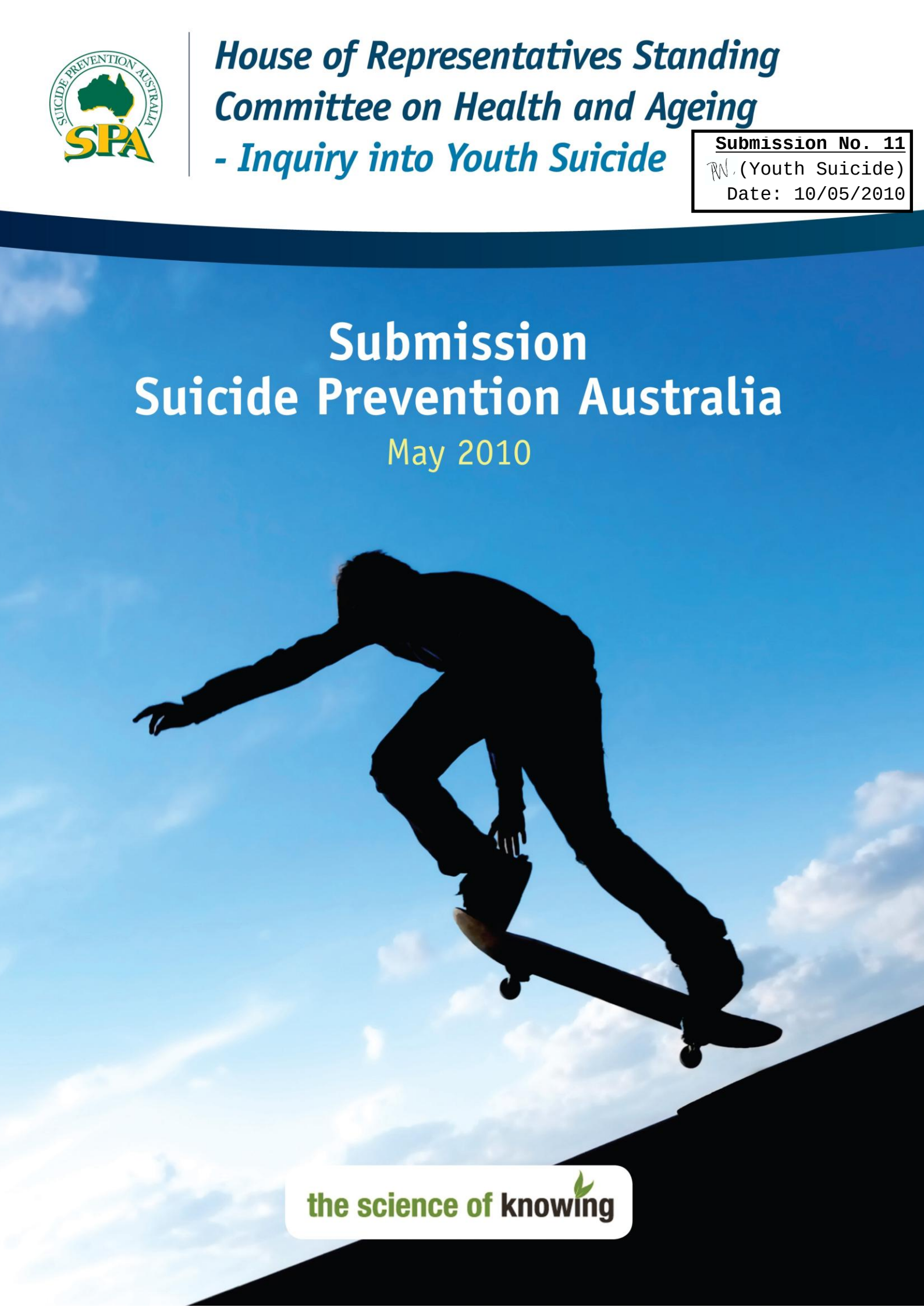
House of Representatives Standing Committee on Health and Ageing - Inquiry into Youth Suicide

Submission No. 11
(Youth Suicide)
Date: 10/05/2010

Submission
Suicide Prevention Australia

May 2010



the science of knowing

Submission to House of Representatives Standing Committee on Health and Ageing – Inquiry into Youth Suicide

Prepared by The Science of Knowing Pty Ltd for

Suicide Prevention Australia

May 2010

Preface

About Suicide Prevention Australia

Suicide Prevention Australia (SPA) is a non-profit, community organisation working as a public health advocate in suicide and self-harm prevention, intervention and postvention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting:

- Community awareness and advocacy;
- Collaboration and partnerships between communities, practitioners, research and industry;
- Information access and sharing; and
- Local, regional and national forums, conferences and events.

As a national organisation, SPA supports and assists both individuals and organisations throughout Australia, by promoting collaboration and partnerships in suicide prevention, intervention and postvention. SPA is supported by funding from the Australian Government under the *National Suicide Prevention Strategy*.

Acknowledgements

The development of Suicide Prevention Australia's (SPA) submission to the *House of Representatives Standing Committee on Health and Ageing, Inquiry into Youth Suicide* has benefited from the valuable input of a diversity of perspectives. SPA acknowledges the input of those members, trusted advisors and other stakeholders whose expertise and experience has informed and inspired this submission.

In particular, sincere gratitude is expressed to Victoria Visser, Director of The Science of Knowing, for her commitment to the researching, drafting and editing of this submission.

Finally, SPA acknowledges and appreciates the ongoing contributions of the SPA Board and SPA team members. In particular, the efforts of SPA Chairperson, Dr Michael Dudley, Chief Executive Officer, Ryan McGlaughlin, and Research and Policy Development Coordinator, Sara Maxwell, without whom this submission would not have been possible.

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In November 2009, SPA made a Submission to The Senate Inquiry into Suicide in Australia. This Submission was a comprehensive analysis of current issues of suicide prevention in Australia and outlined SPA's recommendations for change. These recommendations include:

- The transformation of attitudes towards suicide and suicidal behaviour via a national suicide prevention awareness campaign that promotes understanding among the community.
- A national whole-of-government and whole-of-community approach to suicide prevention underpinned by consistent and effective collaboration, coordination and communication between a range of agencies and services.
- Stronger recognition of the diversity of voices involved in the prevention of suicide and suicide attempts, as well as greater inclusion of those with lived experience in research, policy, prevention strategies and service provision.
- The charting of a long-term vision to promote the health and wellbeing of all Australians and the need to enhance community capacity and resilience in approaches to suicide prevention.
- Improvements in support and funding of Australian-based suicide and suicide prevention research and evaluations, particularly of interventions.
- Policies and services that more effectively respond to and meet the specific needs of high risk population groups and communities.
- The development of "a community that values people and the quality of life; a nation where no-one believes suicide or self-harm is the only option for them" (SPA Vision).

SPA would like to invite the House of Representatives committee to view the complete Submission available at: http://suicidepreventionaust.org/SenateInquiry.aspx.

The following document, by comparison, is a specific analysis of youth suicide prevention programs and their evidence base. SPA advises that both documents combine to form a solid and informative foundation for change and improvement.

Acronyms and Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and linguistically diverse
CCYPCG	Commission for Children and Young People and Child Guardian Queensland
DoHA	Department of Health and Ageing
LIFE	Living is for Everyone Framework
MHCA	Mental Health Council of Australia
NYSPS	National Youth Suicide Prevention Strategy
PSA	Peer Support Australia
SPA	Suicide Prevention Australia
SPT	Suicide Prevention Taskforce

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Introduction to Youth Suicide

Suicide and self-harm amongst young people

Incidence and prevalence of suicidal behaviours amongst young people

Suicide is a tragic, and yet largely preventable, cause of death that claims the lives of approximately 2,000 Australians each year. In particular, the suicides of children, teenagers and young adults results in an enormous loss of potential life years, immeasurable grief and loss for family and friends and a huge financial, emotional and social cost to society.

In Australia, official youth suicide rates reached a peak in 1997, with the rate per 100,000 recorded as 31.0 for males and 7.2 for females between the ages of 15 and 24 years (ABS, 2007). Since then, the rate of suicide amongst young people has decreased and in 2008, the recorded rate of suicide for young people aged between 15 and 24 years was 14.3 per 100,000 for males and 4.2 per 100,000 for females. Despite the decrease in youth suicide rates over the past decade and the relatively low rates per 100,000 for the younger age groups (the male suicide rate for 15-24 year olds is the lowest rate for any male age group), suicide accounts for a very large proportion of all deaths amongst young people. In fact, suicide is now one of the two main causes of death for young people between the ages of 15 and 24 years, alongside road traffic accidents. Suicide accounts for more than 1 in 4 of all deaths of males between the ages of 20 and 24 and approximately 1 in 5 of all deaths of females in the same age group.

Suicide attempts and self-harm (without suicidal intent) are more common amongst young people than older age groups and, unlike completed suicide (which is approximately four times more common in males than females), self-harm is much more common in young women. Current research suggests that between 7% and 14% of adolescents will engage in self-harm (Hawton & James, 2005). Self-harm and suicide attempts are often associated with mental health conditions, such as depression, anxiety disorders and borderline personality disorder and may range from severe attempts to take one's life to less severe and/or habitual behaviours, such as cutting, burning or picking at one's skin or deliberately injuring oneself (e.g. punching oneself, walls or other objects). Although self-harming behaviours may or may not involve suicidal intent, there is strong evidence suggesting that people who engage in self-harming behaviours or who have previously attempted suicide have a much higher risk of suicide in the future (Hawton, Harriss, & Zahl, 2006; Hawton & James, 2005; Zahl & Hawton, 2004).

The incidence of suicide and suicidal behaviours for young people in Australia are known to vary across different demographic groups. As previously mentioned, death by suicide is approximately four times more common in males than females (ABS, 2007). In addition, Indigenous youth are known to have a much higher risk of suicidal behaviour than their non-Indigenous peers (Hunter & Milroy, 2006; Pridmore & Fujiyama, 2009). This is compounded by rurality, social disadvantage and incarceration, all of which

disproportionately impact on Indigenous youth. Given the unique social and cultural variants of Indigenous youth suicide, prevention and intervention measures need to be targeting and culturally appropriate. Furthermore, all universal programs and mental health professionals in every field should be trained to respond to the unique needs of Indigenous youth (see SPA 2008b for more information). Other high-risk groups include young people living in rural and remote areas, gay, lesbian, bisexual, transgender or intersex young people and some ethnic groups (e.g. young people from refugee backgrounds) (De Leo et al., 2009 ; Eisenberg & Resnick, 2006; Page, Morrell, Taylor, Dudley, & Carter, 2007).

Data availability and accuracy

The accuracy of suicide-related data has been questioned in recent years, with many experts suggesting that the rate of suicide across all age groups may actually be between 11% and 16% higher than officially reported figures (De Leo et al.2010). For a number of reasons, under-reporting of suicide may be more frequent amongst younger age groups. Firstly, due to the relative rarity of suicide amongst children and the low number of cases (both nationally and within each State and Territory), suicide rates for children under the age of 15 years are not officially reported by the ABS. Secondly, there are numerous sensitivities surrounding determining suicidal intent for children. Some groups suggest that children do not fully comprehend death and its finality and are, thus, unable to consciously decide to take their own lives and understand the irreversibility of such behaviours (CCYPCG, 2009b). In addition, there is evidence that some cases of childhood or adolescent suicide are not accurately reported due to requests from family members, who fear serious stigma or discrimination should a finding of suicide be determined (De Leo et al., 2010). However, recent reports and discussion papers released by the CCYPCG in Queensland show that, although rare, these deaths do occur and account for a significant proportion of deaths for younger children (10 to 14 years) and adolescents (15 to 17 years) (CCYPCG, 2009a, 2009b).

Data regarding the incidence and prevalence of self-harming behaviours and suicide attempts amongst young people are limited. However, a recent report from the AIHW shows that despite declining rates of suicide deaths, the number of hospitalisations for self-harm have increased by more than 40% in the past decade, particularly amongst young women (Eldridge, 2008). Furthermore, almost one-third of hospitalisations due to self-harm during 2005-2006 were for young people (Eldridge, 2008). However, current hospitalisation figures are likely to significantly underestimate the number of actual incidents of self-harm and suicide attempts, as many young people never have their injuries medically treated. In addition, there are innumerable cases involving less severe forms of self-harm that do not result in life-threatening injuries, but which still indicate a significant level of distress within the individuals involved (Hawton & James, 2005).

Accurate and reliable data regarding suicide and suicidal behaviours are essential to ensure appropriate action can be taken to prevent future suicides and self-harm from occurring. As such, strategies that aim to improve the quality and availability of data and statistics are both welcome and necessary (De Leo et al., 2010; Studdert & Cordner, 2010).

Risk and protective factors for suicide specific to young people

Many of the risk and protective factors for suicide are well-known and affect all age groups. However, there are some risk and protective factors that affect young people specifically or more so than other age groups. How different issues and circumstances impact on individual young people is complex and can be influenced by genetic, environmental and social factors. In fact, there are several factors that have the potential to affect young people both positively and negatively, depending on the context of their exposure or experience. For example, the internet provides opportunities to connect positively with peers and support services, yet it also has the potential to cause harm through cyber-bullying, inaccurate information related to suicide or pro-suicide websites.

It is also accepted that the presence of more protective factors, regardless of the number of risk factors, lowers the level of risk (Resnick et al., 1997). However, it cannot be assumed that protective factors will always override the effect of risk factors, as resilience can be put under extreme pressure. Indeed, young people, even those with high levels of resilience, are still vulnerable to adverse life events and circumstances (DoHA, 2000).

Adolescence and young adulthood are a recognised time of self-exploration and the need for acceptance and belonging is paramount. Thus, many of the known risk and protective factors relate to young people's self-esteem and identity. Detailed descriptions of individual factors and warning signs of suicide that relate particularly to young people are readily available via a range of sources (e.g. LIFE website, Reach Out website). The following list outlines some of the factors that are known to influence the risk of suicide and suicidal behaviours in young people:

- Self-harm and previous suicide attempts;
- Family environment (e.g. violence/discord, foster care, divorce/separation);
- Relationship breakdown or conflict;
- Prior experience of sexual/physical assault;
- Onset of mental health problems (i.e. evidence that 75% of mental health conditions have initial onset during adolescence/early adulthood. These include mood disorders such as depression and bipolar disorders, behavioural problems, psychoses);
- Substance use and abuse and their relationship with mental illness and suicide (e.g. binge drinking, marijuana use, "party" drugs);
- Sexual orientation, sex and/or gender identity;
- Ethnicity/background;
- Socioeconomic status;
- Education, training and employment;
- Homelessness;
- Involvement with criminal justice system/juvenile detention;

- Social connectedness and support;
- New media (e.g. social networks, internet-dating, cyber-bullying, cyber-stalking, internet-based interventions);
- Learning difficulties/disabilities;
- Bullying, harassment, discrimination and vilification;
- Body image, including eating disorders (e.g. anorexia nervosa, bulimia nervosa);
- Potential and/or unwanted pregnancy;
- Youth cultures that promote risky behaviour (e.g. Emo, grunge, Gothic, etc.);
- Risk-taking behaviours (e.g. reckless driving, involvement in dangerous activities);
- Influence of media (e.g. television, radio, music, film, news, internet, computer games); and
- Pressure caused by religion and spirituality (although these can also be protective factors).

History of youth suicide prevention in Australia

Australia was one of the first countries to respond to the alarming incidence of youth suicide through the Federal Government's development of the National Youth Suicide Prevention Strategy (NYSPS) in 1995. Suicide Prevention Australia had been formed in 1990 in response to rising male suicide rates at that time (Kosky, 1987; Dudley et al, 1992), and was involved in youth suicide prevention, through national conferencing, education and training, communications and research (Dudley et al, 1997, 1998 a&b). Its advocacy was significant in promoting the establishment of NYSPS.

The Strategy aimed to develop and implement a national plan for youth in distress and was allocated a total of $31 million between 1995 and 1999. The Strategy's main objectives were to reduce the incidence and prevalence of suicidal ideation and behaviours (including self-harm), decrease the suicide rates for young Australians and increase protective factors (such as resilience and social connectedness) for young people.

A comprehensive review of youth suicide epidemiology, risk factors and interventions, and a comprehensive evaluation of the NYSPS were undertaken and completed in 2000 (NYSPS, 2000; Mitchell, 2000). The evaluation showed that many of the programs and activities that were funded through the Strategy had a positive impact on reducing risk factors for suicide, increasing protective factors and improving community awareness and capacity to respond to suicidal ideation and behaviours amongst young people. However, due to limited availability of data and the Strategy's relative infancy in its development, the evaluation was not able to report on the Strategy's effectiveness and efficiency in reducing overall youth suicide rates or increasing their health and wellbeing. Nonetheless, the evaluation identified numerous strengths and limitations of the NYSPS, including:

- the appropriateness of the multi-dimensional approach to suicide prevention (i.e. the provision of a range of types of activities, from population-level activities to individual case management);
- improved capacity of services to deliver effective programs and to undertake ongoing evaluation of their effectiveness;

- barriers to engagement of young people and their access to existing services and the need to focus on increasing help-seeking behaviours amongst young people;
- the need to focus on interventions that address protective factors, as well as risk factors;
- limited resources to provide evidence-based services; and
- the need for coordination and partnerships within the suicide prevention sector and the sharing of information, evidence of effectiveness and practical examples and guidelines (Mitchell, 2000).

In response to changes in the number of youth suicides in Australia and the demography of those who completed suicide, the NYSPS was expanded in 2000 to include suicide prevention strategies that extended across the lifespan (i.e. the Living is for Everyone Framework, 2000). In addition to young people, a number of other high risk groups were identified, including Indigenous Australians, men across all ages, people living in rural and remote communities and people from culturally and linguistically diverse or immigrant backgrounds (DoHA, 2000).

The LIFE Framework was then revised in 2007 and formally released in 2008 (DoHA, 2008). Based on available evidence of reduced suicide rates amongst young people in Australia in the decade since the very high incidence recorded in 1997, young people were not identified as a specific high risk group or a priority for action. Instead, strategies for suicide prevention aimed to address all age groups, including young people, acknowledging the particularly high rate of suicide for adults between the ages of 25 and 44 and older adults (especially men).

However, a number of recent issues and events sparked a renewed interest in suicide prevention activities specifically targeting young people. These include the growing recognition of mental illness as a major cause of disability and mortality in Australia, increasing evidence of the significant cost of suicide to society, the focus on increasing social connectedness and inclusion within society and the recent spotlight on potential and known inaccuracies in official suicide data. In addition, recent research suggests that the NYSPS was a significant contributor to the reduction in suicides amongst young Australian men since the very high rates recorded in 1997 (Morrell, Page, & Taylor, 2007). Furthermore, several high-profile organisations have developed mental health, anti-bullying, wellbeing and suicide prevention programs and activities designed especially for young people, which aim to address their often unique needs and preferences (e.g. Inspire Foundation, Headspace, Youth Focus, youthbeyondblue, National Centre Against Bullying). Ten years later, it is timely to undertake a review of the state of youth suicide risk, prevention and intervention to understand the continuing and new challenges for those working on this issue today.

Evidence of effective youth suicide prevention activities

There is now extensive research and understanding of the factors that both increase and decrease the likelihood of suicidal behaviours. However, despite it being over a decade since the introduction of the NYSPS in Australia, there is still a paucity of demonstrable and unequivocal evidence of the most effective, efficient and cost-effective programs and activities that demonstrably reduce the rate of youth suicide and self-harm. Although evaluation of government funded suicide prevention programs are now mandatory

under funding requirements, some evaluations employ less rigorous methods due to a lack of resources, funds and expertise and many evaluation findings are not published or publicly reported or available.

For a variety of reasons, rigorous evaluation of suicide prevention activities is a challenging task. Due to the relative rarity of suicide in Australia, and especially youth suicide, and the inherent difficulty in eliminating all other impacting variables, it is extremely difficult to use changes in the youth suicide rate as a measure of a suicide prevention program's effectiveness. As such, many evaluations use alternative measures of effectiveness, such as the incidence of suicide attempts or suicide ideation and/or the incidence of known suicide risk and protective factors. However, as these are indirect measures of suicide prevention, we must then *assume* that any improvements in these variables lead to a subsequent reduction in suicide rates. Furthermore, there are a range of ethical considerations that must be addressed during an evaluation of youth suicide prevention programs, including protecting the confidentiality and privacy of research participants, ensuring equitable access to treatment/services, managing consent where minors may be involved and protecting the safety of potentially vulnerable individuals.

Despite these difficulties, the number of published research, reports and documents is growing and there are numerous examples of best practice activities and services that have shown strong evidence of reducing risk factors for suicide, increasing the prevalence of protective factors and improving community capacity to respond to suicide amongst young people. Furthermore, there is now some evidence of activities that are not effective, either through failing to demonstrate any significant impact on the target group or through revealing the potential to increase risk factors or cause harm to young people.

The following section describes some of the types of youth suicide prevention activities and the current existing evidence supporting or opposing their efficacy.

Preventing Youth Suicide

Suicide is a complex problem that is often caused by a range of interrelated factors and issues. As a result, SPA believes that suicide prevention must involve several sectors and fields, including those that lie outside of the conventional health domain. Coordination and cooperation across these sectors is essential to achieve significant reductions in youth suicide rates in Australia (see submission by the Suicide Prevention Taskforce and SPA, entitled *Let's Get Serious: The Infrastructure to Effectively Address Suicide in Australia*, submitted to the Senate Community Affairs Committee Inquiry on Suicide in Australia in November 2009 (SPT, 2009)). Examples of some of the fields that must be included in suicide prevention efforts include health, education, employment, communities, youth, housing, communications, courts and human services, as well as industries across the public, private and not-for-profit sectors.

Suicide prevention activities have been operating in Australia and internationally for decades. The subsequent establishment of the NYSPS in 1995 spawned the development of a range of youth-specific suicide prevention activities, many of which still operate in Australia today. However, the quality of evidence evaluating the different types of activities and programs varies considerably. Nonetheless, there is now a growing body of research supporting a number of evidence-based activities and also some solid evidence of approaches that are ineffective or have the potential to cause negative outcomes.

The following sections outline some of the most common forms of youth suicide prevention activities and the available evidence of their effectiveness. The activities have been loosely categorised according to the USI (Universal, Selective, Indicated) model of health interventions, as follows:

- Universal – activities that focus on the youth population as a whole;
- Selective – activities that target specific groups of young people within the community that are known to be at a higher level of risk of suicide; and
- Indicated – activities directed at individual young people with a particularly high-risk of suicide.

Population-based methods (Universal)

School-based mental health, wellbeing and resilience awareness, information and education programs

In most developed countries, children and young people spend a significant proportion of their time attending some form of education institution, including schools, TAFEs, universities and other education and training facilities. As such, these facilities have long been recognised as a potential setting for health promotion, prevention and early intervention, particularly in the field of mental health and wellbeing. In Australia and internationally, a number of programs have been created that aim to address young people's mental health, wellbeing and the development of appropriate skills to cope with life's inevitable challenges and build resilience. These programs also often aim to improve students' awareness of mental illness and

boost help-seeking behaviours amongst students in need of support. In schools, these programs are often integrated into the overall curriculum or personal development courses and many involve teacher training courses and/or community workshops (e.g. parent information evenings). In universities, TAFEs and other training facilities, these programs may be incorporated as part of student welfare services, general campus activities/programs or within curriculums (for example Ozhelp's apprentice programs).

In general, evaluations of school-based education and awareness programs have demonstrated that, overall, teachers and other key stakeholders (e.g. parents) regard the programs highly and become actively involved in their implementation and training, particularly where there is a strong school culture and an interest in student wellbeing. In relation to student outcomes, there is a general trend towards improved awareness and knowledge of mental health issues (Aseltine & DeMartino, 2004; Eggert, Thompson, Herting, & Nicholas, 1995; Thompson, Eggert, & Herting, 2000). However, this increased knowledge may or may not translate into a change in behaviours, particularly outside the teaching environment. Furthermore, research is unequivocal regarding whether these programs significantly reduce the incidence or prevalence of mental health conditions known to increase the risk of suicide (e.g. depression) or reduce actual suicide rates (Aseltine, James, Schilling, & Glanovsky, 2007; Mazza, 1997; Sawyer et al. 2010).

Nonetheless, these programs may contribute to greater knowledge and awareness amongst teachers and other "gatekeepers", which may enable them to recognise students in need of support earlier and be better equipped to provide or refer students to appropriate support services or interventions. Furthermore, the mere existence of these programs within an institution may have beneficial effects by promoting a positive and caring culture. For instance, students who feel that their educational facility cares about their students' wellbeing may feel more comfortable seeking help in times of crisis and discussing issues related to mental health and wellbeing, feel more connected to their peers, teachers and community and may be less likely to engage in risk-taking or negative behaviours (e.g. alcohol/drug use, truancy).

In the early development of school-based activities that aimed to address suicide prevention, some programs included specific modules related to suicide awareness and prevention. Evidence on the efficacy of school-based suicide programs is mixed. For example, Gould et al (2005) found no risk for increased suicidality following questioning youths about suicide. However, school-based programs remain controversial, with older research showing that these programs may inadvertently increase suicide risk amongst vulnerable individuals, possibly through normalising suicidal behaviours, reducing help-seeking and increasing a reliance on maladaptive coping mechanisms (Bridge, Goldstein, & Brent, 2006; Klimes-Dougan, Yuan, Lee, & Houri, 2009; Mazza, 1997). In response, mental health awareness and education programs for young people generally focus on reducing suicide risk factors and aim to build young people's protective factors (e.g. resilience, help-seeking behaviours, coping strategies), rather than addressing the issue of suicide directly. SPA believes that this is an area in need of further research, as the culture of not talking about suicide contributes to the stigma and lack of awareness that acts as a barrier to understanding and help-seeking.

Example programs – MindMatters and KidsMatter

MindMatters is a national mental health initiative for secondary schools that provides mental health resources for school community members in Australian secondary schools. The project was initiated in 1997 and provides resource kits and information booklets to every Australian secondary school. The project is a flexible source of resources, curriculum and training that is provided to secondary schools and allows

schools to implement a whole school approach to providing care and support for the mental health and wellbeing of all students and the school community.

A similar mental health initiative, **KidsMatter**, is aimed at providing resources for primary school communities and was initiated in 2007. The project is a promotion, prevention and early intervention initiative specifically developed for primary schools that focuses on several components where schools can make a difference to student mental health. The project provides training and resources to the school community, helping schools to develop individual strategies to achieve a positive difference in student mental health.

A number of studies and evaluations from independent bodies and universities have been conducted on both MindMatters and KidsMatter programs with positive outcomes (Askell-Williams, 2005; Slee PT, 2009). Regular reviews and action on the results of these evaluations, as well as updating the content and media provided by the programs, ensures the relevance and success of these initiatives.

Anti-bullying programs

Bullying, harassment and discrimination are known risk factors for suicidal thoughts and behaviours, as well as increasing the risk of developing mental health conditions, such as depression and anxiety. Bullying and harassment are especially common for young people and can occur at school, home, university, workplaces, recreational facilities and within other environments. Bullying is also becoming increasingly prevalent through new mediums of communication, such as the internet, social networking, and mobile phones. As bullying and its forms are varied and originate from different prejudices (e.g. homophobia, racism, gender stereotyping etc) and motivations (e.g. exerting control, punishment or a form of self promotion), measures that address bullying must be conducive to tackling the causes of the behaviour.

In Australia, the substantial negative effects of bullying have been recognised over the past decade. Both federal and state/territory governments have developed anti-bullying policies and frameworks, and anti-bullying campaigns and programs are well-publicised through the media. Many individual schools have also developed their own programs and activities to reduce the incidence of bullying and harassment. These school-based programs typically involve multiple methods for reducing bullying, including:

- Awareness-raising and educational programs for teachers to increase knowledge of the issues surrounding bullying and effective teaching methods to reduce bullying;
- Educational processes to build students' skills in tolerance, values, effective anger management and how to manage bullying incidents; and
- Anti-bullying policies and procedures to effectively manage, control and discipline bullying behaviours.

Overall, research suggests that school-based anti-bullying programs are effective in reducing bullying behaviours, particularly amongst younger (pre-secondary) students (K Rigby, 2002; K. Rigby & Slee, 2008). In particular, programs that featured a problem-solving approach, rather than a punitive (i.e. rules and consequences) approach to bullying, show more consistent positive results (K Rigby, 2002). The direct impact of anti-bullying programs on suicide rates has not yet been determined. However, the strong evidence of their effectiveness in reducing a known suicide risk factor suggests that their expansion and standardisation is warranted. A more consistent approach to reducing bullying, perhaps through the

integration of an anti-bullying program with the ongoing development of a national education curriculum, will ensure that all Australian schools are involved and that they implement evidence-based approaches and activities.

Activities to reduce the incidence of bullying amongst older young people, especially removed from the school environment, are less widespread. However, several recent widely-publicised cases of suicide of young workers following extreme cases of workplace bullying and harassment have brought this issue into the spotlight and highlighted the need for evidence-based policies and guidelines. Examples of successful measures to address this include OzHelp's anti-bullying programs for young apprentices and workers in some industries (e.g. construction), who may experience considerable bullying during the initial years of their training and employment (e.g. through "initiation rituals", verbal/physical abuse, deliberate withholding of information/resources necessary to do the job) (OzHelp, 2010). These programs may be particularly important in industries and sectors where suicide rates are higher than the national average (e.g. construction, transport, nursing, dentistry) or where there are a high proportion of young, inexperienced workers, who are more likely to experience bullying and/or harassment.

Physical activity programs

Unfortunately, in many Australian schools, mandatory physical activity classes have been removed from or severely reduced in the curriculum, due to a lack of resources and the perceived need to focus more heavily on the academic achievement of students, to retain funding and enrolment numbers (Dodd, 2002). Not only does this have implications for young people's physical health, but current literature shows that there is a negative correlation between physical activity and the risk of suicidal ideation and behaviours and symptoms of mental illness, such as depression and hopelessness (Brown et al., 2007; Taliaferro, Rienzo, Miller, Pigg, & Dodd, 2008; Taliaferro, Rienzo, Pigg, Miller, & Dodd, 2009; Taylor, Dal Grande, Gill, Fisher, & Goldney, 2007). It has been suggested that, in addition to the physical health benefits resulting from physical activity, young people's involvement in physical activity and/or organised sport increases the levels of certain chemicals within the brain (e.g. serotonin), as well as improving their connectedness, self-esteem, problem-solving skills and sense of belonging (Brown et al., 2007; Taliaferro et al., 2008). These findings suggest that activities that promote physical activity and encourage participation amongst young people have the potential to reduce suicide risk factors and increase protective factors. Based on this evidence, ongoing support and funding for school- and community-based sporting clubs, social groups and physical education classes and activities for young people will likely produce improvements in both physical and mental wellbeing, reducing the prevalence of suicide risk factors and increasing social inclusion, connectedness and problem-solving skills, which may have a positive impact on overall youth suicide rates in the long-term.

Media awareness and reporting guidelines

Young people are heavily influenced by media in all its forms – television, magazines, newspapers, internet, music, films and videos, social networking, etc. As such, it is critical that the information presented in these communication channels is accurate and safe, particularly in relation to suicide and mental illness. Research shows that how suicide incidents and mental illness are portrayed in the media can substantially change the impact it has on those exposed to it (Pirkis, 2010). Discussions about suicide, particularly regarding suicide methods and locations and incidents involving celebrities and other well-known people, can act as triggers

for vulnerable individuals and may increase the chance of contagion or imitation suicides occurring. Inappropriate or sensationalist coverage of suicide and mental illness may also "glorify" the issues and may potentially encourage a more permissive attitude towards suicide as an appropriate coping mechanism in times of stress or crisis (Niederkrotenthaler et al., 2009). As such, various guidelines and codes of practice have been developed to provide advice and training to media professionals on how to portray these topics sensitively and appropriately and reduce the potential for harm. To date, accurate and appropriate reporting of suicide and mental illness has been shown to be an effective way of reducing the incidence of contagion and imitation suicides (Niederkrotenthaler & Sonneck, 2007; Pirkis et al., 2009).

Although evidence suggests that responsible reporting of suicide and related events has a positive impact on suicide rates, regulation and control of all forms of media is difficult and may constitute a type of censorship, which is strongly opposed by the media industry. For example, there is growing concern regarding pro-suicide internet sites, which may explain and display various methods for suicide and encourage young people to engage in self-harming or suicidal behaviours. However, removing sites of this nature from the internet is extremely difficult under current legislative acts related to freedom of expression (Mishara & Weisstub, 2007).

Ongoing research into the direct impact of media on suicide rates/attempts and the effectiveness of media guidelines in reducing contagion and imitation suicides would strengthen the evidence-base, further providing support for increased, yet appropriate reporting and the ethical portrayal of suicidal behaviours, mental illness and related issues (e.g. euthanasia) (Pirkis, Blood, Beautrais, Burgess, & Skehans, 2006; Pirkis, Burgess, Francis, Blood, & Jolley, 2006).

SPA advocates for the investigation of social marketing as a means to tackle the stigma and lack of awareness that continue to pervade suicide issues. Widespread campaigns that address suicide and educate the public may provide a huge benefit, but must be done in a safe and responsible manner. SPA is very interested in the emerging campaigns in the USA and we hope that they may contribute to the evidence base of suicide prevention social marketing campaigns.

Example program – MindFrame

In Australia, the **MindFrame** National Media Initiative provides media guidelines to inform media representation of issues related to mental illness and suicide. The MindFrame initiative commenced in 2002 and is guided by the National Media and Mental Health Group and is funded by the Australian Government Department of Health and Ageing. The initiative provides a range of information and resources for media professionals, the suicide prevention sector, those involved in film, television and theatre, police and courts. In addition to media guidelines for professionals, MindFrame also operates **Response Ability**, providing curriculum training and resources for university teachers and students involved in journalism and other media-related fields. Research conducted within the MindFrame initiative shows that exposure to inappropriate suicide-related stories in newspaper, television, books, internet and mixed media have a causal association with suicidal behaviour. Other studies completed by the University of Melbourne show that the MindFrame resource "Reporting Suicide and Mental Illness" has improved the quality of reporting and portrayal of suicide in the media (J. Pirkis et al., 2009).

Information and education using new media

The proliferation of the internet and the ongoing development of Web 2.0 technologies (e.g. social networking, YouTube, etc.) means that young people today often communicate far more than previous generations and in a variety of ways (e.g. internet, mobile, SMS, chat, video). The internet, in particular, is now one of the main methods by which young people access information, communicate with friends and family and interact with their communities and the world. Several organisations in Australia have recognised the potential to increase communication with young people through new forms of media and there are now a number of national websites dedicated to providing information, resources and support for young people (e.g. Reach Out, headspace, youthbeyondblue, Headroom, Kids Helpline). These websites have the ability to deliver a range of different services and facilities, ranging from broad-based information for all young people through early intervention and referral services to individual counselling and treatment options for young people. Some of the services offered by these websites include:

- Providing accurate, evidence-based information about mental health, suicide prevention, substance use and many other issues relevant to young people to improve awareness, knowledge and attitudes;
- Delivering information in a range of formats (e.g. fact sheets, podcasts, videos, games, discussion forums, chat rooms, social networking);
- Providing a safe, anonymous and flexible environment where young people feel comfortable;
- Providing a space for young people to connect with peers and the wider community, thereby facilitating stronger social connectedness;
- Involving young people through polls, interactive activities, surveys, blogs and forums;
- Encouraging help-seeking amongst young people;
- Providing young people with information about where to find help and support and referrals to other existing services;
- Offering no-cost or low-cost early identification and intervention services for young people at risk of suicide via a range of methods (e.g. internet, chat, email, SMS, telephone, face-to-face);
- Resources, training and education for other relevant groups, such as health professionals, teachers and parents; and
- Online skills development (e.g. Reach Out Central, MoodGym).

Recent research and evaluations of some information and education web-based programs for young people reveal that these websites and their associated services can be effective in promoting protective factors, including providing accessible, engaging and adaptive information for young people, improving mental health literacy amongst young people and increasing help-seeking behaviours (Burns, Ellis, Mackenzie, & Stephens-Reicher, 2009; Jorm, Wright, & Morgan, 2007; Santor, Poulin, LeBlanc, & Kusumakar, 2007; Shandley, Austin, Klein, & Kyrios). Some websites have reported high levels of satisfaction of young people using the websites and services, with many young people stating that they would use the websites during "tough times" and would also refer friends to use them (Burns et al., 2009; Shandley et al.2010). However, these findings are not replicated in all studies (Gould, Munfakh, Lubell, Kleinman, & Parker, 2002).

Internet-based services also have the advantage of being highly cost-effective, both for users and service providers, particularly when compared to other available forms of suicide intervention services (e.g. face-to-

face counselling, telephone services) (Burns et al., 2009; Christensen et al., 2010; McCrone et al., 2004). Similarly mobile phone SMS counselling services, such as those offered by Kids Helpline and the UK Samaritans are providing alternative forms of communication for youths with restricted internet access. In light of the fact that between 60% and 80% of young people experiencing a mental health or substance use problem fail to seek or receive help, these types of services have a demonstrated potential to increase support and treatment options in a confidential, non-threatening way, which appeals to young people.

However, despite growing evidence that internet-based services and those using other forms of new media are effective ways to engage, involve and support young people and to provide information, resources and services related to suicide prevention and mental health, there is a need to better understand and manage potentially dangerous web-based information and to ensure that those young people most at risk access accurate and helpful information (Harris, McLean, & Sheffield, 2009). Ongoing evaluation of existing services, especially those operating in Australia, will strengthen the evidence-base and contribute to the understanding of best practice in this field.

Example program – Reach Out

Reach Out (www.reachout.com.au) is a web-based service for young people aged 16–25 years. Its aim is to improve the mental health and wellbeing of young Australians by enhancing mental health literacy, increasing resilience, and facilitating help-seeking. Reach Out, created in 1998, was developed by young people, in consultation with mental health professionals, and is the flagship program for the **Inspire Foundation**. In the last twelve months, Reach Out is averaging over 136,000 unique visits each month and studies confirm that Reach Out is successful in providing mental health information and encouraging help-seeking amongst young people (Burns et al., 2009). A sister site, Reach Out Pro, has also been developed to respond specifically to the needs of professionals, particularly in relation to their use of technology and engagement with young people.

Methods for at-risk groups (Selective)

Suicide prevention and mental health training for "gatekeepers"

It is well-known that between 60%-80% of young people experiencing mental health or substance use problems or feelings of distress do not seek or receive support for these issues. However, these at-risk young people may present these problems via another means (McKelvey, Pfaff, & Acres, 2001). For example, a young person may visit their GP regarding another health condition, experience difficulties at school or call a telephone crisis about a family issue. How these individuals and services respond to young people's "requests" for help can be critical in preventing potential future suicide attempts or ongoing problems.

"Gatekeeper" training, as it is commonly known, refers to education and training programs that assist those people within the community who regularly come into contact with potentially suicidal or high-risk individuals or groups, to recognise the risk factors and warning signs of suicide and the most effective and appropriate ways to respond. Individuals who may benefit from training include general practitioners, teachers and other education professionals, emergency services personnel (e.g. police, paramedics), crisis

telephone services personnel, emergency department health workers, allied health professionals (e.g. psychologists, psychiatrists, nurses, social workers) and employees within community or sporting organisations who work with at-risk young people. Training programs may cover a range of topics, such as mental health awareness and literacy, suicide risk assessment, screening for known suicide risk factors (e.g. depression, hopelessness, and worthlessness), stigma reduction and effective referrals.

Evaluations of the efficacy of gatekeeper training programs have had mixed results. One community-based program developed by the U.S. Airforce was found to have many positive outcomes, including a 33% reduction in suicide rates following implementation (Knox, Litts, Talcott, Feig, & Caine, 2003). Training for GPs has been shown to increase their knowledge and identification of mental health problems (e.g. depression), but these effects may be temporary and may have a limited influence on subsequent patient management or treatment (Pfaff, Acres, & McKelvey, 2001). Similar findings have been shown in other types of gatekeeper training, including those trialled in Australian Indigenous communities, whereby there have been initial improvements in the attitudes and awareness of suicide risk factors, warning signs and mental health conditions, but limited evidence of long-term behaviour change and/or a reduction in suicide rates (Capp, Deane, & Lambert, 2001; Knox et al., 2003; Stuart, Waalen, & Haelstromm, 2003). Nonetheless, these programs play an important role in building the confidence of front-line workers to manage incidents involving suicide or suicide risk and what steps to take to prevent suicide amongst individuals at risk (Isaac et al., 2009; Knox et al., 2003). Randomised control trials may provide further evidence of the effectiveness of gatekeeper programs in reducing suicide risk in the short-term and suicide rates, in the longer-term (Isaac et al., 2009).

Example program – ASIST LivingWorks

Lifeline Australia operates ASIST (Applied Suicide Intervention Skills Training) LivingWorks training programs, designed to teach people how to help persons at risk of suicide keep safe and access further support. The programs vary from multi-day workshops to short seminars for suicide alertness and suicide intervention training. Lifeline introduced LivingWorks to Australia in 1995 and has worked with over 40 organisations to develop trainer networks in every State and Territory. The LivingWorks program has been thoroughly evaluated and is used in over 12 countries worldwide. The evaluation studies conclude that participants show a significant, stable increase in suicide intervention knowledge, competency and willingness to intervene and an increase in participants' ability to apply new learning from ASIST to simulated situations featuring persons at risk (ASIST).

Mentoring/peer support programs

Mentoring and peer support programs work with at-risk young people and aim to build their protective factors, including self esteem, social connectedness, communication skills, problem-solving skills and sense of purpose. Other objectives of mentoring and peer support programs may include increasing participation in education, training or employment, reduced engagement in risk-taking behaviours (e.g. alcohol/substance use) and decreased criminal behaviour.

Mentors are typically trained adults who are matched to an individual at-risk young person and provide positive role-modelling, encourage goal-setting and discuss life and career aspirations. Peer supporters are generally young adults who are trained to support younger children and adolescents to build self-esteem,

resilience, problem-solving and decision-making skills. Many mentoring and peer support programs operate either through or in conjunction with schools and activities may include one-on-one discussions, group work, workshops and camps. Online mentoring programs are a recent development, which may prove a promising approach for isolated young people, such as those living in rural or remote regions, although further research is needed to ensure relationships between mentors and mentees are effectively developed (Rhodes, Spencer, Saito, & Sipe, 2006).

Although mentoring and peer support programs generally support young people who may be at risk of disengaging from education, family or their community (who may also possess or have experienced numerous known risk factors for suicide), there are some mentoring and peer support programs that are designed specifically for young people who are currently exhibiting suicidality (see below profile of Youth Focus).

Evaluations of mentoring and peer support programs have shown that they are effective in achieving improvements in self-esteem, connectedness, personal relationships and skills in communication, conflict management, problem solving and decision-making (Boras & Zuckerman, 2008; Karcher, 2008; PSA, 2010). They have also been shown to improve young people's attitudes towards bullying and reduce bullying behaviours (PSA, 2010). Other benefits may include reduced offending by young people, decreased risk-taking behaviours and increased participation in education, training and employment (Bellamy, Springer, Sale, & Espiritu, 2004; Moodie & Fisher, 2009; Wilczynski, Culvenor, Cunneen, Schwartzkoff, & Reed-Gilbert, 2003). However, further research is needed to determine the effectiveness of mentoring and peer support programs in reducing the symptoms of mental illness or signs of suicide.

Example program – Youth Focus Peer Group Support Weekends

Youth Focus, based in Western Australia, offers mentoring and peer support programs for young people who show early warning signs associated with suicide, self-harm and/or depression. The programs include Peer Group Support Weekends, which involve camp-based weekend retreats and incorporate pre- and post-camp activities to ensure long-term benefits to participants. The programs aim to develop participants' coping strategies and improve their overall mental health and wellbeing, and have showed positive results by reducing suicide risk factors.

Programs for specific high-risk groups of young people

Within the population of all young people, there are a number of groups that experience a greater general risk of suicide and a higher suicide rate, mainly due to the occurrence of a number of known risk factors and fewer protective factors for individuals within these groups. Some of the sub-groups of young people who are known to experience a higher rate and risk of suicide include Indigenous youth, young people from culturally and/or linguistically diverse or refugee backgrounds, gay, lesbian, bisexual, transgender and intersex young people, young people living in rural or remote parts of Australia, young people bereaved by suicide and young people who have a mental illness or have previously attempted suicide or engage in self-harm (Arria et al., 2009; P. Burvill, 2000; P. W. Burvill, 1998; Caldwell, Jorm, & Dear, 2004; Judd, Cooper, Fraser, & Davis, 2006; Robinson, Gook, Yuen, McGorry, & Yung, 2008; SPA, 2008a, 2008b, 2009b, 2009d).

There is now a general recognition that a "one size fits all" approach to suicide prevention is neither appropriate, nor effective (Pitman, 2007). Different groups experience different risk and protective factors

and have different attitudes and beliefs about suicide, mental health and wellbeing, all of which impact on the effectiveness of different approaches to suicide prevention (P. Burvill, 2000; De Leo, 2009; Farrelly & Francis, 2009; Goldston et al., 2008; McCoy, 2007). As such, youth suicide prevention activities must be developed, implemented and evaluated in ways that address the specific needs of the sub-group for which they are developed. Furthermore, targeting programs and activities towards the groups most at risk of suicide (rather than those with a very low risk) is a more effective and efficient use of scarce resources and funds.

Suicide prevention activities for particular youth sub-groups may operate in a number of ways. Some projects operate nationally, such as Multicultural Mental Health Australia, which provides mental health information and advocacy services for all people from CALD backgrounds, including young people. This program also supports state and community-based projects that deliver services on a local level. Further positive examples of programs that target youth at risk include ACON's mental health services for GLBT youth and Headhigh, the support group for youth bereaved by suicide. Similar programs exist for other sub-groups. While it is important to have targeted programs that youths can relate to and feel comfortable with, it is also crucial that mainstream services are trained and aware of the differing needs and expectations of youth from diverse demographic groups.

Broad-scale campaigns that aim to reduce stigma and promote tolerance within the community may also assist young people from high-risk sub-groups, through a decrease in the incidence of suicide risk factors, such as harassment, discrimination, violence, rejection and abuse. For example, the "This Is Oz" campaign aims to reduce the stigma and discrimination associated with same-sex attraction (see www.thisisoz.com.au).

Many of the programs that specifically target young people from high-risk groups operate community-based, youth-friendly services, such as drop-in centres, recreational activities, sporting groups, school-based workshops or courses and outreach services that aim to increase at-risk young people's social connectedness and sense of belonging, reduce isolation, improve awareness, knowledge and attitudes towards suicide and mental health, build support networks and provide avenues for referrals to other services, where necessary. The involvement of youth, especially those with lived experience of suicide is crucial to informing programs and providing safe environments for at-risk youth to participate in beneficial activities and seek help.

The importance of early intervention for youth at-risk is well-documented (McCrone & Knapp, 2007; Mittendorfer-Rutz & Wasserman, 2008; SPA, 2009a; Valmaggia et al., 2009). However, evidence of the effectiveness in reducing suicide and suicide risk factors for individual programs targeting high-risk groups of young people is currently limited.

Many existing community-based programs have been or are currently being evaluated and there is growing evidence that they increase protective factors and reduce suicide risk factors amongst their particular target group and provide much-needed services where few are available (Capp et al., 2001; DoHA, 2010; Eisenberg & Resnick, 2006; SPA, 2008a, 2008b, 2009b, 2009d; Tsey et al., 2007). Indeed, the existence of at least some services for high-risk groups is better than none and is likely to have a positive impact. Nonetheless, further research investigating the effectiveness of existing programs, similarities with best practice and/or international evidence and increased availability of program evaluation reports would provide a greater evidence-base of how to reduce suicide rates for young people within at-risk minority groups.

Much of the reason why particular sub-groups experience a higher risk of suicide relates to the general attitudes of society towards particular characteristics (e.g. ethnicity, sexuality) and/or a lack of high-quality, accessible, culturally-appropriate services. This suggests that suicide prevention activities must not only target high-risk groups, but also enhance awareness and tolerance of these groups and provide equitable access to services across the whole community.

Example program – QSPACE

QSPACE is a social support group for young people aged 12 – 17 with sexuality or gender identity issues. The group is one of just a few providing youth GLBT services in the Gold Coast region and operates activity days and a weekly drop-in service. Anecdotal evidence suggests that the program increases participants' connectedness, resilience and help-seeking (QSPACE, 2010) and the auspicing agency are currently undertaking a comprehensive evaluation of the QSPACE program to measure its effectiveness in reducing suicide risk factors within this high-risk group.

Postvention programs to prevent contagion/cluster suicides

Young people who have previously been exposed to suicide or suicide attempts, via family, peers or other well-known people (e.g. community leaders, celebrities) are known to have a greater risk of suicidality themselves (Hazell, 1993; Jordan & McMenamy, 2004; Krysinska, 2003; SPA, 2009c). There are various reasons for this linkage, including a familial predisposition for mental illness and suicidality, complex and ongoing experiences of grief and bereavement and potentially negative effects of media reporting of suicide events. Cluster suicides (i.e. where a number of suicides occur close together in time and/or space), imitation suicides (i.e. where a young person "copies" the behaviours of another person who has suicided, including the same method, location, etc.) and pact suicides (i.e. where two or more people agree to suicide together or in the same way, place or time) are far more common amongst young people (Insel & Gould, 2008). These events are also more common in Indigenous communities and there are examples of communities that have experienced multiple youth suicides within a very short space of time. Many communities, institutions and groups are unsure how to best manage a suicide incident to prevent further suicides.

Several programs have been developed, both in Australia and internationally, to provide support and services to people who are bereaved by suicide or who have been exposed to the suicide of another person, either within their community or through the media. These activities are often called *postvention* programs. Services may include crisis support, peer support groups, referral services, training and education courses (e.g. for teachers, lecturers, health professionals) and early intervention (e.g. counselling, psychotherapy) for at-risk individuals and groups. Some general postvention services (i.e. those not specifically designed for young people) do provide services to young people and may also provide assistance and guidelines for schools, workplaces, communities and other groups on how to effectively manage the suicide or attempted suicide of a young person to prevent any further suicidality. There are also some services that have been specifically designed to focus on working with children and adolescents, which often use age-appropriate language and activities, to assist young people to deal with their grief. Some State and Territory governments have also developed guidelines for communities, explaining how to manage suicide incidents and develop best practice response plans (DoC, 2008).

Evaluation of the effectiveness of postvention programs has expanded in recent years and there is now substantial evidence suggesting that these programs can reduce the incidence of suicidal ideation and behaviours and other risk factors in people bereaved by suicide (Bycroft & Visser, 2009; DoC, 2008; Hazell, 1991; Hoffmann, 2006; Leenaars & Wenckstern, 1998; SPA, 2009c; Wilson & Clark, 2005). However, there is still a need to identify the particular service models that are most effective for providing support and reducing the incidence of future suicides, especially for young people and other high-risk groups. Ongoing monitoring of suicide rates amongst those bereaved by suicide and controlled trials of postvention programs will provide more solid and scientific evidence of effectiveness.

Methods for highly at-risk individuals (Indicated)

Referral programs, system integration and coordination initiatives

Identifying and utilising the range of pathways to care and support for young people who are at risk of suicide is critical to ensure they receive the most appropriate support and care at the right time, the right place and from the right people (DoHA, 2008; SPA, 2009a). Many at-risk young people experience numerous known risk factors simultaneously, such as disconnection from school, family violence, homelessness, self-harm and substance abuse. Therefore, young people require a holistic approach and a range of support options and interventions that address their individual needs. This is especially important considering young people's low rate of help-seeking and use of treatment and intervention services.

Recently, a number of initiatives have been established that aim to improve linkages between service providers to encourage better quality care and smoother transitions between services for consumers (Assan et al., 2008; Currier, Fisher, & Caine, 2010 ; Sved-Williams & Poulton, 2010 ; Wasserman et al., 2009; York, 2009). Many youth service providers now develop a "referral pathways" document, which lists contact details for all locally available organisations and services. Furthermore, many youth organisations also establish formal and informal arrangements and committees with other service providers and organisations, including schools, emergency services, mental health services and child safety agencies.

Although many of these initiatives are only in the developmental stages, initial evaluations and research suggest that these approaches improve coordination and collaboration between service providers and build community capacity to respond to suicide events, as well as improving young people's access and use of available services (Assan et al., 2008; Bycroft & Dowse, 2009; Bycroft & Visser, 2009; Hickie, Fogarty, Davenport, Luscombe, & Burns, 2007; Qin, Madsen, & Mortensen, 2009; Wasserman et al., 2009; York, 2009).

Crisis support

Telephone-based crisis and counselling services have been operating in Australia for decades (e.g. Lifeline, Kids Helpline) and data shows that both young people in crisis and third parties concerned about another's wellbeing frequently use these services. There are also newer services that provide ongoing telephone counselling (e.g. Suicide Call Back Service). In general, positive results are reported in anecdotal evidence, as well as studies examining clients' and counsellors' satisfaction with the services provided, resulting in repeat use of services and referral outcomes (Turley, 2006). However, studies assessing the services' impact on actual suicide rates have yielded conflicting results. Some studies show that suicide hotlines may help to reduce suicide rates among particular groups (e.g. young white females) or when certain counselling techniques are used (Gould, Greenberg, Munfakh, Kleinman, & Lubell, 2006; Mishara et al., 2007; Mishara & Daigle, 1997; Turley, 2006).

A study conducted in 2007 (Gould, Kalafat, Harrismunfakh, & Kleinman, 2007) found that crisis hotline services were effective in reaching suicidal individuals (including those people who demonstrated severe

suicidality) and that those individuals were satisfied with the service they received. In particular, young, Caucasian females expressing suicidal intentions were the most likely demographic group to contact the service. However, although the service was effective in reducing feelings of hopelessness and psychological pain, there was no significant reduction in callers' intent to die in the time between the end of the call and a follow-up call conducted 1-2 weeks later. Indeed, only 12% of callers' indicated that the call prevented them from suiciding or harming themselves. This outcome may at least partially explain why suicide rates were not reduced.

Interestingly, the reasons cited by callers' as the cause of their suicidality were wide-ranging, including prior suicide attempts, mental health problems, interpersonal problems, inability to meet their basic needs (i.e. shelter, food), addictions and substance abuse disorders, physical health problems, work problems and abuse/violence. Often, individuals had experienced more than one of these risk factors. This study also found that of those callers' who were referred to other services (including mental health resources), only 35 percent kept or made their appointment during the follow-up period.

Several recent studies have investigated young people's use of telephone crisis hotlines and counselling services. Although young people (particularly young, Caucasian females) do use telephone-based crisis services, there is evidence that those young people most at risk of suicide may be the least likely to use these services, perhaps due to feelings of shame and hopelessness (Gould et al., 2006; Stevens, Klima, Chisolm, & Kelleher, 2009). In addition, the use of telephone crisis services may not increase young people's utilisation of other support services referred by the crisis service (Stevens et al., 2009).

In recent years, many crisis support organisations have made services available via other mediums, such as internet, email, online chatting and SMS. These methods may be more appealing to young people and more likely to stimulate help-seeking (Burns et al., 2009; Hoffmann, 2006; Oh, Jorm, & Wright, 2009). Web-based services also have the advantage of being able to offer a variety of programs, ranging from basic information and education through early intervention to one-on-one counselling services. As such, young people can be guided through different services according to their level of need in a way that may be less threatening than other forms of treatment (Barak & Bloch, 2006; Burns et al., 2009; Haas et al., 2008; Oh et al., 2009; Santor et al., 2007). Crisis services incorporating new media have also been shown to be highly cost-effective. Ongoing evaluation of the impact of crisis support services, especially those incorporating new forms of media, on reducing suicidality and associated risk factors are recommended.

Example program – Kids Helpline

Kids Helpline is Australia's only 24/7 counselling service specifically for children and young people aged 5 to 25 years and has been operating since 1991. Counselling and support is provided via the phone, web and email, with email counselling beginning in 1996 and real-time web counselling starting in 2000. In 2008, almost 300,000 telephone and online interactions were provided through this service and mental health and suicide were the second most common reasons for using the service. Other topics discussed are all significant risk factors for suicidality, such as bullying, self image, sexual assault, relationships, etc.

During 2006, responses required to protect young people regarding suicide risk, such as contacting an emergency service, were actioned during or after 243 counselling sessions. An independent evaluation by the University of Queensland confirmed that Kids Helpline produced improved outcomes for young people, with results showing a significant reduction in suicidality during the course of the calls (King, Nurcombe, & Bickman, 2000; King, Nurcombe, Bickman, Hides, & Reid, 2003).

Early intervention and treatment activities for individuals at high risk

Mental illness has been shown to be a major risk for suicidal thoughts and behaviours, with some studies suggesting that a large majority of suicide cases involve a mental health condition of some kind (SPA, 2009a). Mental illness is also often preceded, accompanied and/or followed by other suicide risk factors, such as substance use, homelessness, abuse, family history of suicide/mental illness and poor socioeconomic status (SPA, 2009a). Research shows that approximately 75% of mental health conditions have their onset during adolescence or young adulthood and between 60% and 80% of all young people experiencing mental health problems do not seek or receive any treatment or care (Burns, Morey, Lagelee, Mackenzie, & Nicholas, 2007). However, current evidence suggests that early diagnosis and effective treatment of mental illness can greatly reduce the frequency and severity of suicidal thoughts and attempts and reduce the risk of completed suicide (Berger, Fraser, Carbone, & McGorry, 2006; Robinson et al., 2006).

Various types of interventions are available for the treatment of mental health conditions, depending on the duration, severity and type of presenting condition. These include:

- Counselling/psychotherapy;
- Pharmacotherapy;
- Outreach services;
- Self-help programs;
- Hospital/residential care; and
- Active follow-up care post discharge, including phone and postcard contact
- Community-based support, including referrals to various pathways to care.

In addition to traditional face-to-face treatment, a number of other means of delivering mental health services are now available, including telephone counselling, and therapies utilising email, internet chatting, discussion forums, mobile phones and texting. These alternatives to face-to-face treatment may be particularly appealing to young people, who often prefer the anonymity, confidentiality and flexibility of online communication channels (Barak & Bloch, 2006; Burns et al., 2009; Oh et al., 2009; Santor et al., 2007).

Several types of therapy and counselling techniques have been shown to be effective in reducing suicidality, including cognitive behaviour therapy, dialectical behaviour therapy, family therapy and problem-solving therapy (Burns, Dudley, Hazell, & Patton, 2005). Many of these therapies are or can be made available via online or telephone services, which may be better utilised by young people. Similarly, outreach services, including those following discharge from an emergency department, involving ongoing telephone contact, letters or postcards have also demonstrated efficacy in preventing suicide attempts amongst young people who had previously attempted suicide or self-harm (Carter, Clover, Whyte, Dawson, & D'Este, 2005, 2007; Vaiva et al., 2006). Restricting access to means is a widely accepted complimentary strategy (Hawton et al 2004) to reduce suicide rates, and SPA supports the ongoing advocacy for legislation to reduce access to paracetamol.

Pharmaceutical treatments for mental illness are widespread and most have been clinically proven to reduce the symptoms associated with the particular mental health condition for which they were developed

(SPA, 2009a). Many medications have also been shown to decrease suicidality, especially for severe mental illnesses, such as schizophrenia and bipolar disorder (Freeman & Freeman, 2006; Sondergard, Lopez, Andersen, & Kessing, 2008). There is ongoing debate within the psychiatric literature regarding the safety of using certain types of anti-depressant medications in child and adolescent populations, due to the emergence of some evidence that these medications may increase the risk of suicidality for young patients, particularly in the early stages of treatment (Cougnard et al., 2009; Dudley, Hadzi-Pavlovic, Andrews, & Perich, 2008; Hall & Lucke, 2006; Sakinofsky, 2007a, 2007b; SPA, 2009a). However, recent studies refute this and some suggest that the risk of suicide may be more closely linked to the use of multiple medications, rather than simply an association with anti-depressants (Alderman, 2009; Fontanella, Bridge, & Campo, 2009; Vitiello et al., 2009). Furthermore, the risk of suicide following prescription of anti-depressants should be balanced against the potentially higher risk that may follow the withdrawal or lack of treatment (Dudley et al., 2008; Libby, Orton, & Valuck, 2009). A combination of counselling/therapy and pharmacotherapy may be the most beneficial course of treatment for young people, which focuses on both reducing symptoms and addressing the psychosocial factors behind their suicidality (Cullen, Klimes-Dougan, & Kumra, 2009).

Treatment of young people experiencing suicidality or mental illness within general hospitals or psychiatric facilities has become substantially less common over recent decades, with a move towards a greater reliance on community-based interventions and services (SPA, 2009a). Changes to policy and funding related to psychiatric in-patient services followed a range of research findings showing that people utilising these types of services may be at a considerably greater risk of suicide following discharge (Geddes, Juszczak, O'Brien, & Kendrick, 1997; Goldacre, Seagroatt, & Hawton, 1993; Hoyer, Olesen, & Mortensen, 2004; Qin & Nordentoft, 2005). Thus, SPA strongly recommends that individuals admitted to psychiatric or hospital care should be carefully monitored post-discharge and referred to other community-based services for ongoing support and care (SPA, 2009a).

As mentioned in the previous paragraph, community-based services and treatment options for people experiencing mental illness are an integral component of Australia's mental health care system. Unfortunately, current evidence suggests that these services are severely under-resourced and a lack of coordination and collaboration between different service types can lead to service gaps and ineffective delivery of complementary services (Inspire et al., 2009; MHCA, 2005; SPA, 2009a). Numerous programs and initiatives are currently underway to improve the level of cooperation, coordination and collaboration between different service types, which aim to improve the quality and availability of care for young consumers. Moreover, in addition to treating mental health conditions, the involvement of a range of youth-friendly community services can also address the range of social and environmental factors that influence the risk of suicide and provide a continuum of care and support (SPA, 2009a).

Summary of evidence for youth suicide prevention activities

The available research and evidence suggest that there are several effective and potentially effective methods for decreasing the rate of suicide amongst Australian youth, through the reduction in risk factors and augmenting protective factors. The following table provides a summary of evidence to date regarding the different types of interventions available to young people and presents some example activities currently operating in Australia.

Each type of youth suicide prevention activity has been categorised according to the level of supporting evidence, based on the availability of data and evidence related to its impact and outcomes, the strength and reliability of evaluation/research findings and the rigorousness of evaluation methods used. The table also shows where activities have demonstrated some ineffectiveness or where evidence of potential harm has been found. These instances are described in more detail in the footnotes at the bottom of the table.

The purpose of this table is not to rank or rate the worthiness of different kinds of youth suicide prevention activities, but rather to show where evidence is strong and where further research and/or evaluation may be necessary to support promising approaches. The table may also be helpful in the ongoing allocation of funds and resources for youth suicide prevention activities to ensure that the most effective and evidence-based programs and projects are developed, implemented and maintained.

Figure 1: Summary of youth suicide prevention activities

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Type of activity	**Level of supporting evidence**				**Australian examples**
Universal approaches	**Strong evidence**	**Moderate evidence**	**Limited evidence**	**Ineffective/ Causes**	
School-based mental health, wellbeing and resilience awareness, information and education programs		✓		possible[1]	MindMatters, KidsMatter
Anti-bullying programs	✓				Bullying. No Way!
Physical activity programs		✓			School-based physical education courses,
Media awareness and reporting guidelines	✓			possible[2]	MindFrame, Response Ability
Restriction of means, legislating for limiting paracetemol and other drug access	✓				Governement legislation
Information and education using new media		✓		possible[3]	headspace, ReachOut!, youthbeyondblue, Headroom, Kids Helpline
Selective approaches	**Strong evidence**	**Moderate evidence**	**Limited evidence**	**Ineffective/ Causes harm**	
Suicide prevention and mental health training for "gatekeepers"		✓			Mental Health First Aid, ASIST (LivingWorks)
Mentoring/peer support programs		✓			Youth Focus (WA), Peer Support Australia, Youth Mentoring Network
Programs for specific high-risk groups of young people		✓		possible[4]	QSPACE, Community Broadcasting Suicide Prevention Project , various across Australia
Postvention programs	✓				StandBy Response Service, Headhigh Support Group, Support After Suicide, Living Beyond Suicide
Indicated approaches	**Strong evidence**	**Moderate evidence**	**Limited evidence**	**Ineffective/ Causes harm**	
Referral programs			✓		CRYPAR Program (QLD), PIM Initiative (QLD)
Crisis support		✓			Lifeline, Kids Helpline, Suicide Call Back Service
Early intervention and treatment activities for individuals at high risk					
Counselling/therapy	✓				headspace centres, private psychologists/ psychiatrists, State-based mental health services
Pharmacotherapy	✓			possible[5]	GPs, psychiatrists, mental health services
Hospital/residential care			✓	possible[6]	Various
Active follow-up care and communication following discharge from hospital	✓				Various
Community-based support/Case management		✓			Various

Footnotes - The following issues are known to have have negative influences on suicidal behaviour

1 *Programs that address suicide directly, rather than addressing risk factors, may increase a permissive attitude towards suicide and increase suicidality in vulnerable individuals*

2 *Innapropriate media reporting methods, such as those that describe methods locations, and sensationalise or glorify suicidal behaviour*

3 *Internet sites that describe methods locations and/or sensationalise or glorify suicidal behaviour*

4 *Culturally innapropriate programs or programs aimed at incorrect target group*

5 *Potential increased suicidality amongst adolescents using certain anti-depressant or similar prescription medications*

6 *Increased suicide risk following discharge from psychiatric care*

The Way Forward

Based on the available evidence of the most effective, efficient and cost-effective approaches, SPA proposes a number of main areas for ongoing focus and recommendations for future action to reduce the incidence of suicide amongst young Australians, in addition to decreasing the prevalence of associated risk factors and increasing the prevalence of known protective factors.

Main areas for focus

Focusing on the specific needs of young people

SPA recognises that activities that aim to reduce the incidence of suicide amongst young people will only be effective if they understand and address the specific needs of young people and the unique factors that affect their wellbeing. Pre-adolescence, adolescence and early adulthood are times of substantial development and change, when individuals clarify their identity and when personal circumstances and the general environment have an immense impact on how they transition from childhood to adulthood. Therefore, suicide prevention activities must build on young people's strengths and needs, while minimising the cumulative effect of individual predispositions and potentially adverse life events. In light of contemporary literature regarding the known risk and protective factors for suicidal behaviours in young people, the key issues to focus on for future suicide prevention research and activities include:

- Improving young people's resilience, including the development of a healthy level of self-esteem, a sense of belonging and acceptance of themselves and others – The capacity to handle difficult circumstances and events, both on an individual and collective level, are critical to preventing young people from seeing suicide as an acceptable or viable option. Promoting young people's tolerance of others' differences and self-acceptance through media, education and culture is an important step to decreasing the incidence of suicidal thoughts and behaviours amongst young people.
- Encouraging a sense of purpose and meaning in the lives of young people - Evidence suggests that people are at a greater risk of suicide when they feel their situation is hopeless or that there is nothing to live for. Encouraging young people to find meaning in their lives, develop goals for the future and pursue their passions will likely reduce the risk of hopelessness and helplessness.
- Building young people's connectedness to their families, peers and community, social inclusion and availability and accessibility of social support – Young people who are connected to those around them and have access to range of high-quality information, resources and services will be more likely to seek and receive appropriate support in times of need and less likely to feel isolated and excluded from society.
- Reducing the stigma associated with suicide, mental illness and other risk factors and encouraging help-seeking amongst young people – Although stigma and discrimination associated with mental illness has reduced in recent years, suicide is still very much a taboo topic. Myths surrounding suicide are still widely held in the general community and often people are unsure how to discuss it appropriately or safely. Safe, evidence-based campaigns that aim to reduce the stigma of suicide

must be developed and implemented and complemented by programs that encourage help-seeking by young people.

- Mental health promotion and the prevention of mental illness – Mental illness is one of the main risk factors for suicidality. Improving the knowledge and attitudes of young people towards mental health conditions, their symptoms and how and where to seek help are essential for ensuring they receive early care and treatment.
- Improving the management and control of bullying, harassment and discrimination – Bullying and harassment are a known risk factor for suicide and contribute to a number of other risk factors for young people, such as low self-esteem, learning difficulties, isolation and social exclusion. Current research suggests that anti-bullying programs are effective in reducing the occurrence of bullying and harassment and promote the development of other protective factors, such as positive coping mechanisms and resilience. They may also assist in identifying high-risk youth, as both young people who bully and are bullied are likely to possess or have experienced other recognised risk factors (e.g. family discord, physical/sexual abuse, family history of suicide/mental illness).
- Addressing the risk and protective factors unique to young people – as discussed earlier in this submission, there are a number of issues that affect young people specifically and impact on their risk of suicide. Suicide prevention activities should focus on these factors, aiming to reduce risk factors and increase protective factors.

Focusing on a national structure for suicide prevention, with specific objectives and structures for youth suicide prevention

There is substantial evidence that suicide prevention strategies and activities will be more effective and efficient if services and organisations work together to deliver programs and achieve goals (DoHA, 2008; Hickie, Groom, McGorry, Davenport, & Luscombe, 2005; SPT, 2009). SPA supports the establishment of a national structure for suicide prevention that includes a number of collaborative organisations and stakeholders with agreed overarching objectives and values, but separate functions and areas for action (see submission by the Suicide Prevention Taskforce and SPA, entitled *Let's Get Serious: The Infrastructure to Effectively Address Suicide in Australia*, submitted to the Senate Community Affairs Committee Inquiry on Suicide in Australia in November 2009 (SPT, 2009)). This structure should include arrangements to specifically address the needs of young people and other high-risk groups, such as the establishment of a committee to address youth suicide prevention, consisting of relevant experts and service provider organisations.

Focusing on providing a range of evidence-based activities across the USI model that are accessible, flexible, youth-focused and available across Australia

Available evidence from both Australia and internationally shows that in order to achieve reductions in youth suicide rates, a range of promotion, prevention and early intervention strategies, services and activities are required across the spectrum of universal, selective and indicated interventions. Despite

identifying at-risk groups and recognising the need for interventions for high-risk individuals, to date, Australia's NSPS has tended to focus on population-based approaches, particularly in relation to young people, and has largely relied on promoting resilience as a protective factor without addressing other social determinants. While important, a broader mental health promotion approach, as well as the development and implementation of selective and indicated initiatives are required, including culturally appropriate and accessible services for identified at-risk groups and a range of youth-focussed approaches for the detection, early intervention and treatment of highly at-risk young people. This should be accompanied by evidence-based initiatives that target all young people and address the social determinants of mental illness and suicide. Most importantly, these activities must be integrated and coordinated to provide a continuum of pathways to care for young people that are consumer-focused, efficacious and based on best practice (SPT, 2009).

Focusing on the best allocation of resources and funding to achieve results

Resources and funding for suicide prevention in Australia are limited and it is essential that available resources and funds be spent on the most effective and efficient programs and services in order to have the greatest positive impact on youth suicide rates in the long-term. In addition to evaluating the effectiveness and efficiency of new and existing youth suicide prevention programs, initiatives should be assessed on their level of cost-effectiveness and sustainability in the long-term. Evidence suggests that services using the internet and other forms of new media are more cost-effective methods of treatment and intervention than traditional face-to-face delivery –continued economic research should be undertaken to confirm these initial findings (Christensen et al., 2010; Haas et al., 2008; McCrone et al., 2004). Other avenues for effective and efficient service delivery should also be explored.

Young people themselves should be involved in the evaluation of services, to ensure that they are appropriate, accessible and youth-friendly. Furthermore, where youth suicide prevention approaches are shown to have limited effectiveness in reducing suicide rates or fail to have a positive impact on suicide risk and protective factors, either further evaluation and research should be conducted to demonstrate effectiveness or funds should be re-allocated to other approaches that are known to be evidence-based and sustainable (Christensen et al., 2010; Hickie, Davenport, & Luscombe, 2006; McCrone & Knapp, 2007; Valmaggia et al., 2009).

Recommendations for priorities for future action

1. Develop a national structure for suicide prevention, including specific structures and objectives for youth suicide prevention, to better coordinate advocacy, research, service delivery and information sharing.
2. SPA advocates for the commissioning of a comprehensive youth suicide review to update the research undertaken by the Strategic Research Development Committee, the National Health and Medical Research Council and the Department of Health and Aged Care in 1999 (see NYSPS, 1999) Roll-out/expand youth suicide prevention activities that have proven effectiveness, efficiency and cost-effectiveness. Based on available evidence, this includes:
    - School, workplace and community-based anti-bullying and resilience building programs;
    - Services utilising the internet and other forms of new media (e.g. mobile phones, social networking, media devices) to provide information, education, foster social connectedness, raise awareness and reduce stigma;
    - Early identification and intervention of young people at high risk of suicide (e.g. screening for and treatment for depression and other mental health conditions by "gatekeepers");
    - Accessible, flexible and youth-friendly counselling and therapy services for young people at high risk, including face-to-face, online, email and telephone services;
    - Stigma reduction measures that promote help-seeking and increase awareness; and
    - Professionally monitored prescription of safe, efficacious pharmacotherapy (ideally accompanied by another form of therapy) to reduce the symptoms associated with mental health conditions and suicidality.
3. Ongoing development of and implementation of programs (including the modification and testing of existing programs) with high-risk sub-groups (e.g. Indigenous youth, CALD youth, GLBT youth).
4. Involve youth in research, the development of new activities and in the evaluation of existing programs.
5. Ongoing investment in rigorous evaluation, including cost-effectiveness analysis, of existing services and programs.
6. Develop a series of standard performance measures for suicide prevention activities to measure effectiveness, efficiency and cost-effectiveness.
7. Implement systems and procedures for ongoing knowledge-sharing regarding youth suicide prevention (e.g. publishing evaluation findings, collaboration between providers, clearinghouse of literature) to foster collaboration between providers, build the evidence base and prevent duplication of effort and the waste of resources.

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7th May 2010

Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600

Dear House of Representative Standing Committee on Health and Ageing,

Thank you for your invitation to comment as part of the Inquiry into Youth Suicide. We commend the House of Representatives for its decision to refer this important issue to a formal inquiry and for providing interested organisations and individuals an opportunity to contribute and have their voices heard.

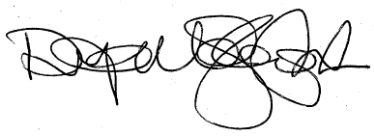
Suicide Prevention Australia (SPA) is the national advocate for suicide and self-harm prevention, intervention and postvention in Australia. A non-profit, community organisation, we actively promote and facilitate community awareness and advocacy; collaboration and partnerships between communities, practitioners, policy-makers, researchers, service providers and industry; information access and sharing; and local, regional and national forums, conferences and events, including the annual World Suicide Prevention Day SPA Community Forum and LIFE Awards.

We support the implementation of sustainable programs targeted at reducing suicide, and play a vital advocacy role in representing the voices of our diverse stakeholders as we strive to create a community that values people and the quality of life; a nation where no-one believes suicide is the only option for them.

The following submission is an analysis of current youth suicide prevention in Australia and provides a foundation and recommendations for change and development. This submission is complemented by the many SPA documents that are referred to in this document, and we advise the Committee to visit our website www.suicidepreventionaust.org to access further information.

We encourage the Committee to host further round-table discussions to diversify the sources of evidence utilised by the Inquiry, especially encouraging those with lived experience of youth suicide to take part.

Yours Sincerely,



Ryan McGlauglin, SPA Chief Executive Officer

II85					
Type of activity	**Level of supporting evidence**				**Australian examples**
Universal approaches	**Strong evidence**	**Moderate evidence**	**Limited evidence**	**Ineffective/ Causes harm**	
School-based mental health, wellbeing and resilience awareness, information and education programs		✓		possible[1]	MindMatters, KidsMatter
Anti-bullying programs	✓				Bullying. No Way!
Physical activity programs		✓			School-based physical education courses,
Media awareness and reporting guidelines	✓			possible[2]	MindFrame, Response Ability
Restriction of means, legislating for limiting paracetemol and other drug access	✓				Governement legislation
Information and education using new media		✓		possible[3]	headspace, ReachOut!, youthbeyondblue, Headroom, Kids Helpline
Selective approaches	**Strong evidence**	**Moderate evidence**	**Limited evidence**	**Ineffective/ Causes harm**	
Suicide prevention and mental health training for "gatekeepers"		✓			Mental Health First Aid, ASIST (LivingWorks)
Mentoring/peer support programs		✓			Youth Focus (WA), Peer Support Australia, Youth Mentoring Network
Programs for specific high-risk groups of young people		✓		possible[4]	QSPACE, Community Broadcasting Suicide Prevention Project , various across Australia
Postvention programs	✓				StandBy Response Service, Headhigh Support Group, Support After Suicide, Living Beyond Suicide
Indicated approaches	**Strong evidence**	**Moderate evidence**	**Limited evidence**	**Ineffective/ Causes harm**	
Referral programs			✓		CRYPAR Program (QLD), PIM Initiative (QLD)
Crisis support		✓			Lifeline, Kids Helpline, Suicide Call Back Service
Early intervention and treatment activities for individuals at high risk					
Counselling/therapy	✓				headspace centres, private psychologists/ psychiatrists, State-based mental health services
Pharmacotherapy	✓			possible[5]	GPs, psychiatrists, mental health services
Hospital/residential care			✓	possible[6]	Various
Active follow-up care and communication following discharge from hospital	✓				Various
Community-based support/Case management		✓			Various

Footnotes - The following issues are known to have have negative influences on suicidal behaviour

[1] *Programs that address suicide directly, rather than addressing risk factors, may increase a permissive attitude towards suicide and increase suicidality in vulnerable individuals*

[2] *Innapropriate media reporting methods, such as those that describe methods locations, and sensationalise or glorify suicidal behaviour*

[3] *Internet sites that describe methods locations and/or sensationalise or glorify suicidal behaviour*

[4] *Culturally innapropriate programs or programs aimed at incorrect target group*

[5] *Potential increased suicidality amongst adolescents using certain anti-depressant or similar prescription medications*

[6] *Increased suicide risk following discharge from psychiatric care*