

**Submission  
No 41**

## **PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES**

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## Black Dog Institute

### Response to the Terms of Reference

## PARLIAMENT OF NEW SOUTH WALES COMMITTEE ON CHILDREN AND YOUNG PEOPLE: Inquiry into the Prevention of Youth Suicide

### TERMS OF REFERENCE

That the Committee on Children and Young People inquire into and report on the current approaches aimed at preventing youth suicide in New South Wales, with particular reference to:

- a. Any gaps in the coordination and integration of suicide prevention activities and programs across all levels of government
- b. Governance arrangements and accountabilities for suicide prevention
- c. Provision of services in local communities, particularly in regional and rural areas
- d. Provision of services for vulnerable and at-risk groups
- e. Data collection about the incidence of youth suicide and attempted suicide
- f. Provision of high-quality information and training to service providers
- g. Approaches taken by primary and secondary schools
- h. Any other related matters.

The Committee is adopting the definition of 'young person' outlined in the Advocate for Children and Young People Act 2014, which is a person who is 12 years of age or above but under 25 years of age.

### RESPONSE

The Black Dog Institute is pleased to submit a response to the **Inquiry into the Prevention of Youth Suicide**, informed by existing evidence for effective approaches to youth suicide prevention, and proposing an agenda for reform and future research.

#### Context

The Lifespan team at the Black Dog Institute is undertaking a systems approach to suicide targeting the population aged 12 to 90. This approach arose from what we saw as the fragmented and non-data driven approach to suicide prevention, characterised by minimal sector coordination and governance/planning beyond health/mental health, inconsistent approaches to lived experience co-design, almost no measurement, minimal evaluation (unable to measure at present what has been implemented where) and uneven effort, skewed towards popular rather than effective approaches. Our approach involved the simultaneous deployment of 9 evidence-based strategies in regional areas. The 9 strategies are:

1. Improving **emergency and follow-up care** for suicidal crisis
2. Using **evidence-based treatment** for suicidality
3. Equipping primary care to **identify and support people** in distress

4. Improving the competency and confidence of **frontline workers** to deal with suicidal crisis
5. Promoting **help-seeking, mental health and resilience** in schools
6. Training the community to **recognise and respond** to suicidality
7. Engaging the community and providing opportunities to **be part of the change**
8. Encouraging **safe and purposeful media** reporting
9. **Improving safety** and reducing access to means of suicide

We consider this approach to be universal, **and applicable to young people aged 12-25**, who are the target of your review.

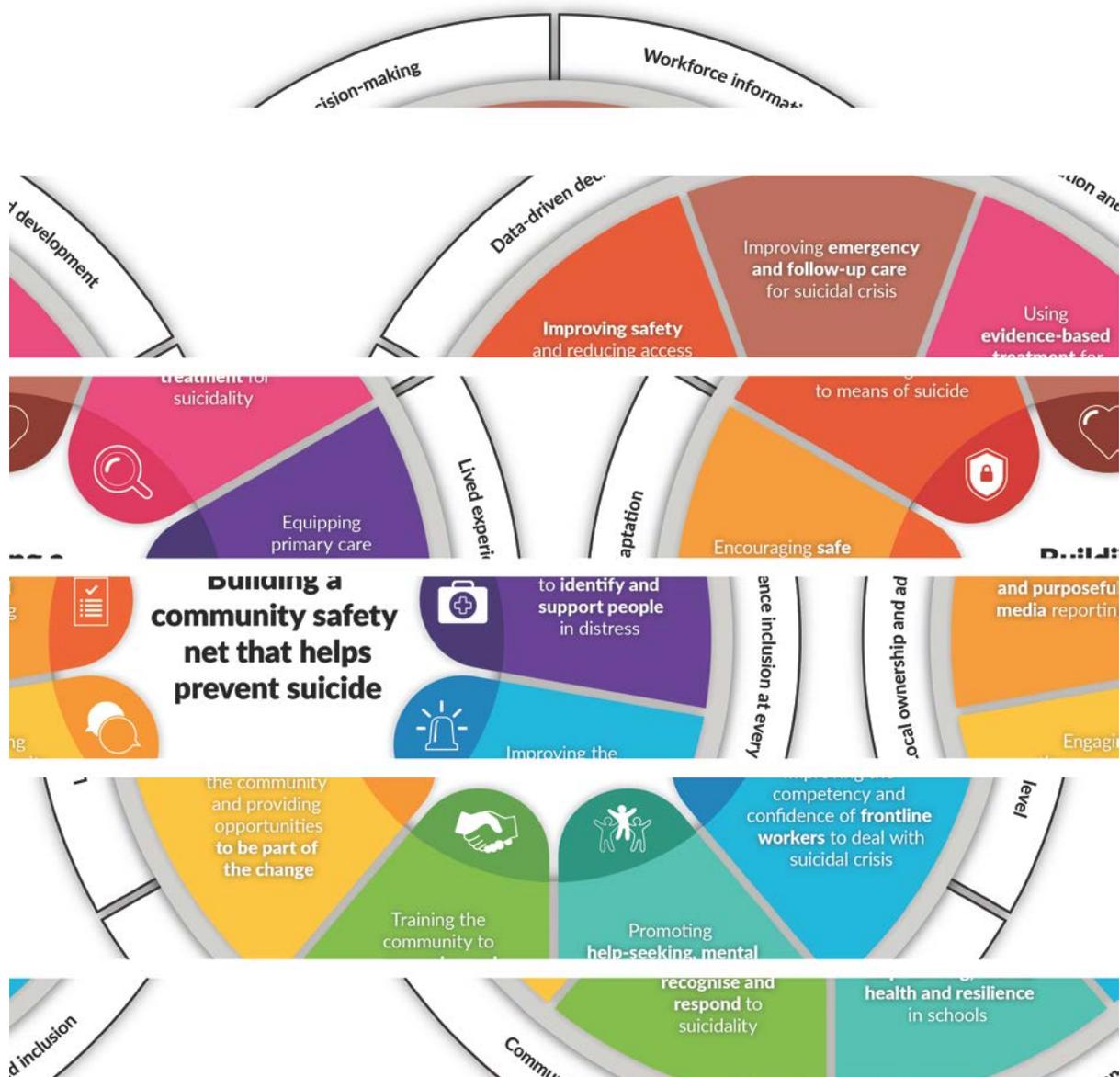


Figure 1: The nine LifeSpan interventions

## **Specific observations relevant to your terms**

### **Any gaps in the coordination and integration of suicide prevention activities and programs across all levels of government**

There exists a range of activities for suicide prevention at individual, local, organisational (work, school), council, health district, primary health care, State and Federal levels. There are attempts to co-ordinate them at the State and Territory, and Commonwealth levels but essentially, the implementation of an integrated plan must involve a regional response in order to align organisations to a framework that is effective and efficient. In the UK, this has been the Trusts, in Australia the approach taken by Commonwealth is through the PHNs. It is important that whatever coordinating mechanism is used, it builds on rather than duplicates efforts already underway, e.g. through the 12 Commonwealth suicide prevention trials. Through LifeSpan we have developed an implementation framework for coordinating and integrating regional suicide prevention efforts.

### **Governance arrangements and accountabilities for suicide prevention**

Currently, there are no clear governance arrangements for the sum of the many regional, State, or Commonwealth activities that underpin suicide prevention. We recommend that suicide prevention activities require oversight by one agency or organisation in order to ensure that duplication of effort is reduced, and outcomes from activities are clearly measured and monitored for impact. Given that suicide prevention extends beyond the health sector, the overseeing organisation would ideally have some influence across sectors such as education and juvenile justice. The governance of suicide prevention activities also requires that organisations involved in suicide prevention have adequate knowledge of implementation practice.

This oversight and co-ordination role would need to monitor, evaluate and assess the activities supported by State and Commonwealth governments, plus those undertaken regional organisations, such as PHNs. Input would be required from education departments, peak organisations, and not for profit and community organisations.

### **Provision of services in local communities, particularly in regional and rural areas**

A key to effective suicide prevention is access to treatment. This can be difficult in local communities, where there may be an absence of psychiatrists, psychologists and GPs with experience. Headspace Centres are also not available in each rural area. Additionally, the 9 strategy Lifespan framework will need to be modified to take into account the strengths of the community and the resources that can be adapted.

In addition, e-health services, telepsychology and tele-psychiatry may provide some alternative input. Extending the Lifeline model of crisis intervention so that it includes evidence-based web programs to support people beyond their initial call for help has been successful in trials. We recommend that this model be trialled more extensively, including

with Kids Helpline and potentially linking in resources from ReachOut, Headspace online, and other youth-appropriate e-health services.

### **Provision of services for vulnerable and at-risk groups**

Young Indigenous people are at greater risk of suicide. We have developed an app for young Indigenous Australians (iBobbly), currently under trial nationally. A small trial shows that it reduces depression and distress in young people in The Kimberley (Tighe et al., 2017). We are also partnering with Aboriginal communities in Central Australia to develop an app with a more culturally traditional approach to suicide prevention and wellbeing, Kurdiji 1.0. The LifeSpan framework is being rebuilt in partnership with the Poche Centre at UWA to be suitable for Indigenous communities.

Although the increased risk of suicide for young LGBTIQ people is widely acknowledged, one of the major gaps in evidence is in programs to prevent suicide for these young people. This should be an area of focus for research funding.

Young people with serious mental illness (such as psychotic disorders and eating disorders) are also at increased risk. Early intervention programs should be part of the prevention strategy, along with improving treatment and increasing access to treatment.

### **Data collection about the incidence of youth suicide and attempted suicide**

A data-informed approach is essential to ensuring effective targeting of youth suicide prevention efforts. Good data allows for: (1) identification of genuine suicide clusters (and to allay community fears where there is no cluster); (2) service and intervention planning; (3) targeted means restriction activities. A registry would allow for better access to data to meet these needs. Given that there will be low numbers of suicide deaths within a region (the level where planning needs to occur), a more informative approach would be to access and code police, ambulance, and hospital data to capture changes in attempts as well as deaths. The development of a suicide audit process has been undertaken at the Black Dog Institute. It can provide data on young people's suicide. We recommend that dedicated funds be provided in order to continue to build and expand on this rich data set.

### **Provision of high-quality information and training to service providers**

#### Training for health professionals

There are a number of treatment approaches that appear to be effective for young people at risk of suicide (e.g. CBT for suicide prevention, problem solving therapy, some family therapies). These are typically the domain of psychologists and youth counsellors and should be made accessible to these workforces. Additionally, when young people seek professional help for their mental health, it is often from familiar sources like a family doctor or school-based counsellor. Black Dog Institute's Advanced Training in Suicide Prevention is an accredited workshop that builds GP skills in recognising and assessing suicidality, needs-based safety planning, collaborative treatment planning and management. Black Dog Institute is currently adapting Advanced Training in Suicide

Prevention specifically for school psychologists and counsellors. The modified program will focus on working with youth in distress and will address topics of depression, anxiety, self-harm, and suicide prevention. Delivery of the first pilot (December 2017) will target secondary schools in NSW, Australia.

### Training programs for community-based support (Gatekeeper training)

Suicide prevention training targeted at key individuals who are likely to come into contact with at-risk youths can be crucial to preventing youth suicide (Kalafat & Ryerson, 1999). Training strategies should be structural in nature, ensuring that people in various roles who might interact with young people are prepared to identify and respond to someone who is feeling suicidal. Gatekeeper training has been tested in a variety of populations, with positive impacts on help-seeking behaviours. In particular, teachers, school counsellors, and child welfare, juvenile justice and youth health workers who received gatekeeper training reported significant increases in referral behaviours and knowledge about suicide (Reis & Cornell, 2008). Individuals within sectors who do not necessarily work closely with youths but who might nevertheless have an impact, such as police officers, first responders, primary care providers, social workers, and mental health care providers, have also been found to benefit from suicide prevention training (Bean & Baber, 2011).

Many young people do not seek help from adults (Rickwood, Deane, & Wilson, 2007), so it is also important to train youths in suicide prevention. Trained youths can then intervene when they identify a peer who might be suicidal, and support them to seek help from an appropriate adult or health professional (Bean & Baber, 2011).

What remains largely unknown is the impact that gatekeeper training has on treatment uptake and suicide outcomes for young people, and this is an area for future research.

### **Approaches taken by primary and secondary schools**

#### Evidence-base for school based programs

A range of prevention programs can lower the risk of suicide. Currently, these programs are not introduced into classrooms. Most schools are unsure of what programs they should use, should they want to improve mental health of the students.

**We take a strong preventative approach to suicide within schools:** depression is a key risk factor for suicide. Depression is one of the leading causes of disease burden in children and adolescents aged 10 to 24 years (Gore et al., 2011), with the disorder often taking a chronic, recurrent, and episodic course (Merry, McDowell, Wild, Bir, & Cunliffe, 2004). Some of the negative effects associated with depressive disorders include poor academic performance, physical ill health, family and social dysfunction, low self-esteem, and suicide (Johnson & Greenberg, 2013; Merry et al., 2004). Depression is also often co-morbid with a number of other psychiatric conditions in children and adolescents, including anxiety, attention deficit hyperactivity disorder, conduct disorder and substance use disorders (Thapar et al., 2012). If left untreated, the negative effects associated with depression can continue into adulthood where further social, occupational, and economic difficulties can arise (Thapar et al., 2012).

A range of online and face-to-face programs are available, with online programs demonstrating effectiveness for this age group.

**We recommend all year 9 students undertake one of the evidence-based cognitive behavioural therapy programs for the prevention of depression.**

- Use screening and integrated platforms to identify students at risk, triage their severity, and facilitate help-seeking. The Black Dog Institute has developed an online mental health service (called Smooth Sailing) that utilises the internet to screen students' mental health, allocate them to a severity "step" and link them in with clinical services (e.g. school counsellor). This service model is based on stepped care, and integrates evidence-based Internet e-health interventions (e.g. online psycho-education, online cognitive behavioural therapy) where appropriate. It uses sophisticated IT solutions to administer a service for use within the classroom setting, with an alert system for school counsellors and other nominated carers. This service has been trialled in four secondary high schools. It has led to greater rates of identification, particularly for suicidal thinking and self-harming behaviour. School counsellors using the service report increased exposure within the school, greater ability to identify students in need, higher rates of student access, and an overall confidence in the service to support their clinical role within the school system.

**We recommend that a review and trial is undertaken to evaluate the usefulness of screening and intervention platforms such as Smooth Sailing**

- Tackle suicide risk in schools using evidence based programs, including those that improve help-seeking.

**YAM:** Youth Aware of Mental Health (YAM) is a school-based suicide prevention program developed by researchers and clinicians from the Karolinska Institute in Sweden and Cornell University in the US, and has been adapted for use in Australian schools and is currently being delivered in four LifeSpan regional trial sites (up to 121 schools in Newcastle, Illawarra Shoalhaven, Central Coast, and Murrumbidgee). It is a universal intervention, meaning it applies to all students rather than being targeting to specific groups. Its primary aim is to reduce suicidal behaviour. In European trials across ten countries, 168 schools and over 11,000 young people, YAM has been shown to reduce depression and anxiety, suicide attempts, and severe suicidal ideation and facilitates healthy lifestyle choices among young people (Wassermann et al, 2015). The Australian trial will evaluate the effectiveness of the YAM intervention for decreasing suicidal behaviour in young people. The NSW Department of education has trained 19 YAM instructors and allocated significant resources to the delivery of YAM in NSW trial schools. An Aboriginal and Torres Strait Islander review of the program is also currently underway.

**Sources of Strength:** The Sources of Strength program utilises peer leaders to improve help-seeking for suicide and general psychological distress by enhancing help-seeking norms, youth-adult communication, and coping skills through whole school messaging (Wyman et al., 2010). The Sources of Strength program has been

evaluated in a randomised controlled trial of 18 high schools in the USA, with results showing consistent intervention effects on the help-seeking norms, attitudes and behaviour of both youth peer leaders and the wider student population. The program increased perceptions of adult support for suicidal youth and the acceptability of seeking help (Wyman et al., 2010). A current trial is underway in Australia (Calear et al., 2016) to evaluate the impact of this program on both help-seeking behaviours and psychological outcomes, including depression. Further research is needed to develop the evidence-based for different social connectedness interventions in the school environment, which have the potential to positively change social norms and behaviour.

**SOS: The Signs of Suicide (SOS)** prevention program has demonstrated a reduction in suicide attempts and improvement in students' knowledge and adaptive attitudes about suicide risk and depression. Listed on SAMHSA's National Registry of Evidence-based Programs and Practices, the SOS Program has shown a reduction in self-reported suicide attempts by 40-64% in randomized control studies (Aseltine et al., 2007 & Schilling et al., 2016). SOS targets high school aged young people and can be implemented in one class period by existing faculty and staff.

**The Good Behaviour Game (GBG)** has been extensively tested in randomised controlled trials in the United States and in Europe. GBG encourages pro-social behaviour in the first two years of school and has demonstrated long-term reductions in suicidal behaviour, substance use, and antisocial behaviours. The Black Dog Institute has applied for funding to pilot this approach in New South Wales primary schools.

**We recommend that these programs be systematically offered in every primary and high school in Australia.**

#### **Any other related matters**

The development of better suicide prevention will come about through understanding the causes of suicide and the best interventions and treatments for whom and when. Currently suicide research receives relatively little funding, and lags behind cancer and cardiovascular disease as a target for NHMRC and philanthropic funding. The priorities for suicide prevention research in young people include:

- An analysis of the effect of social media on suicide risk and the use of social media posts as indicators of distress. Almost all young people use social media. The impact is unmeasured and the usefulness of posts about suicide thoughts untested, although preliminary work has been undertaken by our team.
- An examination of the potential for signals on smartphones to be able to indicate changes in risk profile (such as social withdrawal) as a way to identify risk in young people who do not talk about their feelings or seek help.
- A trial of ketamine in young people, given its potential effectiveness in preventing suicide in older adults

- Continued evaluation of app based interventions for young people, delivering therapy and offering safety nets
- Trials to evaluate the effects of establishing better sleep patterns on suicide ideation
- Mental health literacy for those in high risk occupations
- Interventions to reduce discrimination and stigma around mental health problems.
- Innovative suicide means restriction techniques such as beacons, pulse oximetry for inpatient psychiatric settings, and analysis of security camera footage in suicide prevention
- Investigation of the effectiveness of peer and volunteer supports during and after a suicidal crisis

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