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Foreword from the Minister of Youth Affairs

Suicide is second only to motor vehicle crashes as the main cause of death among young New Zealanders aged 15-24 years. In 1997, 142 young people died by suicide. Government agencies, health professionals, and community groups need to work collaboratively to reduce this number.

The risk factors associated with youth suicide are complex. There is no single way to prevent youth suicide. Reducing the prevalence or impact of the risk factors linked with youth suicide requires work in many areas.

The National Youth Suicide Prevention Strategy, released in March 1998, provides a framework to help co-ordinate both government and non-government work to prevent youth suicide. The Strategy focussed attention on the need to improve information on suicide prevention for people who are in positions to help young people who are at risk of suicide.

Primary health providers can play a key role in helping to reduce youth suicide. Approximately 90% of young people who die by suicide are likely to have had one or more recognisable mental health disorders at the time.

This guideline aims to be of practical assistance to general practitioners, and practice, public health, and student health nurses. The guideline focuses on helping primary health providers recognise young people at risk of suicide, manage their care, and make well-informed referrals to secondary services. A key part offers guidance to support primary health workers provide a youth friendly practice.

The guideline fits into other work under the Strategy, including:

- the publication of guidelines and provision of training for schools on the prevention, recognition, and management of increased suicide risk
- the publication of resources for parents and caregivers on recognition of and response to increased suicide risk
- the creation of the National Youth Suicide Prevention Community Liaison Service and
- the expansion of the child and youth mental health services.

This guideline, combined with other government and community initiatives, will strengthen and support all of us in reducing youth suicide. It is the responsibility of the whole New Zealand community to nurture and support our young people as they develop into adults.

Tony Ryall
Minister of Youth Affairs



Introduction

AIM OF THE GUIDELINES

The aim of these guidelines is to assist primary care providers to recognise young people at risk of suicide and provide appropriate management or well informed referral to secondary services. Young people are defined in the guidelines as being between 12 and 25 years of age. The guidelines are designed for general practitioners, practice nurses, public health nurses and school or educational institution nursing staff. They have been developed by a working party of key individuals utilising an extensive literature review (see appendix 6 for the process used during the development of the guidelines and the members of the working party, and appendix 7 for details on the literature review).

The publication is produced in three forms:

- Guidelines for Primary Care Providers: Detection and Management of Young People at Risk of Suicide
- A Quick Reference for Primary Care Providers: Detection and Management of Young People at Risk of Suicide
- Summary Sheet: Prevention of Suicide in Young People

It is intended that the guidelines document becomes a tool for the planned national implementation strategy. It may act as a resource for issues that arise out of planned Continuing Medical or Nursing education and General Practice or Nursing training. The Quick Reference and Summary Sheet are intended as a decision aid for health professionals to assist when needed during or close to the time of the consultation. As with all guidelines they are designed as a decision aid to complement the primary health provider's expertise and not to substitute for their clinical judgement.

These documents are available by contacting:

The Royal New Zealand College of General Practitioners
PO Box 10440
Wellington
Ph: 04 496 5999 Fax: 04 496 5997

The complete guidelines are also available electronically from the:

- RNZCGP website (www.rnzcgp.org.nz)
- National Health Committee, Guidelines Group website (www.nzgg.org.nz).

Evidence based

The guidelines are evidence based, the levels of evidence are graded using an adapted version of the US Preventive Services Task Force protocol (US Preventive Services Taskforce, 1989). The working party has combined evidence-based technology with best practice principles, bridging the gaps with expert opinion and the working party's experience. Where evidence is not graded, statements are made on the basis of expert opinion. Readers wishing to read a critical appraisal of the literature on which this guideline is based should refer to *Youth Suicide Prevention by Primary Healthcare Professionals: A critical appraisal of the literature*, NZHTA, 1998 (see appendix 7).

- I Evidence obtained from at least one meta-analysis
- II Evidence obtained from at least one randomised controlled trial or from at least one controlled trial without randomisation
- III Evidence obtained from at least one cohort analytical study, preferably based in more than one centre or research group, or evidence obtained from at least one case control analytical study, preferably based in more than one centre or research group
- IV Evidence obtained from at least one study that has used a primarily descriptive study design such as a cross sectional, ecological or time series methodology
- V Opinions of respected authorities based on clinical experience, or reports of expert committees.



Suicide in young people: the extent and nature of the problem

BACKGROUND TO THE PROBLEM OF SUICIDE IN YOUNG PEOPLE

In recent years, considerable concerns have arisen about the issue of suicide among young people in New Zealand. These concerns have been stimulated by two lines of evidence.

Firstly, international comparisons have suggested that New Zealand has one of the highest rates of suicide in young people among developed countries (World Health Organization, 1996). Figure 1 compares the suicide rate for New Zealand males aged 15-24 years with suicide rates for 12 industrialised countries, using the most recent data available for each country. The suicide rate for young males in New Zealand (40.9 deaths per 100 000 in 1997) (New Zealand Health Information Service, 1999) was significantly higher than corresponding rates in recent years in Canada (24.7 per 100 000), the United States (23.4) and the United Kingdom (11.0).

Figure 1: Male Suicide rates (15-24 years) for selected OECD countries

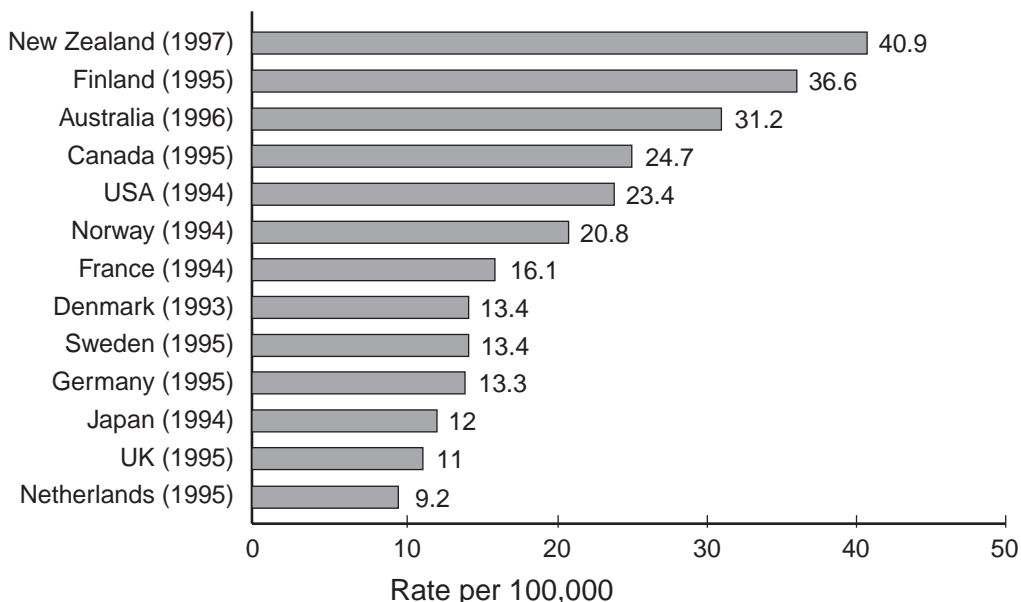
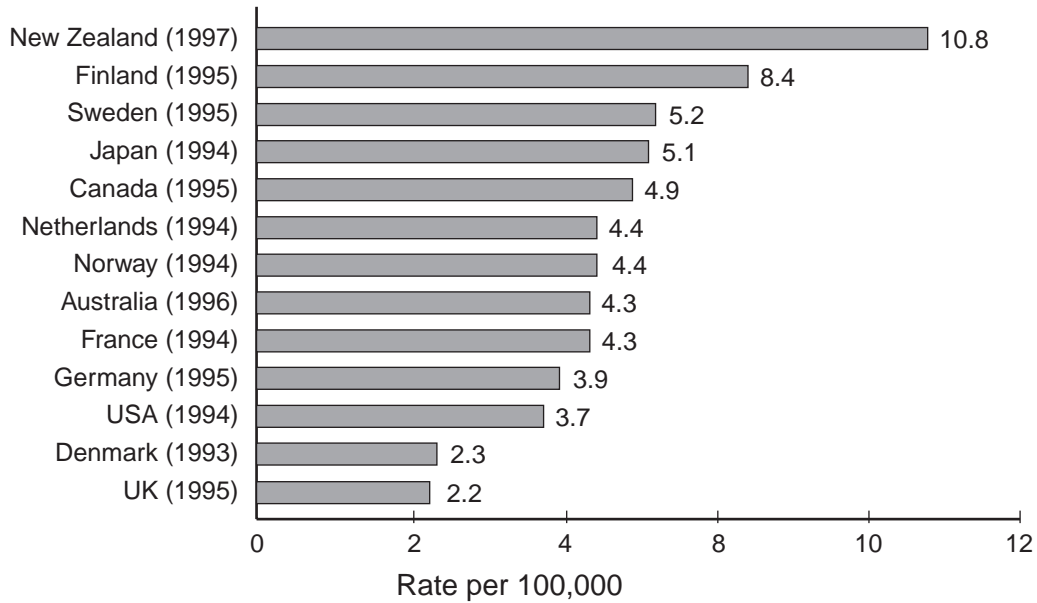


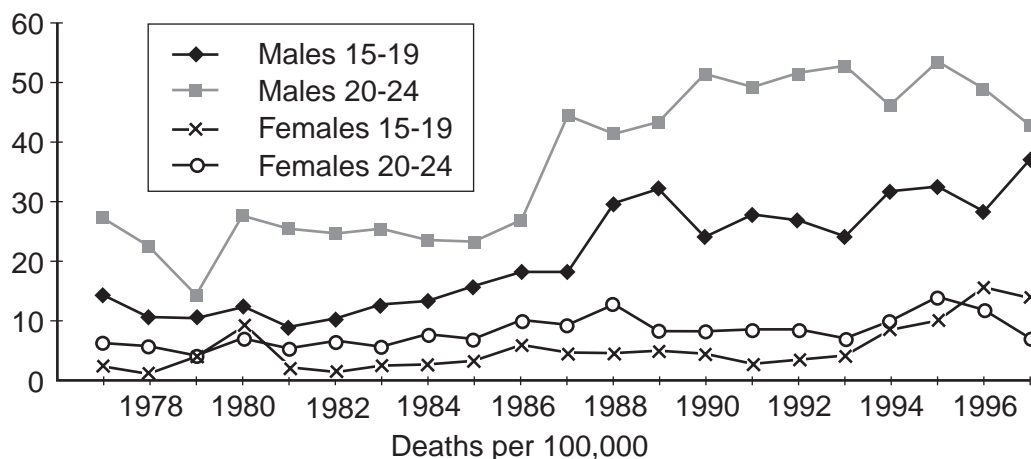
Figure 2 shows corresponding rates of suicide for females aged 15-24 years. While, almost universally, female suicide rates are much lower than those for males, New Zealand has also recorded the highest suicide rates for females aged 15-24 years (10.8 per 100 000 in 1997) during recent years. Comparative rates in Australia (4.3 per 100 000), the United States (3.7) and the United Kingdom (2.2) were all lower than in New Zealand.

Figure 2: Female suicide rates (15-24 years) for selected OECD countries



The second line of evidence is derived from historical time series analyses which show a marked increase in suicide rates among young people in New Zealand during recent decades. Figure 3 shows New Zealand suicide rates for males and females aged 15-19 years and 20-24 years from 1977 to 1997. During this time the suicide rate for males aged 15-19 increased two and a half fold from 14.5 deaths per 100 000 to 38.1 deaths per 100 000. For males aged 20-24 the suicide rate increased 1.6 times (27.4 deaths per 100 000 in 1977 to 43.7 deaths per 100 000 in 1997). For females, the suicide rate has always been markedly lower than that for males, but among young females aged 15-19 years it increased seven-fold from two deaths per 100 000 in 1977 to 14.4 deaths per 100 000 in 1997. For females aged 20-24 the suicide rate remained stable during this time (6.3 deaths per 100 000 in 1977; 7.3 deaths per 100 000 in 1997). Because of the small numbers of female suicides however, these data must be interpreted with some caution.

Figure 3: New Zealand youth suicide age specific rates, by gender, 1977 - 1997



The recent increase in suicide amongst young people in New Zealand now means that youth suicide accounts for 26% of all suicides in New Zealand, despite young people aged 15-24 years making up only 15% of the population (in 1996 there was a total of 540 suicides in New Zealand, 143 of these were in the 15-24 age group).

THE SPECTRUM OF SUICIDAL BEHAVIOURS IN YOUNG PEOPLE

While public attention has tended to focus on completed suicide, there is evidence of a range of suicidal behaviours which extend from thoughts and ideas about suicide which are never acted upon through suicide attempts of varying degrees of medical severity to completed suicide.

Suicidal ideation

Research evidence suggests that a significant minority of young people may have suicidal thoughts and ideas, with the majority not acting upon these ideas. New Zealand studies have suggested that, by 16 years, 15% of young people reported a lifetime history of suicidal ideation; by 18 years, this had increased to 22.7%, and by 21 years, 29% reported suicidal ideation (Coggan et al, 1995 III; Horwood and Fergusson, 1998 III; Fergusson, personal communication III).

These findings are consistent with those in the international literature, and suggest that, in general, up to 25% of young people may have suicidal ideation at some time. This evidence suggests that, for most young people, suicidal ideation is common and, in the absence of other risk factors for suicidal behaviour, not a risk factor for subsequent suicide. Nevertheless, among those who do report suicidal ideation, there is a small group with persistent suicidal ideation associated with significant mental health problems who are at risk for subsequent suicide attempt behaviour and suicide.

Suicide attempt

A second category of suicidal behaviours includes suicide attempts, which may range from the minor to the medically severe. Results from a large number of community surveys are broadly consistent in suggesting that between 2% and 12% of young people report a lifetime history of suicide attempts.

A New Zealand study found that 3% of young people had attempted suicide by age 16 years; 5.4% reported having made an attempt by 18 years and 7.8% by 21 years (Horwood and Fergusson, 1998 III; Fergusson, personal communication III). These findings are consistent with international research findings (Andrews and Lewinsohn, 1992; Dubow et al, 1989; Reinherz et al, 1995; Shaffer et al, 1990b; Velez and Cohen, 1988 III-IV).

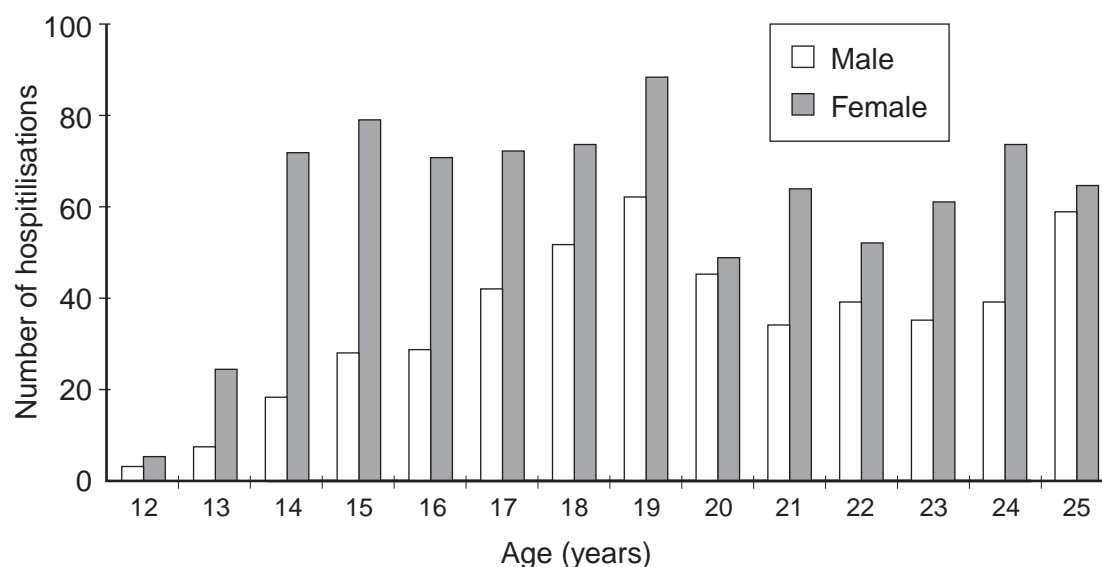
In general, the weight of evidence suggests that most suicide attempts by young people result in no more than minor physical harm, and are not undertaken with serious intent to die. Nevertheless, a small group of young people with persistent suicidal ideation and serious suicide attempt behaviour are at high risk for further suicide attempts and for suicide. Research findings suggest that, among suicide attempters of all ages, approximately 0.5-1% will subsequently die each year by suicide (Granboulan et al, 1995 III; Kerfoot and McHugh, 1992 III; Kotila and Lonnqvist, 1989a III).

One useful indication of serious suicide attempt prevalence is provided by hospitalisation data. Hospitalisation refers to admission to hospital for treatment following suicide attempt incidents, and does not include treatment at Accident and Emergency Departments with discharge home.

Figure 4 shows the number of young people admitted to hospital in New Zealand during 1996/1997 following suicide attempts. In total, 1342 young people aged 12-25 years were admitted to hospital. The majority of those admitted (68.2%) were female. For females, the risk of suicide attempt requiring hospitalisation is highest among younger individuals aged 14-19 years, reaching a peak at age 19 years and declining very slightly with increasing age. By contrast, for young males, the risk of hospitalisation for suicide attempt tends to increase with increasing age, reaching a peak at age 19 years and then declining slightly with age.

These hospitalisation data suggest that, on average, a general practice could expect approximately one young person every two years to be referred back to the practice following hospitalisation after a suicide attempt.

Figure 4: Hospitalisation following suicide attempts, 1997/1998, by gender and age



Suicide in young people

Data relating to the number of presentations to Accident and Emergency Departments which do not result in hospital admission are not collected routinely on a national basis. Data from a survey of management practices in New Zealand public general hospitals suggested generally limited data recording and wide variation in the provision of services and management of suicide attempt presentations (Hatcher, 1997 IV).

Most hospitals are not able to provide information on what proportion of patients who presented following a suicide attempt were subsequently admitted. Those hospitals able to provide this information found that between 40% and 60% of such cases were admitted. Most hospitals are not able to provide information on what proportion of suicide attempt patients were discharged to the care of their general practitioner with no other follow-up. Of those hospitals that were able to provide this information, most discharged 10-20% back to their general practitioner with no other management plans (Hatcher, 1997 IV).

Suicide

Despite increasing rates of suicide among young people in New Zealand, suicide is still rare and a far less frequent occurrence than suicidal ideation and suicide attempt behaviour in young people. In New Zealand in 1997, a total of 142 young people aged 15-24 years died by suicide. This represents a suicide rate for young males for this age group of 40.9 per 100 000, and a suicide rate of 10.8 per 100 000 for females of the same age.

Summary

The research and health statistical evidence suggests that in New Zealand, among young people aged 15-24 years:

- Up to one quarter of young people will experience suicidal thoughts and ideas, with the majority not acting on these thoughts
- Up to one in ten young people will make a suicide attempt, with most of these attempts being of minor medical severity and not requiring medical attention
- Up to one in 500 young people will make a serious suicide attempt requiring hospitalisation
- One in almost 4000 young people will die by suicide.

It should be noted that these figures are population averages and do not necessarily apply to all regions and to all general practices. The features of some general practices, including, for example, location within a region of socioeconomic disadvantage or in proximity to a psychiatric hospital, together with the fact that suicides may cluster, mean that some practices will be more likely than others to have young patients who attempt suicide or die by suicide.

Age and suicidal behaviour

Suicide among children under the age of 10 is very rare. Suicide among those aged 10-14 is also uncommon; in New Zealand in 1997 there were eight suicides among 10-14 year olds.

Until recently, the risk of suicide among young people aged 15-24 years tended to increase with age. However, in recent years suicide rates among 15-19 year olds have tended to converge with those of 20-24 year olds. In New Zealand in 1997, the rate of suicide was 38.1 per 100 000 among males aged 15-19 years, and 43.7 per 100 000 among males aged 20-24 years. For females, the suicide rate in 1997 was twice as high among those aged 15-19 years (14.4 per 100 000) than among those aged 20-24 years (7.3 per 100 000).

Gender and suicidal behaviour

The relationships between gender and suicidal behaviours are complex. In general the rate of suicide among young males is four to five times higher than the corresponding rate for female suicide, although recent trends suggest that the male:female suicide ratio for young people in New Zealand is decreasing.

In contrast, females more frequently make suicide attempts which do not result in death, with community surveys suggesting that females make suicide attempts at approximately twice the rate of males. In New Zealand, hospital admission rates following suicide attempts are approximately one and a half times higher for females aged 15-24 years compared with males of the same age (Ministry of Health, 1999). Similar trends for suicidal ideation to be higher in females have also been reported.

The tendency for young females to make more suicide attempts than males of the same age may reflect the fact that young females are more likely to develop depressive and anxiety disorders than males (Fergusson and Lynskey, 1995a III). The tendency for young males to more often die by suicide, despite the fact that females make more suicide attempts, is explained substantially, but not completely, by the fact that males tend to use methods of suicide attempt (hanging, carbon monoxide poisoning, gunshot) that are more lethal than overdose, which is the predominant method of suicide attempt used by females.

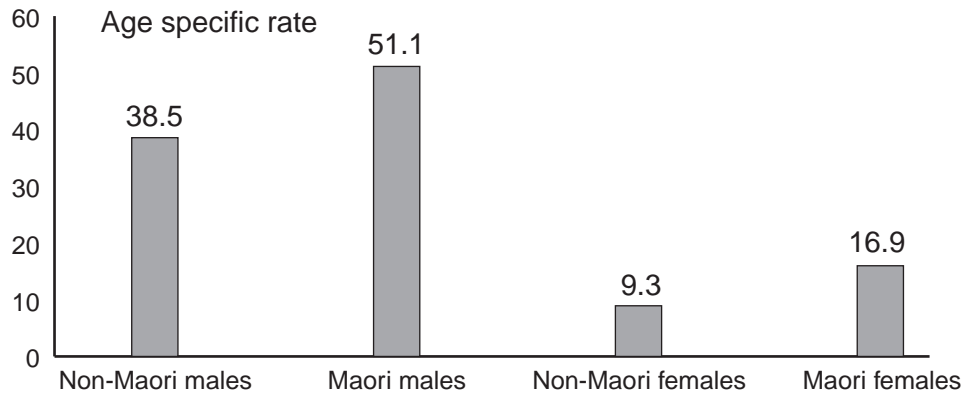
Ethnicity and suicidal behaviour

Interpretation of ethnic specific data and trends in suicidal behaviour in New Zealand has been difficult because of historical inconsistencies in the classification of ethnicity, and because the small numbers involved in both Māori female suicides and Pacific people's youth suicides make these data very unstable. In late 1995, the definition of ethnicity on New Zealand death registration forms was changed from a biological concept to one of self-identification. As a consequence, ethnic specific data prior to, and after, 1995 are not directly comparable. 1996 is the start of a new time series for ethnic specific rates.

In 1997, the available evidence suggested:

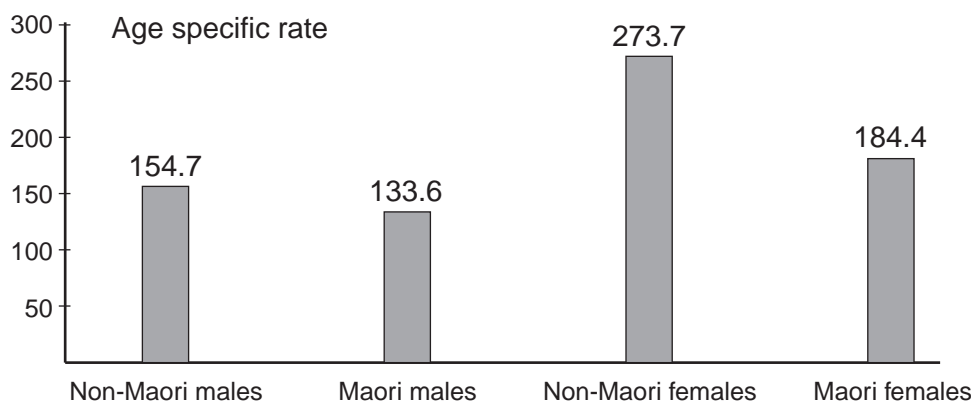
- Of the total number of suicides among 15-24 year olds in New Zealand (142), there were 36 deaths (29 male, nine female) among young Māori people.
- The suicide rate for young Māori (33.9 per 100 000) was higher than that for non-Māori (24.2 per 100 000). Figure 5 compares youth suicide rates for 1997 by gender and by ethnic group.

Figure 5: Suicide rates for young people aged 15-24 years, for Māori and non-Māori, by gender, 1997 (rate per 100 000)



- While research evidence suggests that suicide attempt rates (including those which result in hospital admission and those which do not) are higher among young Māori males compared with non-Māori males (Coggan et al, 1995 III; Fergusson and Horwood, 1997 III), statistical data show that hospital admission rates for suicide attempts are higher in the non-Māori, compared to the Māori, population, for both young males and females. These data are illustrated in Figure 6 which shows hospital admissions for 1996/1997 by gender and by ethnic group.

Figure 6: Rates of hospital admission for suicide attempt for young people aged 15-24 years, for Māori and non-Māori, by gender, 1996/1997 (rate per 100 000)



- There were seven suicides reported among Pacific young people (seven male deaths, and no female deaths).

In general, the current research evidence tends to suggest higher rates of suicide and, perhaps, attempted suicide among Māori than non-Māori youth. However, the majority of suicides and attempted suicides occur in non-Māori because of the higher proportion of non-Māori in the general population.



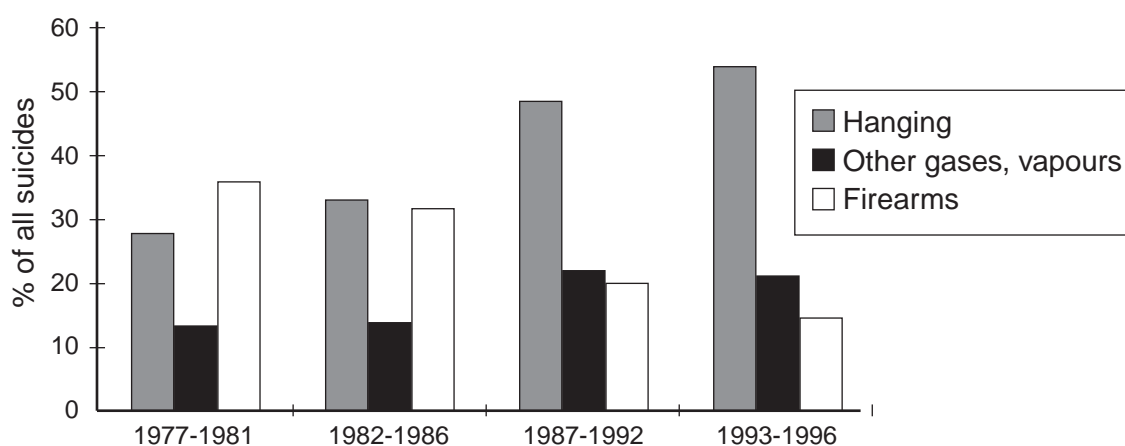
METHODS OF SUICIDE AND SUICIDE ATTEMPT

Methods of suicide

In New Zealand the most common method of suicide among young people is hanging, which, in 1996, accounted for two thirds (67.6%) of suicides in young males (15-24 years) and a little under half (44.7%) of suicides among young females. Carbon monoxide poisoning was the second most common method, accounting for 15% of suicides among young males and 29% of suicides among young females in 1996. Other methods included firearms, used in 7.6% of suicides among young males in 1996, and overdose or poisoning, which accounted for 21% of suicides among young females in 1996.

During the last two decades there have been clear changes in the methods of suicide used by young people in New Zealand. Since the number of annual events for each method of suicide can be small, five year average rates were derived for each method. Figures 7 and 8 shows five year averages of the proportion of all male and all female suicides among young people for a range of common methods of suicide for the period from 1977 to 1996.

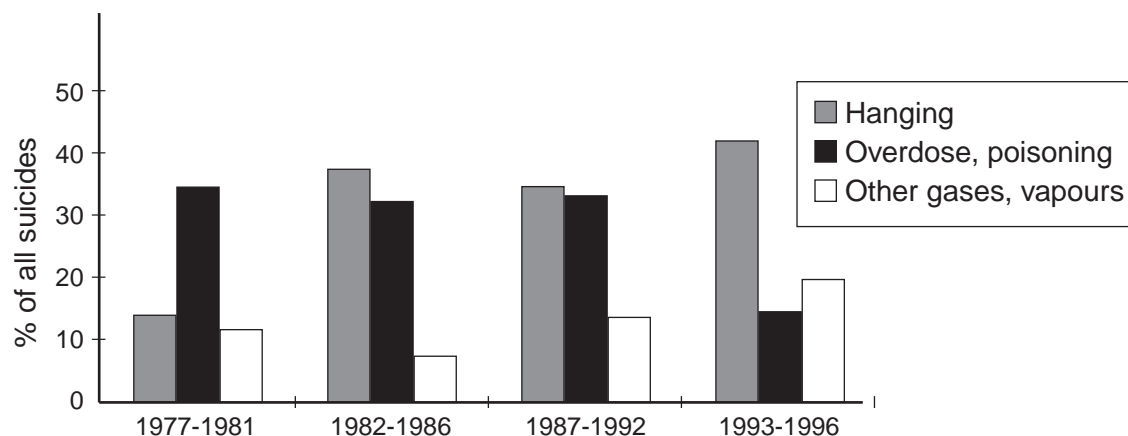
Figure 7: Suicides by selected methods, as a proportion of all suicides, for males aged 15-24 years (five year averages, 1977-1996)



Several trends emerge from examination of Figure 7. For males:

- The use of hanging has more than doubled within the last two decades. During the five year period from 1977 to 1981 hanging accounted for an average of 27% of all suicides among young males annually; by 1993-1996 the proportion of male suicides accounted for by hanging had increased, on average to 53.8% annually
- At the same time there has been a significant decrease in the use of firearms for suicide. On average, firearms accounted for one third (35.7%) of all suicides among young males during the period 1977-1981. However, by 1992-1996, firearms were used, on average, in only 14.4% of all such suicides annually and, by 1996, firearms accounted for only 7.6% of suicides among young males
- The proportion of suicides among young males accounted for by carbon monoxide vehicle exhaust gas showed a slight increase during the two decade period, from an annual average of 13.2% of male suicides during 1977-1981 to an annual average of 20.8% in 1992-1996.

Figure 8: Suicides by selected methods, as a proportion of all suicides, for females aged 15-24 years (five year averages, 1977-1996)



For females, the small number of suicides warrants caution in interpreting trends in method usage during the last two decades. The available evidence, summarised in Figure 8, suggests that three trends emerged during this time:

- The use of hanging trebled among young females. While hanging accounted for, on average, 14.1% of all suicides among young females annually in 1977-1981, this proportion increased to 41.7% annually, on average, in 1992-1996
- The use of overdose or poisoning tended to decrease. For 1977-1981, overdose or poisoning accounted for one third (34.8%) of suicides among young females annually, but by 1992-1996 this proportion had decreased to an annual average of 24.6%
- The use of carbon monoxide poisoning by vehicle exhaust tended to increase. While this method accounted for, on average, 11.4% of all suicides among young females annually in 1977-1981, the use of carbon monoxide poisoning increased to account for almost one in five (19.8%) suicides among young females in 1992-1996.

Methods of suicide attempt

The methods of suicide attempt which do not result in death differ from those used for suicide. While hanging and carbon monoxide poisoning are the predominant methods of suicide, the most common method of suicide attempt is, overwhelmingly, drug overdose, accounting for 85.3% of all hospitalisations for suicide attempts among young people aged 15-24 years in New Zealand in 1996/1997 (New Zealand Health Information Service, 1999).

Among those of all ages who present to hospital Accident and Emergency Departments with suicide attempt overdoses, the most common drugs ingested are antidepressants (approximately 25%), hypnotics/anxiolytics (25%), paracetamol (17%) and antipsychotics (16%) (Hall et al, 1994 IV). Recent observations suggest the use of antidepressants and paracetamol for overdose is increasing.

In a New Zealand study which found that three quarters (78.3%) of all hospital admissions for medically serious suicide attempts among young people under the age of 25 years involved drug overdose (Beautrais, 1996 III), there were clear differences by age in the types of drugs used for overdose. Teenagers who made serious suicide attempts by overdose tended to use paracetamol more often, while those in the older age bracket (20-24 years) more frequently used tricyclic antidepressants.

While suicide attempts by overdose have increased among young people, it should be noted that self-poisoning remains a method of suicide attempt which is of low morbidity and mortality, with estimates suggesting a mortality rate of approximately 1% among those known to have taken overdoses.

RISK FACTORS FOR SUICIDE IN YOUNG PEOPLE

During the last decade there has been an increasing amount of research into the risk factors which distinguish those young people who make suicide attempts or die by suicide from those who do not. This research has clearly established that suicidal behaviour in young people is frequently the endpoint of a multicausal process in which risk factors accumulate to influence risk. The research evidence suggests that risk factors for suicide and attempted suicide in young people may be classified into several broad domains of related risk factors. These domains are:

- Genetic and biologic factors, which may influence individual vulnerability to suicidal behaviour
- Social and demographic factors, which provide contextual factors which may influence both an individual's predisposition to suicidal behaviour and their expression of such behaviour
- Family characteristics and childhood experiences including parental disharmony and separation, parental psychopathology, poor inter-familial communication and exposure to sexual and/or physical abuse during childhood, which may influence an individual's longer-term vulnerability to mental disorder and suicidal behaviour
- Mental disorders, including, in particular, depressive disorders, substance use disorders and antisocial behaviours, which are frequently precursors of suicidal behaviour
- Personality factors and cognitive styles which may reflect individual variations in temperament or related factors which may act to encourage the development of suicidal behaviour
- Stressful or adverse life events or circumstances which may precipitate suicidal behaviour.

This range of risk factor domains suggests that individual risks of suicidal behaviour result from a large number of factors, which reflect biologic and genetic influences, social, family, and environmental influences, and individual temperament and vulnerability to mental disorder. The likely contribution of each risk factor domain to risk of suicidal behaviour is discussed below.

Genetic and biological risk factors

There is some evidence, from twin and adoption studies (Roy et al, 1991 III) and from family studies (Brent et al, 1996), that suicidal behaviour runs in families, suggesting a possible role of genetic factors in risk of suicidal behaviour (Roy et al, 1991 III). However, the mechanisms by which a genetic component to suicidal behaviour may influence suicide risk are not yet clear. It may be that the tendency for suicide to run in families may reflect more general tendencies for the familial transmission of aggressive, impulsive and violent behaviours, rather than the transmission of suicidal behaviour *per se*.

There is, at present, limited evidence to suggest that a number of neuroendocrine and biologic factors (particularly serotonin and its metabolites) may contribute to suicidal behaviour. Studies have suggested that declining or stable low levels of serotonin and/or its metabolite have been found in individuals who attempt suicide or die by suicide, compared with non-suicidal control subjects (see, for example, Malone et al, 1996 III; Mann et al, 1986 III). However, this evidence, as is the case with genetic research, is still too limited to draw firm conclusions about the role of neuroendocrine factors in suicidal behaviour.

Social and demographic risk factors

Rates of suicidal behaviour tend to be elevated among young people from socially disadvantaged backgrounds characterised by low socioeconomic status, limited educational achievement and low income (see, for example, Beautrais et al, 1996b III; Fergusson and Lynskey, 1995a III; Allebeck and Allgulander, 1990 III).

Family and childhood risk factors

A large number of studies have found that young people with suicidal behaviour tend to come from family backgrounds characterised by dysfunctional or difficult circumstances. Research evidence suggests that increased rates of suicidal behaviour in young people are associated with a wide range of adverse family factors including: parental disharmony, parental separation and divorce; parental psychopathology (including parental substance abuse, affective disorders and antisocial behaviours); a family history of suicidal behaviour; high levels of exposure to parental and family discord; exposure to physical and/or sexual abuse during childhood; and impaired parent-child or inter-family relationships (see, for example, Andrews and Lewinsohn, 1992 III; Beautrais, 1996 III, Brent et al, 1996 III; Fergusson and Lynskey, 1995a III; Gould et al, 1996 III).

Often, young people at risk of suicidal behaviour tend to come from multiple problem family backgrounds in which several risk factors are commonly present. This observation suggests, firstly, that it is the density and chronicity of exposure to a range of risk factors, rather than the occurrence of a single risk factor, which contribute to increased family dysfunction and the development of subsequent mental health problems and suicidal behaviour. Secondly, the adverse family backgrounds which characterise young people at risk of suicidal behaviour are very similar to those which occur in other adolescent and young adult psychosocial disorders (including, for example, depressive disorders, substance use disorders and offending behaviours), suggesting that the major life pathways and courses which lead to serious suicidal behaviour overlap and correlate, very substantially, with those that lead to a range of adolescent and young adult psychosocial and mental health problems.

Mental health factors

Mental disorders

Mental disorders are the strongest risk factors for suicidal behaviour. Studies of suicidal behaviour in young people consistently indicate that the majority (80-90%) of young people who die by suicide or make serious suicide attempts have at least one recognisable mental disorder at the time of their attempt (Beautrais et al, 1996b; Brent et al, 1988; Marttunen et al, 1991; Runenson, 1989; Shaffer et al, 1996 III-IV). Most commonly, these disorders are depressive disorders, substance use disorders and antisocial behaviours. Of these disorders, depressive disorders emerge consistently as the type of disorders most commonly associated with suicidal behaviour. A New Zealand study found that young people making serious suicide attempts had elevated rates of depressive disorder (70.5%), substance use disorders (38.8%) and antisocial behaviours (34.9%) (Beautrais et al, 1998a III).

In addition, it should be noted that while psychotic disorders make a relatively small contribution to overall rates of suicidal behaviour, the risks of suicidal behaviour are high within the populations of those with psychotic disorders (Westermeyer et al, 1991 III).

Co-existing disorders

Frequently, young people with serious suicidal behaviour have co-morbid (or co-occurring) mental disorders. Most commonly, the disorders which co-occur are depressive disorders and substance use disorders. Those with more than one disorder, compared with those with a single disorder, tend to have markedly increased risks of suicidal behaviour (Beautrais et al, 1996b III; Brent et al, 1988 III; Fergusson and Lynskey, 1995b III; Shaffer et al, 1996 III).

Previous suicide attempts

Young people with serious suicidal behaviour often have a history of previous suicide attempts. A New Zealand study found that 53% of young people making serious suicide attempts had made at least one previous suicide attempt (Beautrais et al, 1998a III, 1998b III).

Prior mental health care

Those with serious suicidal behaviour often also have a history of prior contact with health services for mental health problems. The study by Beautrais et al (1998a III, 1998b III) reported that 67% of young people who made serious suicide attempts had a lifetime history of outpatient consultation for mental health problems and 22% had been admitted to a psychiatric hospital within the year prior to the suicide attempt.

Axis II personality disorders

In contrast to the large amount of research which has examined the association between (Axis I) mental disorders and suicidal behaviour, the role of Axis II personality disorders has been less examined. Limited evidence suggests that Axis II disorders may be present in up to one third of those who die by suicide, with the most common disorders being borderline, antisocial and avoidant personality disorders (Beautrais et al, 1996b; Marttunen et al, 1991; Runenson, 1989 III-IV).

Personality traits and cognitive styles

There is limited evidence relating suicidal behaviour to certain personality traits and cognitive styles (the ways in which an individual perceives, mentally organises and understands life experiences) (Beautrais, 1996 III; Keinhorst et al, 1992 III; Rotheram-Borus et al, 1990 III). Suicidal behaviour has been associated with cognitive inflexibility, neuroticism, a pervasive sense of hopelessness, poor problem solving ability and a negative or hopeless outlook.

Stressful life events

There is considerable evidence to suggest that suicidal behaviour in young people is often preceded by exposure to stress and personal adversity, notably interpersonal losses and conflicts (commonly, relationship breakdowns) and disciplinary or legal crises. However, there is generally clear recognition that such events occur commonly among young people and may act as precipitating factors for suicidal behaviour only when they occur in those individuals who are vulnerable to suicidal behaviour (Beautrais et al, 1997b III; Brent et al, 1993b III).

Ongoing life difficulties

A range of other life circumstances has been linked with suicidal behaviour. Two circumstances that have been the focus of debate are unemployment and sexual orientation.

Unemployment

While there is some evidence from time series studies that links, at an aggregate level, rates of suicide in young people with rates of unemployment (see, for example,

Crombie, 1990 IV; Morrell et al, 1993 IV, 1994 IV; Pritchard, 1992a IV), these associations have not been confirmed by individual level studies (Beautrais et al, 1998d III; Fergusson et al, 1997 III; Goldney et al, 1995 III; Jones et al, 1991 III). Rather, individual level studies have tended to suggest that associations between suicidal behaviour and unemployment are likely to reflect common adverse social, family and personal factors which are, independently, related to risks of both unemployment and suicidal behaviour.

Gay, lesbian or bisexual orientation

Since 1972 there have been 12 gay community sample studies in North America (Bagley and Tremblay, 1997 III) which show elevated rates of suicidal behaviour (lifetime mean rate of 31.3% up to an average age of 19.4 years). Similar rates have been found in community based studies in the United Kingdom. Less elevated rates have been found among lesbian communities (Saunders and Valente, 1987 III). Several studies indicate that certain factors such as non-disclosure of sexual orientation and social isolation increase the risk of suicidal behaviour (Remafedi, 1994 III). Within the last three years several case control studies (Remafedi et al, 1997; Bagley and Tremblay, 1997; Faulkner and Cranston, 1998; Garofalo et al, 1998 III) and a national community study (Sorensen and Roberts, 1997 III) in the United States have also revealed an association between suicidal behaviour and young people who identify as, or are coming to terms with their identity as, gay, lesbian or bisexual.

However, studies on completed suicides have failed to find increased rates of suicide among gay young men (Rich et al, 1986a; 1988; Shaffer et al, 1995). These studies have been criticised because it has been shown (Bagley and Tremblay, 1997) that medical examiners' and coroners' reports are inaccurate in terms of recording sexual orientation and that homosexual young men most at risk of suicide are less likely to reveal their orientation to family (Remafedi, 1994). This is an area of ongoing study.

Cultural factors

Māori have higher rates of suicide than non-Māori (see page 11). However, further research is required to understand the reasons behind the high rate of suicide in this population (Ministry of Youth Affairs, 1998).

Accumulative risk of suicidal behaviour

There is evidence that the risk factors for suicide attempt and suicide in young people tend to accumulate, so that the risk profile of the young person most at risk of serious suicide attempt and suicide is likely to have the following characteristics:

- Social and educational disadvantage
- A history of exposure to multiple family and parental disadvantages during childhood and adolescence
- The development, during adolescence, of significant mental health problems and/or personality difficulties
- Exposure to a serious or stressful life event (most often, the breakdown of a significant relationship or, less often, a legal or disciplinary crisis).

While suicidal behaviour may occur in young people who do not have this risk profile, it is most commonly the case that young people with serious suicidal behaviour will have some elements of social, educational and family disadvantage, the subsequent development of mental disorder, and related stresses and difficulties.

There is evidence that these risk factors often act cumulatively, so that those young people with greater exposure to risk factors are at substantially higher risk of suicidal behaviour than those with fewer, or no, risk factors (Beautrais, 1996 III; Marttunen et al, 1992 III). These observations suggest that, most commonly, suicidal behaviour in young people is not simply the consequence of mental disorder, or of exposure to stressful life

events, but rather a response to an unhappy or adverse life course which has been characterised by accumulation, during childhood and adolescence, of risk factors from the domains of social, educational and family adversity, mental illness and stressful life events.

These observations suggest that the group of young people most at risk of serious suicidal behaviour may be identified as those who have suicidal ideation and exposure to the multiple risk factors discussed earlier. Conversely, those young people without suicidal ideation and with exposure to few or none of the risk factors will be those least likely to make suicide attempts.

It should be noted that, within the population of those at high risk of suicidal behaviour, predicting which individuals will make suicide attempts is not practicable (Burk et al, 1985; Goldney and Spence, 1987; Goldstein et al, 1991; Gunnell and Frankel, 1994; Murphy, 1983; Nielsen, 1997; Pearce and Martin, 1994; Pokorny, 1983; Tsuang et al, 1992; Van Egmond and Diekstra, 1990). The reason for this is that suicide and serious suicide attempts occur infrequently in the population of young people. The low base rates of these behaviours impose limitations on predictive power since predicting rare events requires extremely strong predictors. These considerations suggest that the best application of the existing research data about risk factors for suicide among young people is for the purpose of identifying the population of young people most at risk of suicide, rather than for predicting individual suicide risk.

FACTORS THAT MAY PROTECT AGAINST SUICIDE

In contrast to the large volume of research into risk factors for suicidal behaviours in young people, there has been comparatively little research on identifying individual, family and community factors that may protect against the development of risk factors for suicidal behaviour in young people. While interest in this issue has recently increased, the available evidence on “resilience” or “protective” factors for suicidal behaviour is, at present, limited and findings should be regarded as tentative.

“Resilience” is broadly conceptualised as an individual’s coping better than expected with stress of a significant nature and duration. It is assumed that resilient individuals have developed protective mechanisms to vulnerability caused by risk factors.

Mechanisms with the best research evidence (III-V) include:

Dispositional attributes of the young person:

- Temperament. If there is a “good fit” between the child’s temperament and their environment (family and culture). In our western culture this would be adaptability, responsiveness, persistence and having a reasonable quality of mood and activity level (Berger, 1985; Carey, 1982; Cowen et al, 1990)
- Having an internal locus of control. The opposite of learned helplessness is the sense of having the feeling of being able to control one’s own destiny (Herrenkohl et al, 1994; Luthar, 1991; Luthar and Zigler, 1988; Moran and Eckenrode, 1992; O’Grady and Metz, 1987; Parker et al, 1990; Werner and Smith, 1982)
- Good self-esteem, self-image, self-confidence, self-efficiency (Werner and Smith, 1992; Parker, 1990; Moran and Eckenrode, 1992; Herrenkohl et al, 1994)
- Intelligence and problem solving abilities. Several studies have found that resilient young people appear to be characterised by higher intelligence and problem solving skills than their non-resilient peers (Herrenkohl et al, 1994; Kandel et al, 1988)
- Gender. A number of studies have suggested that females may be less reactive to family stress than males Emery and O’Leary, 1982, Hetherington, 1989; Porter and O’Leary, 1980).

External support systems and resources:

- An available, adequate, emotional relationship with a caregiver or significant other in the family (Egeland and Erickson, 1987; Honig, 1986; Kellam et al, 1977; O'Grady and Metz, 1987; Quinton et al, 1984; Rutter et al, 1974)
- For Māori, having whakapapa, whether acknowledged or not, which binds them to a potentially caring whānau and community (Ministry of Youth Affairs, 1998)
- An optimal level of social support via social networks eg: extended family and community groups (Crittenden, 1985; Hickox and Furnell, 1989)
- Having a personal spiritual faith (Baldwin et al, 1990)
- Being in therapy (Egeland et al, 1988; Moeller et al, 1993; Dunn, 1993)
- Positive school experience (Rutter et al, 1974)
- External interests and affiliations. A number of studies have suggested that children from high risk backgrounds who develop strong interests outside the home or form an attachment with a confiding adult outside their immediate family may be more resilient to family adversity (Jenkins and Smith, 1990).

If resilience is to be a useful concept in relation to lower youth suicide rates then it should be noted that 'behavioural' competence (ie: what is seen by others) eg: adjustment at school, may not mean that 'internal' competence (ie: psychological wellbeing) exists in the young person. 'Internal' competence is very relevant in terms of potentially containing some of the risk factors for young people. Appearances that a young person is coping well may be deceiving; an opportunity should be taken to inquire into how a young person is feeling.



Principles of care for a young person

Youth friendly service

Services appear friendlier to young people where posters and materials inform them of the primary care provider's genuine interest and expertise in their mental health. Reception staff should try to make young people feel welcome, and maintain flexibility in appointment times. Since the initial assessment of the young person may take a substantial amount of time, sufficient appointment time should be allocated. Confidentiality should be emphasised to all the practice team (NHMRC, 1997).

Within a practice it may be appropriate to identify a key person to work with young people who appear to have complex issues. The practice nurse may be appropriate as potentially they can allocate more time to spend with the young person, building rapport and beginning to gain an understanding of the young person.

Establish a positive relationship

It is important to establish and maintain a trusting relationship with a young person; once trust is lost it is very difficult to re-establish. The primary care provider should treat the young person with respect and identify from the outset that they (and not their parents) are the patient – for example, when the patient is accompanied by their parents, the provider should greet the young person before acknowledging the parents. When the patient is escorted by friends or relatives, the young person should be invited to be seen alone during the consultation (NHMRC, 1997).

The primary care provider is more likely to engage the young person if they understand the tasks and the problems that can be linked to the developmental demands of adolescence. The transition from childhood to adulthood involves major physical, emotional, intellectual and social changes for the young person.

When beginning a consultation it is important that the primary care provider indicates how much time they have available but that if more time is needed there are ways to accommodate this. Experts suggest to enhance engagement with a young person:

- Exhibit friendliness, warmth and an interest in the activities and concerns of the young person
- Listen carefully, compliment the young person on their strengths and avoid arguments
- Be yourself and not attempt to adopt the young person's colloquialisms. Communication should therefore be at a level that the young person can understand, avoiding the use of professional jargon
- Be clear and precise in communicating with a young person who may be suicidal, because they may often be confused or in a state of chaotic feelings in relation to a mental disorder or recent stressful event.

Often if rapport has been established with the community, the primary care provider will have developed a credible reputation and the community and young Māori will be more likely to attend for any ailments.

Primary care providers should be aware that when Māori present with a physical ailment, that the provider should acknowledge the somatic condition whilst being alert to other issues that have a bearing on the mental health of the young person.

Questions to young people may need to be direct rather than open ended, as young people do not always have the confidence, experience or language to express their emotions (NHMRC, 1997). Some examples of questioning which may be helpful with young people:

- Q** Specific questioning: *Where do you live? Who do you live with? How do you get along with them?*
- Multiple choice questioning: *Did that make you feel sad, angry or scared?*
- Making a tentative statement: *My sense is you sound a little bit down - what do you think?*

Recognition of problems

Problems are better recognised when primary care providers ask questions with a psychological or social content (NHMRC, 1997). Important areas of the young person's life should be explored: home, school, peers, relationships and inner feelings and perceptions of how they are going. They should begin with the least threatening topics first and build up to those that are more difficult to cope with. A useful opening statement may be: *We know there is a range of issues facing young people and so I want to ask you about such things as drugs and sexual health.* Here is an example of some mnemonics to use as a guide.

HEADSS	ORGASMS
<ul style="list-style-type: none"> • Home • Education • Activities • Drugs • Sex - orientation, activity, abuse • Suicide 	<ul style="list-style-type: none"> • Occupation - school or unemployment • Recreation - exercise, leisure • Groups - family, peer groups, friends • Appearance - body image, body changes • Substance use/abuse • Mood - depression • Sexuality

Accident and Medical Centres may have a special role in recognising young people with problems where they present for illness or accident. This may provide an opportunity for engagement, particularly with young males. If staff at the centre are concerned this should be followed up by liaison with the young person's family practice.

Clarify confidentiality

Confidentiality is an important issue when working with young people.

It is important to clearly inform the young person of the confidential nature of the therapeutic relationship and that this will be respected in all situations except if there is serious and imminent threat to the young person's life or evidence of physical or sexual abuse (Rule 11 (2d) Health Information Privacy Code, 1994).

However, it should also be explained that some information may be shared with other professionals to assist with the care of the young person and itemise what may be disclosed. It may be necessary for the primary care provider to reassure the young person, discussing the reasons for their reluctance around disclosure to others (significant risk factors in relation to family and care and protection issues may come to light at this point), and the necessity for bringing others in to help with solving the problems.

If a young person is under 17 years of age the provisions of the Children, Young Persons and their Families Act (1989) will apply and a Children, Young Persons and their Families Agency social worker is empowered to take actions to ensure the care and protection of the young person.

Primary care providers should be aware that many young people will ask others to promise secrecy before they make a disclosure. This should be avoided and every effort made to encourage them to share their concerns and plans without any promise of confidentiality.

If the young person is at risk of suicide, the primary care provider must do everything in their power to ensure their safety. If the risk to the young person's life is high, immediate action is required and this may mean informing parents or significant others even if the young person does not agree. Possible conflicts about confidentiality issues need to be resolved early in the assessment and the limits of confidentiality established in each situation. The issue of who to inform will depend on the circumstances of that individual. The focus should be on what information is shared and how this is done in the best interests of the young person.

The Privacy Code legislation relating to seeking information about the young person, as opposed to giving out information about them, is not straightforward. The principles of confidentiality and respect for the person's wishes and rights must be adhered to. However, there will be situations where a comprehensive assessment cannot be completed without additional information from other sources. This is particularly so when the young person is unknown to the primary care provider or reluctant to provide information. In these cases decisions must be made with the primary interest being the young person's safety.

For further information refer to *Consent in Child and Youth Health: Information for Practitioners*, Ministry of Health, 1998.

Barriers to treatment

There have been several New Zealand studies which have examined the reasons for people failing to get professional help for mental health problems.

The major reasons for not seeking treatment relate to a lack of recognition by the individual of possible mental health problems and of the need for treatment (Horwood and Fergusson, 1998 III).

In a study that considered a range of potential barriers to treatment among young people with mental health problems, the majority of those who failed to seek treatment said that it did not occur to them to seek help, that they believed they did not need help or that they could manage the problem without professional help, or that the problem would resolve without the need for treatment. Only a small minority cited issues such as being embarrassed to seek help or fear of what others might think as reasons for failing to seek treatment.

These observations are in broad agreement with those reported for another New Zealand study which examined reasons for failing to seek treatment in a young adult and adult population (Wells et al, 1994). This study also found that common reasons for failing to seek care were doubts about the need for care or beliefs that they should be strong enough to manage without professional care. Again, only a minority of respondents cited health services' characteristics such as cost, times open and travel distance as reasons for failing to seek care.

These findings suggest that people's major barriers to seeking care arise from perceptions that their symptoms are not severe enough to warrant treatment. In turn this implies that greater use of services by young people is likely to arise from educative campaigns that advise and inform young people and their families about mental health problems, how to access health services and the benefits and efficacy of early treatment for mental health problems.

CULTURAL CONSIDERATIONS

The influence of cultural factors must always be considered. Only by understanding the cultural context of the young person will the information about their behaviours, fears and thoughts be correctly interpreted. What may be “normal” in one cultural situation may not be in another.

The more the primary care provider is able to appreciate the cultural perception of the individual to whom they are offering assistance, the better the therapeutic relationship will be. Consequently, compliance with, and the effectiveness of, the treatment will increase. In all cases the primary care provider must endeavour to take the view from the young person’s perspective, and limit the effect of their own preconceptions and beliefs. When a primary care provider is working with a young person of their own ethnic group, it is important not to assume that they subscribe to the same cultural or world views.

While the most frequent cultures will be those based on ethnic groups, the interpretation of culture should not be restricted to this. Groups with specific religious and social beliefs and norms will also have cultural differences that need to be considered. Often, there will be religious and social differences within ethnic groups.

Best Practice Recommendation

Where there is a difference between the cultural views held by the young person and the primary care provider, it is recommended that there is consultation with a cultural advisor or referral to a specialist service with a cultural advisor .¹



If there is a specialist health service for the young person’s cultural group, with the young person’s consent the primary care provider should offer to involve this service in the assessment and support process. This is clearly the case where the person’s primary culture and language (eg: Māori) are not those of the health professional, but could also include situations where religious beliefs and values differ significantly. The offer to arrange and be supportive of a referral should come from the primary care provider.

Having made a referral, the primary care provider should continue to be available to and supportive of the person. In many cases because of the scarcity of specialist services, the young person is likely to be referred back to the primary care provider for ongoing monitoring and treatment. Where shared care is undertaken, there should be a clear understanding of the roles and responsibilities of each party.

The primary care provider may need to contact the young person’s family, appropriate community resources, church or alternative health providers to gain an understanding of the young person’s difficulties. The involvement of cultural advisors such as kaumātua and Māori (and other cultural) mental health workers can be valuable in advising on these matters and resolving any conflict.

Issues of confidentiality and the rights of the individual need to be carefully considered. Consent should be sought to consult with other people or organisations. There may be conflict between the family’s or cultural group’s presumed right to know about their ill member, to contribute to decision making and to be involved in treatment, and the wishes of the young person. This is particularly so among people who are the second generation of the cultural group and who may not adhere to the culture to the same degree as their family/whānau.

¹ There are Māori and Pacific Health Providers in communities who can offer consultation advice. Child, Adolescent and their Families Mental Health Teams often have Māori and/or Pacific specialists.

Māori

Mental health problems are now one of the main concerns for Māori. Mental health admissions for alcohol and drug disorders, suicides and attempted suicides are increasing (Mental Health Commission, 1998). In 1997 the suicide rates for Māori were greater than those for non-Māori.

In recent years there has been increasing acceptance of the links between culture and illness, particularly mental illness. Durie (1998) notes that even for westernised Māori cultural heritage is important in shaping ideas, attitudes and reactions, particularly during times of illness. Health models have been developed within the context of contemporary Māori life, drawing on traditional values, concepts and practices. The Whare Tapa Whā conceptualises “for Māori to be healthy, people need a sense of identity, self-esteem, control over their destiny, a voice that is heard, knowledge of te reo Māori and tikanga and economic and whānau security” (Ministry of Health, 1997). “Māori live in diverse cultural worlds. There is no one reality nor is there any longer a single definition that will encompass the range of Māori life styles. Some Māori are closely linked to established Māori institutions: marae, hapū, iwi. Others are involved in new institutions strongly Māori, but not in any traditional sense, not always readily distinguishable from the institutions of other New Zealanders. A Māori identity even when vigorously defended cannot be presumed to mean conventional Māori lifestyle. Nor should it be forgotten that, for many Māori, cultural identity is a sophistication; it is more than enough simply to get through each day” (Durie, 1998). It is important when working with Māori to take the needs and wishes of the individual into consideration. They should be given the choice of whether they use mainstream or kaupapa Māori services, or both.

Pacific people

Pacific people are the largest growing population in New Zealand, a population that is continuing to grow rapidly. It has a considerably younger population profile than the general population. Almost half (49%) of the Pacific population in New Zealand is under the age of 20 (Statistics New Zealand, 1999). It must be remembered that Pacific people comprise many groups, each with a distinct language and culture. There is also a diverse people. Therefore the approach needed for each of these groups may need to be different.

Official data show low rates of suicide among Pacific people. However, there is a disparity between the statistical data on suicide and anecdotal reportage. Suicide in young people is a major concern for Pacific people. In general Pacific people believe that mental health is dependent on all aspects of a person’s life being in harmony. Spiritual, physical, emotional, cultural and family wellbeing together represent the holistic view with which their mental health needs to be addressed. Conflict between these dimensions will invariably affect mental dimensions and if the conflict is left unresolved suicide or attempted suicide might become an alternative.

Issues of conflict can range from sexuality acceptance to peer pressure, unrealistic expectations, self-esteem, tradition versus westernisation, religion and most importantly concern about success. Signs and symptoms preceding attempts or successful suicides are not readily recognised, mainly owing to the fact that Pacific people tend to rely on non-verbal communication over oral communication (National Health Committee, 1996).

There is growing awareness that the needs of Pacific people are not being met by mainstream services. This has resulted in the establishment of Pacific health providers throughout New Zealand. Primary care providers should be sensitive to and respect the young person’s values and beliefs. With the young person’s permission, the primary care provider should seek guidance from or refer the young person to a Pacific people’s service or recognised community organisation.



Recognising a significant risk of suicide

P primary care providers are a key resource for young people in the community. They have the advantage of knowing the family and community in which the young person lives. Primary care providers' services are often more accessible and less stigmatising than a mental health service for young people. Primary care providers are therefore in an important position to recognise young people who may be at risk of suicide.

There is consistent evidence that a significant proportion of young people who die by suicide have visited a general practice close to the time of their suicide (Appleby et al, 1996; Diekstra and van Egmond, 1989 III).

Key to recognising the potential for suicide is the primary care provider maintaining a high level of suspicion about the possibility of self-harm among young people. Predicting **suicidal behaviour** at a point in time for any one individual is exceedingly difficult. Nevertheless it is possible to identify young people who are likely to be most **at risk of suicide** and the treatments that are required to reduce this risk.

The primary care provider should regard all consultations with a young person as an opportunity to screen for psychological distress and ongoing difficulties. For instance the following questions might be asked:

- Q** *How are you going generally?*
Do you ever feel miserable?
How are things at home (or where you live)?
Lots of young people use alcohol and drugs, how about you?

Background risk factors

The evidence from New Zealand and overseas studies suggests that the risk profile of the young person most at risk of serious suicide attempt and suicide is likely to have the following characteristics:

- A background of social and educational disadvantage
- A history of exposure to multiple family and parental disadvantages during childhood and adolescence
- Development, during adolescence, of significant mental health problems and/or personality difficulties
- The level of risk is especially increased if the young person has made an attempt at suicide.

While suicidal behaviour may occur in young people who do not have this risk profile, it is most commonly the case that young people with serious suicidal behaviour will have some elements of social, educational and family disadvantage, the subsequent development of mental disorder, and related stresses and difficulties.

Individual risk factors

Individual risk factors which may be significant in the absence of mental disorder include:

- Developmental issues, sexual identity
- Family breakdown/dysfunction

- Cultural issues and/or alienation
- Past trauma including physical or sexual abuse.

Recent risk factors

If a young person has a high risk profile (as outlined in background risk factors above) the level of suspicion should be increased if they display any of the following:

- Exposure to a serious or stressful life event (most often, the breakdown of a significant relationship or, less often, a legal or disciplinary crisis)
- A number of the common warning signs (see below).

Warning signs

Changes in behaviour	<ul style="list-style-type: none"> • Isolation or withdrawal from other people • Loss of interest in previously liked activities • Poor performance at school or work • Crying a lot • Odd or bizarre behaviour • Significant or escalating substance abuse • Risk taking • Putting affairs in order • Giving away personal effects or prized possessions
Changes in mood	<ul style="list-style-type: none"> • Sadness • Hopelessness • Anxiety • Desperation
Changes in thinking	<ul style="list-style-type: none"> • Poor concentration • Inability to make decisions • Low self-esteem • Inappropriate feelings of guilt • Strange or bizarre thoughts/psychotic symptoms
Changes in physical features	<ul style="list-style-type: none"> • Loss of weight or weight gain • Loss of appetite or increase in appetite • Loss of energy • Changes in sleep patterns, difficulty in either sleeping or over sleeping
Preoccupation with death	<ul style="list-style-type: none"> • Preoccupation with artwork, reading or writing about death • Preoccupation with thinking about someone who has died • Preoccupation with music with morbid themes or acknowledging suicide as an option
Talk of suicide	<ul style="list-style-type: none"> • Plans for suicide • Asking about methods of suicide • Saying they would be better off dead • Threats of suicide
Stress	<ul style="list-style-type: none"> • Perceived intolerable loss or stress
Apparent resolution	<ul style="list-style-type: none"> • Sudden appearance of happiness and or calmness after a period of some of the characteristics listed above.

(This list is compiled from material including a list of warning signs from the American Association of Suicidology and from research conducted by the Canterbury Suicide Project.)

If the primary care provider has concerns about a young person, particularly if there is a history of previous suicide attempt, the young person should be assessed further through a compassionate and persistent inquiry into what they think is happening.

EXPLORING THE ISSUE OF SUICIDE

While significant numbers of young people visit their general practice before attempting suicide, in many cases the practice team is unaware of the young person's suicidal plans. Certain beliefs and attitudes held by the provider may deter them from raising the issue. These include:

- Lacking experience, confidence or expertise to assess suicide risk
- Being concerned that the young person may be embarrassed by questioning about suicide
- Fearing that raising questions about suicide may instil the idea in the young person's mind
- Believing they would not know how to manage it if the young person did acknowledge suicidal thoughts
- Seeing suicidal behaviour as attention seeking and manipulative.

Asking a young person about suicide in the context of the consultation will not increase suicidal behaviour (Arya, 1998; Hirschfeld and Russel, 1997; Zimmerman et al, 1995). The benefits far outweigh any risk of precipitating suicide. Most young people are relieved that someone has given them the opportunity to talk about these thoughts and from knowing that someone else understands and is responsive to their distress.

A primary care provider raising the issue of suicide with a young person should:

- Talk to the person alone without family members (although in some situations or cultures this may not be appropriate)
- Acknowledge that it may be difficult to talk about sensitive topics
- Discuss the limits of confidentiality and not be sworn to secrecy
- Ask permission to obtain a collaborative history from significant members of the family or others.

Rather than abruptly asking questions directly about suicide, it is most appropriate to ask a series of questions leading up to the issue, such as:

- Q** *Do you see a future for yourself?*
Do you think about death?
Have you ever thought you would be better off dead?

Best Practice Recommendation

Make time - you may not get another chance.

- Threats of suicide should never be dismissed as gestures or attention seeking measures
- If you have a suspicion that a young person is potentially suicidal this may be the most important consultation of your day
- Once you have recognised the young person is at risk of suicide, you are responsible for following through with an assessment to determine the level of risk
- Once this assessment has been completed and the appropriate management response(s) identified, then, and only then, can the young person be handed over to a colleague to arrange for further assessment, referral or care.





Assessing suicide risk

If a young person attends a health service and the primary care provider is concerned that they are at risk of suicide, a systematic assessment is recommended to gain an understanding of the situation and what has brought the young person to consider suicide. The primary care provider needs to combine objective responses with their own “gut feeling” in determining if the young person is at low, moderate or high risk. An assessment guide is provided to assist with this. During the assessment the primary care provider should attempt to obtain information from each of the areas outlined in Table 1:

- Personal difficulties
- Positive resources
- Previous attempts
- Suicide plan.

Personal difficulties

Stressful events:

Explore how they feel about their life; for example ask:

*Q What are the pressures on you at the moment?
Has there been any significant life crisis eg: breakdown of close relationship, problems with the law, academic difficulties, or death of a friend?*

Check for presence of mental disorders:

- Depression
- Other disorders, such as substance abuse, conduct disorder, personality disorders, psychosis (see mental disorders” page 38).

Ongoing life difficulties:

- Past trauma eg: physical or sexual abuse (see page 37)
- Alienation, parental reaction around issues such as disclosure of sexual orientation (see page 36)
- Family difficulties (see page 36).

Cultural issues:

The identification of Māori at risk of suicide may require carefully and respectfully probing some of the following issues (Coupe, 1999 personal communication):

- Unresolved grief or loss of a significant other (whānau or friend)
- Breakdown of relationships can mean a lot more to Māori youth
- Irritability and uncharacteristic aggression
- Issues of injustice (especially cultural) result in intense shame or guilt
- Talk of hearing voices or of unexplained spiritual experiences
- Somatic complaints that have no apparent physiological cause.

Coping behaviour:

Consider the young person's ability to cope with problems in their life, for example:

- How frequent are their thoughts of suicide?
- What problem solving strategies do they use to cope?
- Do they have rigid, inflexible ways of viewing life, "black and white thinking" eg: If things are bad the only option I have is death?
- Check degree of hopelessness and how they see their future
- Check impulsivity and high risk taking
- Self harming behaviour
- Disturbances in daily functioning eg: sleeping, eating, working
- Self neglect.

Positive resources and resilience factors

Family and friends:

- Establish who are the important people in their lives and how available they are to the young person
- Do they have stable relationships with family or friends?
- How much could they help the young person and would the young person be willing to let them help?
- Do they have a feeling of belonging to a community or group of peers
- School/work performance
- Do they have a personal spiritual faith
- Internal locus of control (ability to be independent of their circumstances)
- Access to whenua, te reo, whakapapa, whānau, hapū and iwi.

Lifestyle:

- Investigate the young person's lifestyle and the stability of their relationships
- Evaluate the presence of high risk taking behaviour such as drug abuse, driving dangerously etc.

Communication:

- Assess the young person's ability to express their suicidal thoughts and active help seeking
- Explore what they see as their goal of suicide eg: punish someone, join a loved one, or escape their problems.

Previous suicide attempts

- A history of previous attempts by a young person is one of the strongest predictors of a future suicide
- Suicide or suicide attempts among family or friends should also be considered a risk factor.

Suicide plan

Explore the extent to which the young person has formulated and reports a clear plan of the way they intend to take their lives. For instance, does the plan include how the suicide will be attempted, the availability of the method, the lethality of the method and the proposed timing (including the likelihood of being discovered and stopped)?

Young people are not good estimators of lethality, particularly with drugs and the significance of the method or dose should not be relied on as an indication of intent (Myers et al, 1992 III).

If suicidal ideation is present, questions should be asked to ascertain the extent of suicidal thoughts and plans, and to establish if the means of making an attempt are available. Some of the questions below could be used to assess suicide risk:

- Q** *How often have you had these thoughts?*
Has anything happened recently to make you feel this way?
On a scale from one to ten (where one is the lowest and ten is the highest) how strong is your wish, at present, to kill yourself?
What would it take to move you down one point on the scale?
Have you ever thought about how you would kill yourself?
Do you have the method for doing this available to you?
When would you do this?
Where would you do this?
Have you ever tried to kill yourself before?
Did things change as result of this attempt/these attempts?
Is there anything that would stop you killing yourself?

(Adapted from Fremouw et al, 1990)

It is important to note that some individuals with definite suicide plans may minimise these plans or even deny them when asked.

Having collected the information, the primary care provider should compare the person's situation with the profiles in Table 1 to determine the best fit of low, moderate or high risk. It is important to pay particular attention to the viability of the plan, the lethality of the method, any impulsivity and the provider's intuition. If in doubt, rate the risk higher. The level of risk will not necessarily depend on the number of symptoms but on their severity and likelihood.

Best Practice Recommendation

Suicidal ideation in particular and mental state in general can fluctuate considerably over short periods of time, therefore a young person at risk should be reassessed regularly, especially if circumstances change.



Table 1: Assessment tool to determine the level of risk of suicide for a young person

During the interview with the young person, investigate each of the areas in the column on the left and CIRCLE THE RELEVANT DESCRIPTION OF THE YOUNG PERSON'S CURRENT SITUATION. In investigating any suicide plan (note 4 below), it is important to use direct questions as the young person is likely to be reluctant to volunteer the information. Direct questioning will not aggravate the risk of suicide but failure to fully investigate, categorise the risk and respond appropriately may result in a suicide that could have been avoided. On the basis of the young person's responses, determine which of the three risk levels: LOW, MODERATE or HIGH, best describes the situation. If there is any risk then proceed with the management plan (Table 2).

Areas to Consider	Low Risk	Moderate Risk	High Risk
1. Personal difficulties Stressful events (pg 28) Presence of mental disorders depression, substance abuse, conduct disorder, psychosis (pg 38) Ongoing life difficulties Significant trauma Sexual identity issues Family difficulties (pg 28) Cultural issues (pg 28) Coping behaviour (pg 29)	<ul style="list-style-type: none"> No significant stress Mild: feels slightly down Minimal impact but aware of some potential difficulties Minimal impact Only occasional thoughts about suicide Daily activities continue as usual with little change Help available; significant others concerned and willing to help Stable family relationships; personality and school performance Direct expression of feelings and suicidal thoughts associated with distress and active help seeking None or one of low lethality (see 4.4 for lethality) Vague Not available No specific time or in the future Pills or slash wrists Others present most of the time 	<ul style="list-style-type: none"> Moderate reaction to loss or environmental change Moderate: some moodiness, sadness, irritability, loneliness and decrease of energy Having some impact on everyday life Having some impact on everyday life Recurring thoughts of suicide Intentional self-harming without expressed suicidal intent eg: cutting Some daily activities disrupted; disturbance in eating, sleeping, school work Family and friends available but unwilling to help consistently Recent acting out behaviour and substance abuse Acute suicidal behaviour in stable personality Interpersonalised suicide goal ("They'll be sorry", "I'll show them", "I don't deserve to live" or "I want to be with someone who has died") Multiple of low lethality or one of medium lethality; history of repeated threats (see 4.4 for lethality) Suicide among family or friends Some specifics Available, has close by Within a few hours Drugs and alcohol, and car accident Others available if called on 	<ul style="list-style-type: none"> Severe reaction to loss or environmental change Many recent social/personal crises Overwhelmed with hopelessness, sadness and anger (verbal/physical), feelings of worthlessness Extreme mood changes Delusions, paranoia, lost touch with reality Major concerns, impacting on many areas of their life Major concerns, impacting on many areas of their life May resist help Constant suicidal thoughts Significant disturbances in daily functioning Participation in high risk behaviours (ie: alcohol and drug abuse, potential for accidents etc) Family and friends not available or hostile, exhausted, injurious Significant self neglect Suicidal behaviour in unstable personality; emotional disturbance; repeated difficulty with peers, family Very indirect or non-verbal expression of internalised suicide goal (guilt, worthlessness) One of high lethality or multiple of moderate lethality Several attempts over the last weeks and/or suicide among family or friends Well thought out; knows when, where, how Has means at hand Immediately Gun, hanging, jumping, carbon monoxide No one nearby; isolated
2. Positive resources (pg 29) Family and friends Lifestyle Communication			
3. Previous suicide attempts (pg 29)			
4. Suicide plan (pg 29) 1. Details 2. Availability of means 3. Time 4. Lethality of method 5. Chance of intervention			

(Adapted from Ministry of Education 1997 Young People at Risk of Suicide: A Guide for Schools)



Managing suicide risk

Once a young person is identified as being at risk of suicide, a management plan should be devised in consultation with other services involved, which clearly documents the interventions and responsibilities of professionals and agencies. The plan should be commensurate with the level of risk determined during assessment. Everyone involved should have a copy of the plan.

The management plan should take into consideration:

- Assessed level of risk (see Table 1)
- The age of the young person
- Supports available to the young person
- The knowledge, experience, qualifications and interests of the primary care provider
- Services available in the community which can be mobilised for the support of the young person and their family
- Cultural considerations (see “Principles of care for a young person” on page 23)
- The limits of confidentiality (see “Principles of care for a young person” on page 21).

The level of risk can change and this should be monitored and the management changed accordingly. Any young person who is considered to be at risk of suicide should be treated as being at risk until it is clear that the risk no longer exists.

It is not possible to assess and eliminate suicide risk entirely. Even in the best circumstances and using the best assessment and management methods, a young person may still commit suicide. The objective is to minimise this risk.

The following principles should be followed:

- Reduce immediate risk
- Consult and/or refer
- Manage underlying factors
- Monitor and follow-up.

REDUCE IMMEDIATE RISK

The first concern in caring for a young person at risk of suicide is to provide safety.

Remove means to harm themselves

The following are suggestions for providing a safer home environment:

- Prevent access to weapons and where possible remove these from the house, in particular firearms
- Remove cords, ropes, vacuum cleaner hoses, poisons and any other obvious means to self harm in the immediate environment
- Ensure that all medications are locked away and accounted for
- Remove alcohol from the house
- Prevent easy access to transport so that an individual’s movements are limited.

Table 2: Managing suicide risk in young people

Select column relevant to level of risk identified in assessment. Suicide risk fluctuates and management needs to be adjusted accordingly.

Action	Low Risk	Moderate Risk	High Risk
Reduce risk (pg 32)	<ul style="list-style-type: none"> Remove means to harm themselves Establish an appropriate regime to monitor young person Check on family's/friends' support as appropriate, provide information on resources centred around the needs of the young person In collaboration with young person and support people, write a clear action plan 	<ul style="list-style-type: none"> Remove means to harm themselves Ensure young person has appropriate support eg: family/whanau, friends Arrange back-up support which is available 24 hours a day In collaboration with young person and support people, write a clear action plan 	<ul style="list-style-type: none"> Remove means to harm themselves (in extreme circumstances this may mean calling the police) Involve all management outlined in moderate risk, but urgent action is required Support and supervise at all times until responsibility is passed to another agency or individual Make urgent referral to mental health team
Consultation and Referral (pg 34 and appendix 5)	<ul style="list-style-type: none"> Consider discussing case with a colleague or specialist mental health provider Children, Young Persons and their Families Agency (CYPFA) must be informed where care and protection are required (under 17 years)² Check if any other services are involved and who has responsibility for co-ordination eg: school counsellor, Specialist Education Services, CYPFA or mental health services Network with school or educational institution 	<ul style="list-style-type: none"> Consult with or refer to specialist cultural health service prior to other agency consultation for Māori Consult with or refer to mental health services on the same day Involve family/whanau, friends if permission given or arrange alternative support³ CYPFA must be informed where care and protection are required (for 17 years and under) Recommend to young person and support people appropriate agencies or other resources, and assist them in accessing these services Ensure there is a management plan in collaboration with all services involved 	<ul style="list-style-type: none"> If immediate referral is not possible, mobilise professional networks to assist in the management, support and supervision of the young person in consultation with mental health professional Contact family/whanau, friends if not already present and involve as appropriate CYPFA must be informed where care and protection are required (for 17 years and under) Consider arranging assessment under the Mental Health Act if appropriate Ensure there is a management plan in collaboration with all services involved with explicit handover of responsibility between agencies or professionals
Manage underlying factors (pg 36)	<ul style="list-style-type: none"> Initiate/optimize treatment of any underlying mental disorders or problems Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties 	<ul style="list-style-type: none"> Must initiate/optimize treatment for any underlying mental disorders or problems Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties 	<ul style="list-style-type: none"> Must initiate/optimize treatment for any underlying mental disorders or problems Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties (undertaken in most cases by the specialist mental health services)
Monitor and follow up (pg 50)	<ul style="list-style-type: none"> Make regular follow-up appointments Monitor changes in suicide risk Telephone contact may suffice If no improvement in one to two weeks treat as moderate risk 	<ul style="list-style-type: none"> Make regular follow-up appointments Contact regularly Monitor changes in suicide risk Check outcome of any agency referrals 	<ul style="list-style-type: none"> Ensure the following processes are in place and working effectively Make regular follow-up appointments Contact regularly Monitor changes in suicide risk Check outcome of any agency referrals

(Adapted from Ministry of Education, 1997 Young People at Risk of Suicide: A Guide for Schools)

² This may include family's inability or unwillingness to provide care, support and monitoring.

³ If there is serious or imminent threat to the young person's life, permission to contact family/support people is not required, decisions must be made in the interests of safety.

Safety issues with medication

When prescribing medications for a young person at risk of suicide it is important to be cautious:

- Prescribe one week's supply at a time
- Explore if any other doctor has prescribed medications
- Consider the toxicity of prescribed medications
- Monitor and review the young person regularly
- In some circumstances it may be appropriate to have a responsible adult collect the prescriptions and dispense the medications. In these cases medications should be kept locked away.

Provide support

- Discuss with the young person and their family/friends the need for support and supervision. Advise them of the level of supervision required
- Arrange extra support if required
- Arrange back-up support that can be accessed 24 hours a day if suicidal behaviour increases
- Caregivers should be aware that the Mental Health Act can be used as a resource to set boundaries for the person and that the police can be called in emergencies (see appendix 3)
- Provide support for the caregivers
- The way in which the family is involved will depend on the developmental level of the young person. As a guide, 13-15 year olds are still dependent on their parents, 16-17 year olds vary in their level of independence and people 18 years and over are relatively independent.

Provide clear information to the young person and support people

The young person should be involved in decision making and always kept fully informed of steps taken to promote safety.

Best Practice Recommendation

An action plan should be written for the young person outlining steps to take if suicidal ideation increases. This is similar to an asthma action plan. An important part of the plan is back-up support that is available 24 hours a day with names and contact numbers (see appendix 3).



From time to time the use of a written contract in which young people agree not to harm themselves is raised ("no suicide" contracts). These have not been shown to be effective and mental health professionals working in this area do not support their use.

Provide support people with information to assist them to understand about suicide and how to support their family member or friend (see appendix 4 for recommended pamphlets and resources).

CONSULTATION AND REFERRAL

Networks

Networks need to be established to provide appropriate, effective care for young people. These networks will differ depending on services available in the area. Local knowledge of support services is vital. It is important that these networks are

established before they are needed and good working relationships maintained. These could include school teachers, public health nurses, general practitioners, practice nurses, mental health services (adult and child and adolescent if available), cultural experts/services, ministers, counsellors, paediatricians, alcohol and drug services, community police and resources in the community for young people and families. (See Appendix 5: Resources for referral or assistance).

Referral

In some circumstances it is important to refer the young person to another service to provide effective and safe care (see Table 2). The referral process needs to be handled with care as young people can interpret referral as either rejection, or confirmation that their problems are enormous.

Referral is a time when young people slip through the cracks.

A primary care provider making a referral should:

- Include their assessment of the young person's risk of suicide to convey their level of concern
- Establish that the young person has arrived at the service
- Be explicit about the level of their involvement in the young person's management
- Request progress reports
- Clarify the process for handing back the responsibility of the young person's care.

In some areas where there are limited resources, the primary care provider may need to assume a greater responsibility for caring for young people at risk of suicide. In these circumstances if referral is not possible a "shared care" arrangement will provide greater safety for the young person and the primary care provider.

There is little conclusive evidence available to confirm that in-patient care for young people at risk of suicide is the optimal treatment, however it may be appropriate in some circumstances (Garrison et al, 1990; Vivona et al, 1995 III).

In New Zealand many young people at risk of suicide are managed in the community, with support from mental health crisis teams. The level of support varies from area to area, but may include:

- Respite care
- Residential or halfway houses
- Varying levels of domiciliary or community care support.

However, in some cases the extent of the young person's mental health problems or suicide risk may be such that admission to hospital is necessary.

Self care

Managing troubled young people can be a stressful, frustrating, disheartening and at times abusive experience. Never feel pressured into coping alone.

- Never work alone, even if managing the young person independently. Always discuss the management with a colleague or mental health professional
- Peer group discussion or mentoring may also be valuable.

MANAGING UNDERLYING FACTORS

Once actions have been taken to reduce the immediate risk of suicide, underlying factors should be managed. These will be identified in assessment (see Table 1) and will be dealt with under:

- Precipitating events
- Ongoing life difficulties
- Mental disorders.

Precipitating events

Suicide is the endpoint of a multicausal process, which may be triggered by a final precipitating event. This precipitating event will be different for each individual but common factors are relationship breakdowns and disciplinary or legal crisis (see page 16). Assistance should be provided to deal with these factors. The primary care provider should provide information about and/or refer the young person to agencies or groups that may be able to help. They should identify appropriate support services - these may include counselling, legal assistance and budgeting support (the local Citizens Advice Bureau may be able to give information on services available in the area).

Sometimes precipitating issues that may appear minor to an adult can take on enormous proportions and importance for the young person. Young people and their families may need help in addressing these problems. Problem solving, which involves identifying and clarifying the problem, searching for solutions, looking at the barriers and then choosing a solution, has been shown to be effective, feasible and acceptable to patients (National Health Committee, 1996). Problem solving interventions teach the person to use their own skills and resources to cope with both present and future problems.

Ongoing life difficulties

Family circumstances

A large number of studies show that young people at risk of suicide come from family backgrounds characterised by dysfunctional or difficult circumstances. These include parental disharmony, separation, divorce and parental psychopathology (see page 15).

Referral to a therapist trained in family therapy methods should be considered. However it is recognised that the cost and the difficulty in engaging all family members may be barriers to family therapy (see appendix 1).

Referral to a specialist cultural service may be more appropriate for Māori.

Sexual orientation

Studies suggest higher rates of suicidal behaviour among gay and lesbian people (see page 17).

Gay and lesbian people face particular stresses in terms of acceptance by society and their family of their sexual orientation. These play a big part in their own self-acceptance and self-esteem. "Coming out" can be particularly stressful, especially if the person feels they must hide their sexual orientation for fear of disapproval or rejection. When there is any indication of "confusion about sexual identity" this

should be sensitively explored.

Reassure the young person that it is natural to feel confused or anxious about sexuality issues when these contradict how your family sees you.

When such confusion is present, the primary care provider should provide non-judgemental information together with support and reassurance about conflicting feelings about self and family attitudes/relationships. Information on support services/groups available could be offered (see the Personal Help Services section of the phone book for local services).

Trauma issues

Research studies suggest that exposure to physical or sexual abuse during childhood can increase the risk of suicidal behaviour (see page 15).

Physical and sexual abuse is often undetected at the primary health care level. Health professionals who are suspicious should not be reluctant to ask directly, in a supportive, non-judgemental manner.

If violence has occurred, the safety of the young person takes precedence over other interventions. If they are under 17 the Children, Young Persons and their Families Agency should be contacted. In addition, all age groups should be referred to community mental health services.

A primary care provider communicating with a young person who they believe has suffered abuse should:

- Employ reflective listening and encourage disclosure (Pennebaker, 1997)
- When examining injuries look for discrepancies between what is said and what is seen
- Validate the person's experience of and perspective on the abuse
- Review safety issues associated with full disclosure and negotiate future action
- Inform them about Women's Refuge, marae based services and specialist support groups
- Inform them about the police and the Domestic Violence Act.

It may sometimes be necessary, after discussion with the young person, to breach confidentiality if the health professional comes to know of intended harm to the young person or others (National Health Committee, 1996).

Māori issues

Māori have higher rates of suicide than non-Māori (see page 11).

Official statistics show that suicide among young Māori has risen considerably in the past 10 years, however changes in the way that ethnicity is recorded make historical comparisons difficult. Anecdotal evidence from Māori communities suggests that suicide rates among young Māori may even be considerably higher than official statistics reveal.

The risk factors for Māori are the same as for the general population, however there is a difference in the magnitude and prevalence of risk factors. It is proposed for Māori there is an additional risk factor that relates to the alienation of the people from their land and their culture, which subjects them to a fragmentation of identity and a loss of spirit. For young Māori, having a strong cultural identity and a whakapapa which bind them to a caring community, has a protective effect against suicide (Ministry of Youth Affairs, 1998).

A primary care provider assisting in assessing and treating a young Māori person should take all care to ensure that the individual has a supportive environment to go to post treatment. The slightest indication of suicidal ideation, tendencies or previous attempts must be taken with all seriousness. Young Māori who are presenting with physical ailments are often hiding their true feelings. The primary care provider must try and dig a little further, looking into past family history and for deep cultural awareness, appreciating that moving on to the next world is a possibility for young Māori. If a young Māori has recently experienced loss of friends and/or whānau and talks openly of this with others, they may be predisposed toward the next world. A lot of young Māori suicides have been in trouble with the law and tend to be ashamed and embarrassed by this and often seek other avenues of escape.

Mental disorders

There is substantial evidence to show that 80-90% of young people who die by suicide or make a serious attempt at suicide have a recognisable mental disorder at the time of death. Therefore improving the recognition and treatment of mental disorders may contribute to decreasing the rate of suicide.

The mental disorders that are of most concern in relation to suicide are depression, substance abuse and conduct disorders because of the relatively high prevalence of these conditions in young people. Psychotic disorder is also of concern because the rates of suicide are high among the small number of young people who have psychotic disorder (see page 15).

Furthermore there is evidence that risk of suicide is increased to a greater degree among those young people with co-morbid mental disorders and the degree of increased risk may be in direct proportion to the number of co-morbid conditions.

It is also important to recognise mental disorders early. Helgason (1990) found in a prospective cohort study that better outcomes for young patients were associated with individuals who received earlier treatment for their first episode of serious mental illness. Early treatment has been associated with shorter in-patient care and fewer episodes of subsequent hospitalisation, and consequently less expensive treatment for young people with serious mental illnesses (Loebel et al, 1992).

Depression

Until recently, depressive symptoms in young people were viewed as a transient period of normal development which did not require treatment. It is now recognised that young people do suffer from depressive disorders which are similar in nature to those suffered by adults. However, the majority of young people with depression still go undiagnosed and receive no treatment for their disorder (National Health and Medical Research Council, 1997).

The link between depression and suicide is particularly important because depression is relatively common in young people and a large number of young people exhibiting suicidal behaviour have depression.

- Clinical depression affects 1-3% of young people at any one time. It is more common in older adolescents and females. Up to 24% of adolescents will have a major depression by the age of 18 (National Health and Medical Research Council, 1997)
- A New Zealand study (Beautrais et al, 1998a) of rates of mental disorders in young people who had made a serious suicide attempt showed 71% of those attempting suicide had depressive disorder.

Recognition and diagnosis

Major depressive disorder (Modified From DSM IV)

Five or more of the following symptoms have been present during the same two-week period and represent a change from previous function; at least **one** of the symptoms is either depressed mood or loss of interest or pleasure.

- Depressed mood most of the day, nearly every day
- Markedly diminished pleasure or interest in all or almost all activities nearly every day
- Significant weight loss when not dieting, or weight gain (5% is suggested as significant)
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observed by others)
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional)
- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death or suicide, or suicide attempt.

The symptoms must be a cause of significant distress or impairment, not be due to a medical condition or substance abuse, and not be accounted for by a grief reaction (ie: persisting for longer than two months or characterised by marked functional impairment, suicidal ideation, psychosis or psychomotor retardation).

Managing
risk

Differences between young people and adults

- Depressed young people are more prone to suicide attempts
- Young people may appear more irritable than depressed and demonstrate mood lability compared with depressed adults, who tend to have uniformly low mood no matter what their circumstances
- Young people are more likely to oversleep rather than experience insomnia
- Young people may also be more likely to present with physical complaints.

Treatment of Depression (under 18 years)

Non pharmacological (first line)	
Proven efficacy	• Cognitive behavioural treatment (I)
Probable/possible efficacy	<ul style="list-style-type: none"> • Relaxation therapy (I) • Therapeutic support groups (III) • Social skills training (III males, IV females) • Interpersonal therapy (III) • Family therapy (IV) • Exercise (IV) • Electroconvulsive therapy for severe, non-responsive or life-threatening symptoms (IV)
Pharmacological (reserved for those not responding to non-pharmacological treatments)	
Possible efficacy	• SSRIs (IV)
No proven benefit	• Tricyclic antidepressants (I)

(*Depression in young people: Clinical practice guidelines*, National Health and Medical Research Council, 1997).

(For descriptions of psychological therapies see appendix 1.)

Referral to mental health services is recommended where there is:

- Severe major depression, particularly with suicidal ideation
- Depression with psychosis
- Age less than 16 years with major depressive disorder (treatment with antidepressants less efficacious, most treatments involve family and methods unlikely to be available to primary care providers)
- Family history of bipolar affective disorder (higher likelihood of bipolar affective disorder in child)
- Serious co-morbidity
- Failure of initial treatment.

Longer-term considerations

- Any teenager who has experienced an episode of depression is at risk of further episodes (40% within two years and 70% within five years). On current best evidence the best way to reduce relapse rates is teaching cognitive strategies and how to identify early warning signs of impending relapse (see below)
- Treatment for first depressive episode should be actively managed for nine months and any subsequent episode for three years to improve compliance with treatment and to monitor for relapse (National Health Committee, 1996)

- One of the more important considerations in teenagers is that depression may be part of a more serious long-term disorder. In practice, any teenager with a family history of severe mood symptoms, or a depression with psychotic features, or a depression severe enough to require admission, is more likely to have bipolar affective disorder with manic episodes occurring over time.

Bipolar

- Bipolar disorder episodes often begin in late teenage years. Under-diagnosis of manic states in teenagers is relatively common, since young people are usually resistant to seeing anyone and those around them may mistake the manic state for the exuberance or rebelliousness of youth
- Bipolar is characterised by mood swings. In young people the predominant feature may be irritability and they are more likely than adults to present with a mixed affective picture
- Referral to specialist mental health services is strongly recommended for initial treatment.

Early warning signs and action plan

After an episode of depression, it is important to sit down with a teenager and/or their family and discuss the early signs of illness. What did they notice first? Was there anything unusual which could “flag” another episode? What should they do if this happens? Who should they see? How quickly? (an analogy is the asthma action plan). Writing everything down makes the plan more formal and may improve compliance.

Substance Use Disorder (SUD)

Substance abuse and dependence disorders including alcohol, cannabis and other drug use are present in over one third of those attempting suicide (see page 15).

- 30% of males under the age of 25 have hazardous or harmful patterns of drinking
- 34% of males and 19% of females aged 15-19 describe current use of marijuana (National Health Committee, 1999).

Recognition and diagnosis

The majority of young people are likely to use drugs⁴ and those who have significant life difficulties are the most likely to use drugs in a way that is harmful to their health and relationships. Most of these “harmful users” will also have another mental disorder (including conduct disorder mood disorders, schizophrenia and post traumatic stress disorders, any of which can be substance induced). The consumption of drugs is very likely to be part of a pattern of behaviours which is destructive to their physical, emotional, social and spiritual wellbeing.

Drug use can also be an attempt at “self-medication” to reduce the distress and pain they are experiencing – requiring a focus on the underlying reasons why they are using drugs in this way.

Questioning the young person aims to assess pattern of use, onset, type of drugs used, negative consequences, context, control of and progression with substance use:

Q What do you do for fun? What things do you do with friends? What do you do with your spare time?

Many young people experiment with drugs, alcohol and cigarettes. Have you ever tried them? What have you tried? How often would you use (alcohol, marijuana speed)?

*What are some of the good things for you about using (alcohol, marijuana, speed)?
What are some of the less good things?*

What worries you about using (alcohol, marijuana, speed)?

*Do your friends, parents worry about you taking (alcohol, marijuana, speed)?
How do you feel about them worrying?*

Substance abuse disorder (modified from DSM IV)

A maladaptive pattern of substance use which does not meet criteria for substance dependence, and which includes at least one of the following features:

- Recurrent substance use which affects performance at school, work or home
- Recurrent substance use in situations in which it is physically hazardous
- Recurrent substance related legal problems
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused by the effects of the substance.

⁴ Generically referred to as “drugs” because in New Zealand most young people who abuse use a variety of substances including alcohol.

Substance dependence disorder (modified from DSM IV)

A maladaptive pattern of substance use, leading to a significant impairment or distress, and including at least three of the following features which occur within the same 12-month period:

- Tolerance—indicated by either the need for greatly increased amounts of substance to achieve intoxication (or the desired effect) or markedly diminished effect with continued use of the same amount of the substance
- Withdrawal—indicated by either the characteristic withdrawal pattern for the particular substance, or the use of the same or similar substance to relieve or avoid withdrawal effects
- The substance is often taken in larger amounts or over a longer period than was intended
- There is a persistent desire to decrease or stop substance use
- A great deal of time is present in activities necessary to get the substance, to use it or recover from its effects
- Important social, occupational or recreational activities are given up or reduced because of substance use
- Use of the substance continues despite knowledge of having a persistent or recurrent physical or psychological problem with the substance.

Management

All indications are that any use of drugs (including alcohol) should be reduced to the least possible, ideally (especially if they have a mental disorder and/or are suicidal) becoming drug free. If there are co-morbid conditions or disorders, they should be treated concurrently.

The most important factor in determining what treatment is appropriate is whether or not, and to what extent, the young person wants to change their use of substances. Prochaska and DiClemente (1982) describe a model of “Readiness to Change”.

Confrontation or acceptance of “poor motivation” leads to the young person becoming resistant to treatment. Motivation is enhanced when the primary care provider adjusts their intervention to the readiness of the young person.

Treatment options for substance abuse

It is recommended that the initial treatment be selected on the basis of the young person’s assessed level of motivation to change.

- For young people less than 16 years, consultation or referral should be made to a specialist mental health service
- For young people over 16 years, brief interventions (eg: information on the effects of the drugs they are using) provided within the young person’s usual environment should be used first and be given a reasonable trial (six to eight weeks)
- If the brief interventions are unsuccessful, referral should be made to specialist mental health services for more intensive community based therapies (eg: structured problem solving, Cognitive Behavioural Therapy).

Principles of treatment

- Treatment should be in the least restrictive setting that is safe and effective, be intensive, multimodal and of adequate duration with a focus on maintaining gains made and preventing of relapse
- Treatment should be given in settings specifically designed for young people, be peer oriented and provided by professionals trained in recognising specific developmental needs
- Treatment should be individualised to specific needs, culturally appropriate, comprehensive and address dysfunction in relevant domains.

For further information on the treatment of substance abuse refer to *Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care*, National Health Committee, 1999.

Schizophrenia

Schizophrenia is a major mental disorder. It usually begins in late adolescence, but prodromal symptoms may be present up to two years prior to this. The course of the illness is diverse with a quarter of those affected making a full or nearly full recovery, but a third are seriously disabled by the disorder.

While schizophrenia makes a relatively small contribution to the overall rates of suicidal behaviour, the rates are high among the population of people with schizophrenia (see page 15).

- Of those young people who are diagnosed with schizophrenia, 10% will take their own lives, with young males within the first two years of illness being at highest risk (Westermeyer et al, 1991)
- Life time prevalence rates for schizophrenia are around 1% (Ministry of Health, 1997).

Recognition and diagnosis

The main features of psychosis are:	These features may be preceded by prodromal symptoms such as:
<ul style="list-style-type: none"> • Prepsychotic features such as magical thinking • Hallucinations • Delusions • Thought disorder • Deteriorating work/school work • Deteriorating social relationships 	<ul style="list-style-type: none"> • Sleep disturbance • Appetite disturbance • Marked unusual behaviour • Feelings that are blunted or seen as incongruous to others • Changes in the way things appear, sound or smell • Marked preoccupations with unusual ideas • Persistent feelings of unreality (Mental Health Commission, 1999). <p>However these symptoms are very common in young people.</p>

Referral to mental health services

- Primary care providers have a role in the early identification of schizophrenia/psychosis while acknowledging that the prodromal symptoms are extremely common in young people
- Early treatment is vital as the longer the duration of psychotic symptoms before treatment, the more likely there is to be residual symptoms (Loebel et al, 1992)
- Primary care providers should refer all young people at initial diagnosis for confirmation and initial management.

Managing risk

Treatment for schizophrenia	
Proven efficacy	· Antipsychotic medication (Werry and Aman, 1999)
Probable efficacy	· Family intervention programmes reduce relapse (Falloon, 1992)
Possible efficacy	· Individual therapy/support for goal setting and advice · Social skills training in association with medication and family therapy (Falloon, 1992).

Ongoing management

- Relapse rate is high hence medications are given prophylactically
- Side-effect incidence is high with older antipsychotic medications hence difficulty with compliance, however, newer medications have less side effects and therefore improved compliance
- Treatment should be multifaceted.

Identifying other mental health disorders

Other serious disorders that may be encountered in this age group and are associated with increased risks of suicide include:

CONDUCT DISORDER

Research suggests conduct disorders and antisocial behaviours are present in one third of young people making serious suicide attempts (see page 15).

Conduct disorders are a constellation of antisocial behaviours in which the key factors are a repetitive and persistent violation of major age appropriate social norms and basic rights of others. Conduct disorders are among the most common disorders in young people. Approximately 5% of 11 year olds meet the criteria. Conduct disorder is three times more common in males than females (Ministry of Health, 1997).

Management:

- Requires multimodal treatments for long periods
- Early consultation or referral to mental health services is recommended.

PERSONALITY DISORDERS

Evidence suggests that personality disorders may be present in up to one third of those who die by suicide, with the most common being borderline, antisocial and avoidant personality disorders (see page 16).

Personality disorders are characterised by inflexible and enduring behaviour patterns that may impair social functioning. There is a range of personality disorders: paranoid, schizoid, schizotypal, avoidant, dependent, obsessive-compulsive, histrionic, narcissistic, borderline and anti-social. Information on prevalence rates for personality disorders is sparse and rates depend on definition used. The estimated prevalence rates from overseas studies suggest rates of around 10-11% (Ministry of Health, 1997).

Management:

- Requires long-term therapy
- Early consultation or referral to mental health services is recommended.

EATING DISORDERS

The rates of suicidal behaviour are elevated among the small number of people in the community with eating disorders.

There is a range of eating disorders, the central feature being an overvalued idea about body shape and size which is often accompanied by dissatisfaction with the body and an attempt to change body size by dieting and other weight control measures. The two most serious forms of eating disorders are anorexia and bulimia. These disorders predominantly affect women and the peak age of onset is during adolescence. Lifetime prevalence rates in New Zealand for anorexia are 0.1% and for bulimia 1%. These disorders tend to have chronic and fluctuating courses and may persist for many years (Ministry of Health, 1997).

Management

Early consultation or referral to a specialist eating disorder or mental health service is recommended.

ANXIETY DISORDERS

While the risk for suicide is not greatly increased by anxiety disorders alone, if there are co-morbid affective disorders, personality disorder and/or substance abuse disorders, the risk of suicide is increased beyond that typically associated with any of these disorders alone.

Anxiety disorders include panic, obsessive compulsive behaviour, generalised anxiety, acute and post traumatic stress, and a range of phobias. For information on assessing and managing anxiety disorders, refer to *Guidelines for Assessing and Treating Anxiety Disorders*, National Health Committee, 1998.

CO-MORBIDITY

There is evidence that the risk of suicide is increased to a greater degree among young people with co-morbid mental disorders and the degree of increased risk may be in direct proportion to the number of co-morbid conditions (see page 16).

A large number of studies have shown that many young people who present with one disorder are at an increased risk of other disorders. Studies in Christchurch and Dunedin found that at the age of 18 years 40% of young people who present with a mental disorder meet the criteria for more than one mental disorder. Both studies showed strong tendencies for co-morbidity between the internalising disorders of anxiety and depression and externalising disorders of conduct and substance abuse (Ministry of Health, 1997).

Co-morbidity complicates the clinical presentation, making recognition difficult. If co-morbidity is present it is recommended that these disorders be treated concurrently.

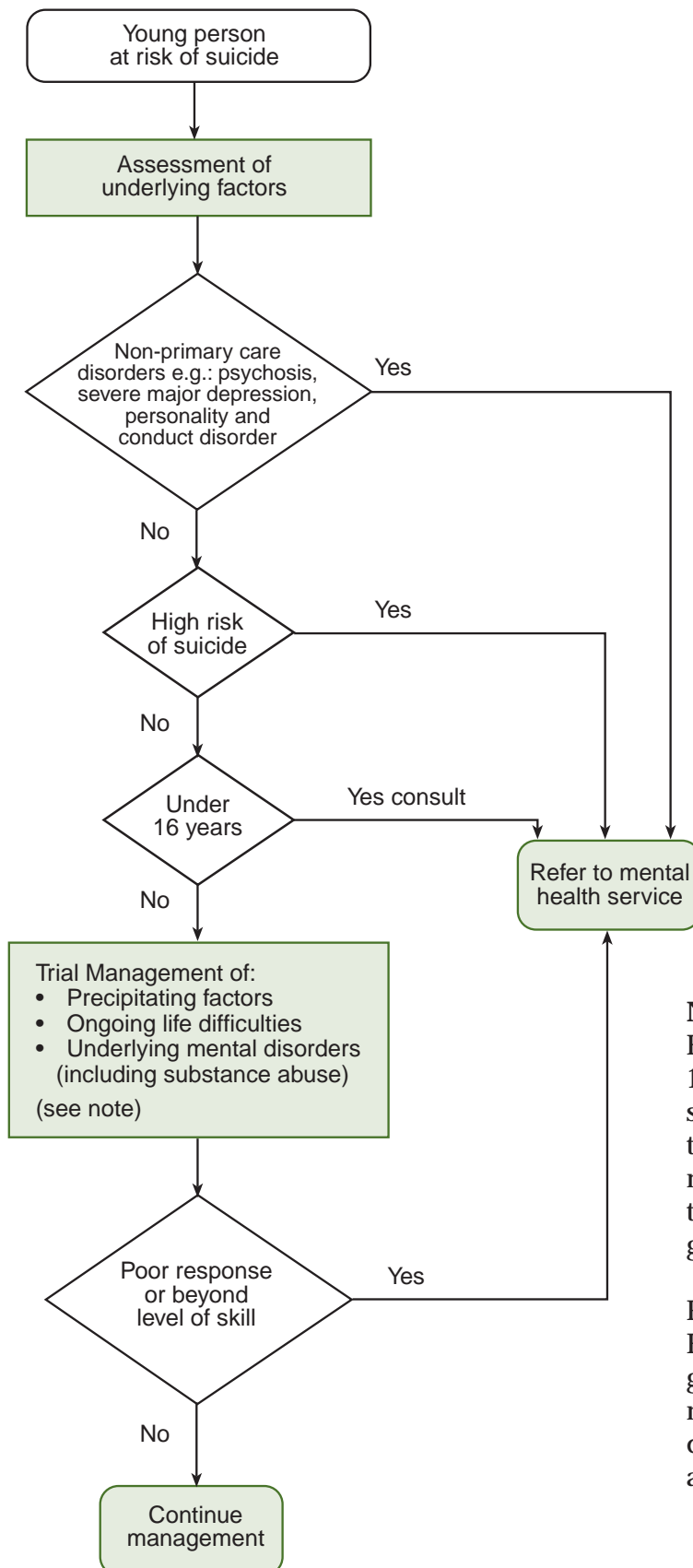
SUMMARY

The management a young person will be dependent on the type of underlying problems identified during assessment, the level of risk of suicide and the age of the young person.

- For management of **non-primary care disorders** eg: psychosis, severe major depressive disorder, and personality disorder it is recommended that referral is made to specialist mental health services
- **High risk of suicide:** it is recommended immediate referral is made to specialist mental health services
- Medium or low of suicide
 - Age 16 years and under consultation with mental health services is recommended
 - Age 16 and over consider trial management of precipitating factors, ongoing life difficulties or underlying mental disorders including substance use disorders according to level of skill and expertise. If low response consultation or referral to mental health services is recommended (in the 16-18 year age group there should be a lower threshold for referral).

Refer to National Health Committee Guidelines on the treatment of depression, anxiety and substance abuse.

ALGORITHM FOR THE MANAGEMENT OF UNDERLYING FACTORS IN A YOUNG PERSON AT RISK OF SUICIDE



Note:
For young people aged 16-18 years there should be a lower threshold for referral to mental health services than in the over 18 age group.

Refer to National Health Committee guidelines for management of depression, substance abuse and anxiety.

Managing risk

MONITORING AND FOLLOW-UP

Those who have been assessed as being at risk of suicide should be followed up regularly. The frequency of follow-up will depend on the level of risk and the support available.

Principles for follow-up

- Suicide risk fluctuates and should be reassessed frequently, especially if circumstances change. The management plan should be altered in response to changes in suicide risk
- Monitor if there have been any changes in the precipitating events, stresses or situation
- Monitor if any of the specific problems have been resolved
- Check the young person's:
 - response to treatments of underlying disorders
 - compliance with treatments
 - difficulty with side effects
- Monitor the attendance to any referral
- Follow up any "did not attend" (some do not attend as they are afraid to reveal the extent of their suicidal ideation)
- Monitor shared care arrangements. How do they feel about the people they are seeing? Regular contact should be kept between all services involved in the young person's care
- Relapse rates are high, review the plan and the safety net for such possibilities.



Special populations

YOUNG PEOPLE WITH AN INTELLECTUAL DISABILITY

There is no available evidence on the rates of suicidal behaviour among young people with an intellectual disability, however there is some evidence that intellectual disability is a risk factor for mental disorder in adults (National Health and Medical Research Council, 1997). People with intellectual disabilities are more sensitive to all types of stress (National Health Committee, 1998).

Recognition of problems may be difficult because these young people may not be able to describe their mood changes. They are often brought along to the doctor by someone who presents the problem from their perspective. Distinguishing what the caregiver sees as problem behaviours from mental disorder is often difficult. It is important to follow up any changes in mood or behaviours reported by the caregiver.

YOUNG PEOPLE WITH A MEDICAL ILLNESS

Diagnosing a mental illness can be difficult in young people with a medical illness, as many symptoms can overlap. The primary care provider must attempt to determine if symptoms such as lack of energy, sleep disturbance, weight loss etc are a result of the medical illness or a sign of an underlying mental illness.

In young people with a medical illness who also present with symptoms suggestive of depression, it is also important to eliminate an organic basis for depression. Potential causes for such a depression could be:

- Metabolic abnormalities
- Alcohol or substance abuse (possibly from attempts to self medicate)
- Endocrine disorders eg: diabetes
- Neoplasms or central nervous system disorders
- Pharmacotherapy (past or present) (National Health and Medical Research Council, 1997).

It is important to be aware of the impact a serious medical illness has on the developmental tasks of adolescence, for example the need for independence, body image, privacy etc. Open discussion about these issues and designing treatment programmes with these issues in mind may be helpful.

RURAL

There is no prevalence data for New Zealand that can compare the rates of suicide or mental disorders between rural and urban areas, however people in rural areas face different circumstances that could place them at higher risk. In rural areas there are higher rates of unemployment, fewer career opportunities and less opportunity for vocational or tertiary education. As a result of this many young people are faced with leaving their family and friends to pursue further education or work.

Mental health services are often limited in rural areas, thus general practice may need to undertake a larger part of care. To receive specialist care young people may have to travel long distances. Young people may also be more reluctant to seek help owing to concerns about confidentiality.

In rural communities the higher number of at risk populations (young Māori, lower socioeconomic status, and unemployment) may be offset to some extent by better psychosocial understanding of the young person's situation and a more integrated approach by family/whānau, the general practice team and local agencies including community police.

A particular issue for young people in rural areas is their ready access to firearms. Families should be encouraged to keep their firearms locked away.



Postvention

Postvention probably has an effect on preventing any further suicidal deaths by imitation (Brent et al, 1989; Klingman, 1989 IV). Postvention refers to an intervention that is commenced after a suicide with family survivors, school pupils or members of the community. The intervention aims to serve as a process where people acquainted with the victim can try and understand why the young person killed themselves and prevent anyone from inappropriately assuming the guilt for the victim's death. Importantly the intervention is designed to prevent any further suicidal deaths by imitation.

Very little research evidence is available to assess the effectiveness of postvention. Despite this most experts agree that there is a strong need for postvention to prevent further deaths by imitation, and to assist with providing support and counselling to the victim's peers.

The primary care provider's role in postvention is to:

- Assist the bereaved
- Assist in preventing further suicides by imitation
- Address their own feelings.

The death of a young person by suicide is an especially traumatic event for those close to the young person but can also have a deep effect on the whole community, particularly in close communities.

ASSISTING THE BEREAVED

If the young person or their family are patients of the primary care provider's practice, or the provider is called because there is an unexpected death, they should contact the family as soon as possible to provide support and information.

The support should ensure that the family and friends have access to standard grief counselling that in particular addresses the deep sense of loss and confusion, and the idiosyncratic aspects of suicide such as stigma and family shame. It is critical to talk to family and friends about their needs and the cultural, religious and social factors that are important to them. The bereaved should be advised of culturally appropriate support people and organisations available within the community (see appendix 5). Postvention support groups are available in some areas.

Some areas on which the bereaved may need support and information are:

- Searching for reasons and understanding
- Viewing the body and arranging for appropriate ceremonies (ie: funerals, tangi)
- What to tell other family members, children and other people
- Need for support during the period immediately following the suicide (including requests for medication)
- Issues relating to the autopsy and the coroner's report⁵.

Assistance might also be provided to the family through a funeral director, minister of religion or other person taking leadership in a tangi, funeral or similar ceremony. An issue of particular concern to Māori is the release of the body and all body parts in the case of an autopsy being required.

⁵ All deaths that appear to be the result of suicide must be reported to the police and the coroner.

A suicide is likely to have a detrimental effect on the physical and mental health of the family and friends. Opportunity should be made, where possible, to gently and persistently inquire into their wellbeing and to offer support and assistance as required.

Those grieving following the suicide of someone close to them will require support past the initial period of grieving. A few months after the death may be one of the most painful periods. This is a time when the reality of the death is starting to sink in, the short-term physical coping mechanisms have stopped and often support from family and friends has lessened. The family may also need help in planning how to cope with anniversaries and events such as birthdays and Christmas, as these times may emphasise the absence of the loved one.

Grieving is a process that will affect each individual and family differently. Bereavement can persist for years. Inquiry should be made during regular consultations to see how they are coping and the primary care provider should be alert for abnormal variants of the grief process such as:

- Post traumatic stress disorder
- Chronic grief
- Delayed, absent or inhibited grief.

ASSISTING IN PREVENTING FURTHER SUICIDES

In the event of a serious attempt or death by suicide it is important that the effects are well managed in order to limit the consequences for other people in the community, particularly those who are vulnerable or close to the bereaved. In general, this is the same for any similar trauma, but in cases of suicide there is also a risk of other young people being more likely to consider suicide as a possible “solution” to their distress. This contagion effect is well documented in New Zealand and a serious threat in any community where there has been a well publicised suicide (Ministry of Health, 1998). While in New Zealand many communities may not have a traumatic response plan in place, schools and other educational institutes may have a planned response to trauma. Specialist Education Services has people trained to provide support either in schools or communities following a suicide. Following a suicide of a young person in the community, it is recommended that the local school is contacted to plan a response. Victim Support⁶ could also be contacted.

Talking with the media

Increasing evidence exists of media influence in suicide by not only descriptions of suicide but also discussions of suicide itself (Ministry of Health, 1998 V).

The following advice from *Preventing Suicide: Guidelines for the Media on the Reporting of Suicide*, Ministry of Health, 1998 is provided for those asked by the media to give comment on a suicide:

- If approached by the media don't feel pressured into giving an immediate response. Take time to consider what comment should be made and who is the most appropriate person to provide comment
- Refusing to speak with the media will not prevent coverage but will prevent your opportunity to influence the way it is covered
- Suicide is a result of a complex interaction of many factors. Avoid reporting a simplistic explanation for suicide, such as conveying the final precipitating factor eg: relationship breakdown as the cause

⁶ Victim Support may be contacted through the local police station

- Promote the awareness of the strong relationship between mental disorders and suicide
- Minimise sensationalist reporting of suicide by not providing information on the method or site of the suicide
- Avoid commenting in a way that may glorify suicide or present suicide as typical
- Discuss with the media the potential for suicide contagion associated with certain types of reporting and suggest ways to minimise the risk for contagion
- Take the opportunity to mention support networks available to people who feel vulnerable or are close to the bereaved.

For further information on the potential for contagion related to media reporting on suicide refer to *Preventing Suicide: Guidelines for the Media on the Reporting of Suicide*, Ministry of Health, 1998.

Your own feelings

As a primary care provider, if you have recently treated the young person it is inevitable you will feel some of the following:

- A sense of loss
- Regret for not having spotted the signs
- Anger at yourself for not having done enough
- Fear of repercussions (including litigation)
- Fear of facing the family
- Anger at the young person for wasting their life
- Pity for the victim
- Pity for the family
- Relief that the young person's suffering has ended
- Nervous about other young people in the community, perhaps your own children
- These events may also raise issues from your own life experiences.

You will have developed your own ways of dealing with the death of a patient but don't underestimate the disturbing nature of the death of a young person by suicide. It is important that you don't neglect your own grieving or shock. Seek help from a colleague, friend, peer group, professional support or Doctors' Health Advisory Service (for contact details see appendix 5). The extent to which you can support the bereaved in their grieving will depend very much on how you can manage your own emotions.



Appendices

APPENDIX 1: PSYCHOLOGICAL INTERVENTIONS

When a psychological intervention is selected as a treatment the following principles may be useful:

- The referral should be made to therapists who are experienced and trained to work with young people. It is strongly recommended that referrals are only made to therapists who are members of a recognised professional organisation which has documented ethical guidelines, professional conduct procedures and requirements for supervision
- In making a referral it is important to consider the ethnic and cultural background of the therapist in relation to the young person and other factors influencing the effectiveness of the intervention
- It is helpful when making a referral to indicate the needs of the young person and their suspected problem areas, the expectation of the referral and ongoing responsibilities for management and crisis management
- The intervention should generally be time limited, focused on those current problems identified with the young person and aimed at symptom resolution
- To ensure that adequate feedback is received, the referrer should specify when and how they would like a report on progress. This should be done with the young person's consent, but also in accordance with accepted principles of confidentiality. Where issues of safety are relevant, client consent is desirable but not mandatory
- There is a need to measure and monitor the outcome of psychological intervention whenever treatment is initiated. This is especially important where the young person fails to show any improvement. In such situations the process should be re-evaluated in conjunction with the therapist (National Health Committee, 1996).

Practical problems with models of therapy include:

- The small number of mental health practitioners working with young people and skilled in psychological therapies
- The considerable time commitment for health professionals to learn the technique
- The considerable time commitment for practitioners and patients to undertake the treatment, hence additional expense for a young person or their family in a fee-for-service environment
- Psychological therapies have mainly been developed and evaluated among westernised cultures; their effectiveness in other cultural groups is less well understood.

Descriptions of therapies

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy is based on the theory postulated by Beck that people with depression develop a negative view of themselves, others and the world. This leads to a constant negative interpretation of situations that perpetuates depression. Therapy involves teaching self-monitoring of thoughts and behaviour; “cognitive restructuring” where the young person is taught to question their negative thoughts and replace them with more constructive and positive ideas. Activities are monitored and the young person is encouraged to increase the amount of time spent doing pleasurable and active things. Relapse in depression after two years is a possibility so other additional interventions may be necessary (Gortner et al 1998).

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) was developed for use with borderline personality disorders. DBT utilises a variety of methods (including pharmacotherapy, skill training and individual psychotherapy) to assist the patient to understand their problems and provide them with the skill based training to overcome their difficulties.

Interpersonal psychotherapy

Interpersonal psychotherapy is a focused, time-limited treatment (of approximately 16 sessions) which emphasises current interpersonal relationships. The therapy aims to clarify and resolve one or more interpersonal difficulties such as confusion about identity, social isolation, prolonged grief reaction and role transition. The therapist and young person work together to identify the interpersonal difficulties which are causing, exacerbating or maintaining the depressive disorder, then focus on resolving the difficulties that have been identified.

Crisis intervention

Crisis intervention involves the out-patient management of young people with suicidal behaviour by means of short, crisis oriented therapy which focuses on patient problem solving in relation to the stressful events that may have precipitated the suicide attempt. Crisis therapy emphasises the role of the stressful events and suicidal behaviour as a crucible for change.

Family therapy

Family therapy is therapy that treats the family as a system. The therapy views an individual's behaviours as being influenced by or directed at other family members. Therapy encourages family members toward positive relationships and improved communication.

Family therapy has several disadvantages where there is difficulty in engaging the family and where some family members are unwilling to participate (National Health and Medical Research Council, 1997).

Support groups

Many of the support groups around New Zealand are culturally based. An attempt to find out what resources are available locally and how young people can access these groups could be beneficial.

Contact details of organisations involved in psychological therapy

The organisations listed below may be contacted by a primary care provider who is considering making referral for psychological therapy. These people will be able to advise the appropriate mental health workers in their region.

New Zealand College of Clinical Psychologists

PO Box 28-219

Remuera

Auckland

Ph: 09 529 4501

New Zealand Psychological Society

PO Box 4092

Wellington

Ph: 04 801 5414

Fax: 04 801 5366

New Zealand Association of Counsellors

PO Box 165

Hamilton

Ph: 07 823 6496

APPENDIX 2: MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

This is a resource available for the management of mentally ill patients who are suicidal or seriously incapacitated in their self care, if their mental disorder falls within the definition of mental disorders in the Mental Health (Compulsory Assessment and Treatment) Act 1992. Duly Authorised Officers (DAOs) are available to provide information and assistance to patients and their families where compulsory assessment or treatment under the Act is being considered.

If the patient is voluntary, whether in the community or in hospital, application can be made under section 8. If the resulting examination under section 10 of the Act finds that the patient should undergo compulsory treatment, then treatment can take place even if the patient cannot or will not consent, subject to the provisions of the Act. If the person is in the community, the DAO may seek police assistance if necessary (section 41). Similarly if the police are called to a situation where a person “is acting in a manner which gives rise to reasonable belief that he or she may be mentally disordered”, the police may take the person to hospital, police station or surgery for a psychiatric assessment. This may lead to a section 8 application under the Act.

The purpose of the DAO is to allow a more easily accessed “door” into the compulsory treatment provisions of the Mental Health Act. The DAOs are experienced mental health professionals who act as front line operators of the Mental Health Act. Their role is to provide advice and assistance with assessments of whether compulsory treatment is required, to receive applications and to facilitate assessment, and they may provide assistance with transport to hospital. DAOs can be contacted by phoning the local Mental Health Team. The Mental Health Team can be contacted through your local hospital.

APPENDIX 3: EXAMPLE OF AN ACTION PLAN

This should be designed with the young person and be backed up by supports that are available 24 hours.

If I feeling like harming myself, I can:

1. Distract myself by phoning a friend, taking the dog for a walk, playing my guitar
2. Talk to Mum or a friend about it. See if anything is upsetting me or has set the feeling off. See if I can do anything about it.

If the feeling is strong and I have trouble controlling it I can:

1. Tell Mum urgently
2. Phone doctor Phone:
3. Call the Crisis Team Phone:

APPENDIX 4: YOUTH SUICIDE RESOURCES

New Zealand Youth Suicide Prevention Strategy Guidelines and Policies

A range of guidelines and policies are being produced as part of the National Youth Suicide Prevention Strategy (some of these were still in development at the time of printing):

- Establishment of a National Suicide Prevention Information Service (SPINZ) in May 1999
- Emergency departments (Australasian College of Emergency Medicine and Royal Australasian and New Zealand College of Psychiatrists) to be completed late 1999
- Mental health services (Ministry of Health) to be completed in 2000
- Children, Young Persons and their Families Agency *Recognition of Young People at Risk : Guidelines for Youth Service Workers* due to be completed September, 1999
- *Guidelines for the Media on the Reporting of Suicide* (Ministry of Health) being reviewed second edition to be completed September, 1999
- Māori communities (Ministry of Health) currently being scoped
- Schools and communities on traumatic incident planning (Ministry of Education, Specialist Education Services and Department of Internal Affairs) A poster has been produced as a resource for schools and consultation with communities will commence shortly
- Police and police youth aid workers on custodial practice (Police) new policy is due to be released October, 1999 and then a review of training will take place
- Corrections prison officers (Department of Corrections) training programmes are being reviewed

Information on the National Youth Suicide Prevention Strategy can be obtained from the Ministry of Health.

Suicide Prevention Information New Zealand SPINZ

SPINZ is designed to provide advice to the community on youth suicide and youth suicide prevention. The core functions of the service are; the gathering, managing and dissemination of information on youth suicide prevention. In addition general advice will be provided to communities on youth suicide prevention.

SPINZ will also link to other relevant websites, databases and clearing houses nationally and internationally. Information on youth suicide prevention programmes and services will be collated and made available. Contact phone number is 09 630 8573.

The National Health Committee has produced guidelines on detection and management in primary care of:

- Depression
- Anxiety
- Alcohol and Cannabis Abuse.

Ministry of Health:

- *Better Times: Contributing to the Mental Health of Children and Young People.*

Resources for young people and their families

The Mental Health Foundation has a range of pamphlets available for young people and their families including:

- *A Practical Guide to Coping with Suicide* (for community health workers and lay people)
- *Feeling Good: Grief and Loss; Anger, Bullying: What to Do*
- *Grief*: a booklet illustrated and developed by young people
- *Stressed Out*: a Practice Guide for Young People on How to Keep it Together Under Pressure
- *Understanding Teenager's Depression*: a Booklet for Parents or Family.

Ministry of Youth Affairs:

- *Spin*: a cartoon pamphlet for young people
- *Helping Troubled Young People*: a Guide for Parents
- *Te Āwhina I Ngā Rangatahi e Raru nei - Helping Troubled Young People*: A Guide for Parents.

Samaritan Centre:

- *Youth Suicide*: Guidelines for Family and Friends.

Websites

Many websites are available of varying quality. Some that are recommended for health professionals are:

New Zealand

The Mental Health Foundation website at www.mentalhealth.org.nz provides information on a wide range of mental health topics, including Suicide Prevention Information New Zealand (SPINZ)

The Ministry of Health New Zealand Youth Suicide website at www.moh.govt.nz/youthsuicide.html contains all the key documents under the New Zealand Youth Suicide Prevention Strategy

The New Zealand Health Information Service website at www.nzhis.govt.nz provides official New Zealand suicide statistics

The Ministry of Youth Affairs website at www.youthaffairs.govt.nz

Canterbury Bereaved By Suicide Support Group: <http://users.netaccess.co.nz/cbssg/> (Christchurch, New Zealand for families and friends post suicide)

International

Reach Out professional resources for Youth Suicide prevention in Australia: www.reachout.asn.au (designed for young people)

Suicide Information and Education Centre (SIEC) (Alberta, Canada): www.siec.ca
SIEC provides a comprehensive international resource centre, computer database and library service for English language print materials on suicidal behaviour.

American Association of Suicidology (Washington, DC): www.suicidology.org

American Foundation for Suicide Prevention (New York, NY): www.afsp.org

Centre for Disease Control (Atlanta, Georgia): <http://wonder.cdc.gov>

CRISIS journal (published under the auspices of the International Association for Suicide Prevention): www.hpub.com/journals.crisis

World Health Organization (Geneva, Switzerland): www.who.org

The Samaritans: www.samaritans.org.uk

General information on suicide and suicide prevention: www.rochford.org/suicide/resource/stats/

APPENDIX 5: RESOURCES FOR REFERRAL OR ASSISTANCE

Who you turn for referral or assistance with a young person at risk will depend upon your role and the nature of the problem. Your local phone book will be a good source of information as will the Citizens Advice (local number or 0800 367 222). Some areas will have local social service directories.

The following people or organisations may be helpful for consultation, referral or support for the young person and their family:

- Social workers working in Social Workers in Schools programme
- School guidance counsellors
- Specialist Education Services (including the Eliminating Violence, Managing Anger programme)
- Public health nurses
- Māori social services
- Māori mental health providers: Contact the Health Funding Authority's Māori Health Group for a directory of Māori providers in your local area.
- Pacific health and mental health services
- Cultural advisors are attached to many Mental Health Teams
- Children, Young Persons and their Families Agency
- Victim Support: provides support for victims and their families following crime, accident or emergencies, available 24 hours a day. Can be contacted through local police station.
- Alcohol Helpline: 0800 787 797 open 2pm to 10pm daily. They can provide information on alcohol and other drugs and advise on treatment services available in your area.
- Doctors' Health Advisory Service: free phone 04 471 2654 24 hours.

Look in Personal help services section in the white pages for local support services such as:

- Youthline 0800 376 633
- Lifeline
- Samaritans
- Support groups eg: Gay and lesbian support groups, postvention support groups.

APPENDIX 6: PROCESS USED IN DEVELOPING THE GUIDELINES

These guidelines have been developed using the following process:

- A development team was formed by inviting individuals who could represent and understand the perspectives of the stakeholders. (See “Membership of development team” below.) The role of this working group was to evaluate the literature review, identify “closeable gaps” and key issues identified by this review, decide the content of the guidelines, draft the guidelines, make recommendations around the key issues, and devise implementation strategies to address the closeable gaps
- Other opinion leaders in the field were invited to review guideline drafts for accuracy of technical content, language and style suitability for the target audience, and cultural appropriateness
- The systematic review and critical appraisal of the literature was completed by New Zealand Health Technology Assessment (NZHTA)
- The first draft was developed and reviewed by the development team
- A review of current practice was undertaken by the Wellington School of Medicine
- The second draft was sent to the development team and reviewers for comments
- A small writing group was formed to develop the third draft
- The third draft was sent to the development team and reviewers for comment
- Feedback and comments requiring consensus on content and wording were incorporated into the final draft
- The final draft was compiled incorporating feedback
- A post implementation practice survey will be undertaken by the Wellington School of Medicine.

Project leaders notes

1. There is comparatively less high quality research available for many of the issues surrounding youth suicide. To meet the need for useful information and guidance, sections of the guideline have been based on available expert opinion, we have attempted to be explicit where this occurs.
2. There is minimal evidence that closing the identified gaps will alter the rates of suicide among our young people. Some members of the working party felt that in focusing only on the “closeable gaps” we are not addressing the real psychosocial or societal gaps that contribute to the meaninglessness in some young people’s lives. While guidelines can raise the awareness of these issues they are not able to address the wider societal issues behind youth suicide. These guidelines address only what can be achieved within the context of the clinical encounter.
3. There is no magical tool that will identify the young person who is going to attempt suicide. There are background risk factors, individual risk factors, recent risk factors and resilience factors. However $A+B+C$ minus protective factors does not equal D . Certainly risk factors are cumulative but they can only indicate the young person who is more likely to attempt suicide.
4. I commend to you Kiri Lightfoot’s contribution on “Understanding the Worlds of Young People” (inside front cover).

5. I would like to thank the Ministry of Youth Affairs for commissioning the development of these guidelines and the Health Funding Authority who is funding the implementation. I especially would like to thank the members of the working party who have contributed to developing these guidelines, especially during times when strongly held beliefs came into conflict. This document represents an achieved consensus.

Membership of development team

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Sue Fitchett	Psychologist, Resource Team for Borderline Syndrome, North Shore Hospital
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Reviewers

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Dr Robynanne Milford and GP peer group, Christchurch	
New Zealand Guidelines Group	
Māori Health Branch, Ministry of Health (cultural sections)	
Dr Jonine Penrose-Wall	Chair of Evaluation Working Group, National Youth Suicide Prevention, Australia
Members of the Evaluation Working Group, National Youth Suicide Prevention, Australia	
Debbie Sorensen	Chief Advisor Pacific Health, Ministry of Health (cultural sections)
Dr Josephine Stanton	Child Psychiatrist, Auckland
Don Smith	Living Stones Consultancy
Child Psychiatrists Peer Review Group, Auckland	

APPENDIX 7: LITERATURE REVIEW

The literature review was carried out by the New Zealand Health Technology Assessment (NZHTA), Department of Public Health and General Practice, Christchurch School of Medicine.

Databases searched included Medline, Embase, Cinahl, Healthstar, Clinpsych, Psychlit, Current Contents, Cochrane Library, Database of Abstracts of Review of Effectiveness (DARE), NHS Economic Evaluation Database, Best Evidence NZBN (New Zealand Bibliographic Network), New Zealand university and medical libraries.

A limited search of Internet sources was undertaken along with the reference lists of publications obtained during the course of the project. Studies were selected and appraised if they met various selection criteria. A wide range of study types was included in this review (including expert opinion articles) and approximately 300 articles were appraised.

Critical appraisal forms standardised by study design were used to assist with the appraisal, which was conducted by a single reviewer. Most appraised articles were included in tables and then presented in the text. Evidence grades were applied to all of the literature based upon the study design of each article. The level of evidence was graded using an adapted version of the US Preventive Services Task Force protocol (US Preventive Services Taskforce, 1989).

A number of limitations were identified in the quality of the published literature that has examined the effectiveness of interventions to prevent suicidal behaviour among young people. Many studies have been unable to exclude chance, bias or confounding variables as alternative explanations for their findings. A significant amount of the research that has examined the recognition or assessment of suicide risk in young people has been based solely on expert opinion.

Copies of the literature review can be obtained from the
New Zealand Health Technology Assessment,

ph: 03 364 1152,

fax: 03 364 1152

email: nzhta@chmeds.ac.nz website: <http://nzhta.chmeds.ac.nz/>



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