

Contacts

Youth Suicide Prevention Clearing House

Mental Health Library (03) 9342 2574

Royal Park Hospital (03) 9342 2575
Park Street

Parkville 3052

Child and Adolescent Mental Health Services

Metropolitan Areas

Alfred Hospital (03) 9526 4400
(Brighton, Caulfield, Chelsea, Malvern, Moorabbin, Mordialloc, Port Melbourne, Prahran, St Kilda, Sandringham, South Melbourne)

Austin & Repatriation Hospital (03) 9496 5108

(Camberwell, Collingwood, Diamond Valley, Doncaster/Templestowe, Eltham, Fitzroy, Hawthorn, Heidelberg, Kew, Northcote, Preston, Richmond, Whittlesea)

Maroondah Hospital (03) 9870 9788
(Croydon, Healesville, Lilydale, Ringwood, Sherbrooke, Upper Yarra)

Monash Medical Centre (03) 9550 1300

(Berwick, Box Hill, Cranbourne, Dandenong, Flinders, Frankston, Hastings, Knox, Mornington, Nunawading, Oakleigh, Pakenham, Springvale, Waverley)

Royal Children's Hospital (03) 9345 6011

(Altona, Broadmeadows, Brunswick, (03) 9345 5511

Bulla, Coburg, Essendon, Footscray, Melbourne, Werribee, Williamstown)

Western/Sunshine Hospital (03) 9365 1333

(Bacchus Marsh, Keilor, Melton, Sunshine)

Country Areas

Barwon South Western Region
(Bannockburn, Barrabool, Barwon South, Bellarine, Camperdown, Colac, Corio, Geelong, Geelong West, Hamilton, Newtown, Portland, Queenscliff, Warrnambool)

Colac Child & Adolescent Mental Health Service (052) 21 7532
Geelong Hospital Child & Adolescent Mental Health Service (052) 21 7532

Warrnambool Child & Adolescent Mental Health Service (055) 61 9100

Gippsland Region

(Bairnsdale, Korumburra, Moe, Morwell, Orbost, Sale, Traralgon, Warragul, Wonthaggi)
Gippsland Child & Adolescent Mental Health Service (051) 71 1255

Grampians Region

(Ballarat, Grampians, Wimmera)
Grampians Child & Adolescent Psychiatry Service (053) 34 1904

Hume Region

(Benalla, Bright, Seymour, Shepparton, Wodonga, Wangaratta, Yea)

Goulburn Valley Child & Adolescent Mental Health Service (058) 32 9490

North East Child Adolescent & Family Psychiatry Service (057) 21 9988

Loddon Mallee Region

(Bendigo, Eaglehawk, Kerang, Kyneton, Mildura, Northern Mallee Area, Swan Hill)

Bendigo Child & Adolescent

Mental Health Services (054) 43 5166
Mildura Hospital, Child & Adolescent Mental Health Service (050) 22 3500
Public Hospital Emergency Departments
(see pages 1247-8 of 1996 Melbourne 'White pages')
¥ Alfred (Prahan)
(03) 9276 2000
¥ Austin & Repatriation Medical Centre (Heidelberg)
(03) 9496 5000
¥ Box Hill
(03) 9895 3333
¥ Dandenong
(03) 9791 6000
¥ Monash Medical Centre (Clayton)
(03) 9550 1111
¥ Maroondah (Ringwood)
(03) 9871 3333
¥ Preston & Northcote Community Hospital
(03) 9285 2222
¥ Royal Children's (Parkville)
(03) 9345 5522
¥ Royal Women's (Carlton)
(03) 9344 2000
¥ Royal Melbourne (Parkville)
(03) 9342 7543
¥ Saint Vincent's (Fitzroy)
(03) 9288 2211
¥ Western (Sunshine)
(03) 9319 6666
Telephone Counselling, Information and Referral Services
¥ Lifeline
131 114
¥ Kidsline
(freecall) 1800 551 800
¥ Crisis Line
(03) 9329 0300
¥ Poisons Information

131 126
¥ Direct Line (alcohol & drug information service)
(03) 9416 1818 or (freecall) 1800 136 385
Other
¥ Medical Practitioners
(see pages 1790-1811 of 1996 Melbourne 'Yellow pages')
¥ Community Health Centres
¥ Compassionate Friends
300 Camberwell Road
Camberwell 3124
(03) 9882 3355

How Can I Help

All suicidal threats must be taken seriously. While contemplating suicide, an adolescent's perception of reality is often quite different from actual reality. If contact is made with a young person who is suspected of showing suicidal tendencies, it is essential to take rapid and appropriate action. Do not assume the situation will cure itself. It is far better to take action if the possibility of suicide exists, than to deal with the aftermath of a suicide. While caution is required, what you do between identifying the imminent risk and the arrival of professional help may save a life. During this time, you can assist the adolescent to feel less isolated and alone.

Suicide Intervention Is Based on an Approach of:

¥ affirming the person - using whatever technique one feels comfortable with to make the

adolescent feel valued and worthwhile.

¥ affirming the problem - recognising the adolescent's concerns about the problem and not denying the issue or its importance to the person.

¥ Negating the solution - presenting alternatives and facilitating different perspectives with the adolescent in such a way as to avoid lecturing or preaching.

The Following Guidelines for Dealing with Youth with Suicidal Tendencies May Prove Useful:

¥ Believe the person - take the person's claims seriously.

¥ Be calm and understanding - don't sound shocked by anything the person tells you.

¥ Show concern, listen carefully and ask constructive questions about the way the person is thinking and feeling.

¥ Suggest that the person get professional help as soon as possible. Refer to the list of contacts in this kit. Help the person make this contact. Check that appointments are kept.

¥ If the person refuses or is incapable of seeking help, immediately consult with a health or welfare professional for advice on how to handle the situation. This should be done with the parent's involvement. However, in emergencies, direct action without the consent of the parents may be necessary.

What To Do If Your Child Talks About Suicide

Show Your Understanding and

Support by:

¥ Being there fully.

¥ Listening and encouraging them to talk.

¥ Acknowledging their fear, sadness or despair.

¥ Showing you are taking their concern seriously.

¥ Providing reassurance without dismissing the problem.

Try to Avoid:

¥ Interrupting with stories of your own.

¥ Being judgemental or moralising.

¥ Offering too much advice.

¥ Becoming angry.

¥ Panicking.

In Dealing with a Suicidal Adolescent

You Should:

¥ Be willing to listen and hear.

Reflect back the thoughts and feelings of the person.

¥ Show interest, concern and a willingness to help.

¥ Avoid judging the person's problems. While the break-up of relationships, for example, may seem trivial, it can be significant to an adolescent.

¥ Be sensitive to the relative seriousness of the thoughts and feelings.

¥ Be prepared to ask if the person is thinking of hurting or killing themselves.

¥ Avoid panic if the answer is 'yes'.

¥ Avoid debating suicide as an option, moralising or challenging the person. It may be more useful to accept what has been said and to suggest any action be

postponed until other options have been explored.

- ¥ Avoid allowing yourself to be sworn to secrecy.
- ¥ Get help from professionals.
- ¥ Build support and trust.
- ¥ Present options.
- ¥ Use mainly open-ended questions, with closed questions when a definite response is needed.
- ¥ Watch and listen for warning signs.
- ¥ Show a willingness to discuss the issue of suicide openly and frankly.
- ¥ Tell the person you care.
- ¥ Trust your knowledge, observations and feelings.
- ¥ Assess lethality.
- ¥ Use terms like 'Harm yourself' and 'kill yourself'.
- ¥ Involve others, for example, colleagues, family and friends.
- ¥ Inform the person you must act on the information and inform others.
- ¥ Stay with the person if he or she is considered to be an acute risk.
- ¥ Acknowledge the reality of suicide as a choice, but indicate that there are other alternatives.
- ¥ Acknowledge the person's feelings of hopelessness.
- ¥ Convey a message of hope.
- ¥ Point out the consequences of suicide for the person and those left behind.
- ¥ Establish a plan for what is to happen next.
- ¥ Take action and affirm that something is being done.

- ¥ Ensure no access to lethal weapons and medications.
- ¥ Give 24-hour emergency contact numbers.

- ¥ Keep calm.
- ¥ Show empathy.
- ¥ Keep diagnosis, analysis and interpretation to yourself.
- ¥ If possible, follow-up and monitor progress after the immediate crisis is over.

Further Information

Other information sheets are:

How Can I Help

Statistics on Suicide Among Young People in Australia

Suicide Bibliography

The Myths of Suicide

What Are Suicide Risk Factors

What Are the Warning Signs

What Causes People to Commit Suicide

Youth Suicide Prevention

Activities

and are available from:

Mental Health Library

1st Floor, Clinical Services Centre

Royal Park Hospital

Park Street

Parkville, Victoria 3052

Tel: (03) 9342 2574/5

Fax: (03) 9342 2578

E-mail: Mhealth@Vicnet.net.au

August 1996

The Myths of Suicide

There are a number of commonly-held incorrect beliefs about suicide. These myths of suicide stand in the way of providing assistance for those who are in danger.

By removing the myths, those

responsible for the care and education of young people will be more able to recognise those who are at risk and provide the help that is needed.

Myth

Young people who talk about suicide never attempt or complete suicide.

Fact

Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt. Those who are most at risk will show other signs apart from talking about suicide. If you have concerns about a young person who talks about suicide:

¥ Encourage them to talk further and help them to find appropriate counselling assistance.

¥ Ask if they are thinking about making a suicide attempt.

¥ Ask if they have a plan.

¥ Think about the completeness of the plan and how dangerous it is. Do not trivialise plans that seem less complete or less dangerous. All suicidal intentions are serious and must be acknowledged as such.

¥ Encourage the young person to develop a personal safety plan. This can include time spent with others, check-in points with significant adults, plans for the future.

Myth

A promise to keep a note unopened and unread should always be kept.

Fact

Where the potential for harm, or

actual harm, is disclosed then confidentiality cannot be maintained.

A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note is a late sign in the progression towards suicide.

Myth

Attempted or completed suicides happen without warning.

Fact

The survivors of a suicide often say that the intention was hidden from them. It is more likely that the intention was not recognised. These warning signs include:

¥ The recent suicide, or death by other means, of a friend or relative.

¥ Previous suicide attempts.

¥ Preoccupation with themes of death or expressing suicidal thoughts.

¥ Depression, conduct disorder and problems with adjustment such as substance abuse, particularly when two or more of these are present.

¥ Giving away prized possessions, making a will or other final arrangements.

¥ Major changes in sleep patterns - too much or too little.

¥ Sudden and extreme changes in eating habits, losing or gaining weight.

¥ Withdrawal from friends, family or other major behavioural changes.

¥ Dropping out of group activities.

¥ Personality changes such as

nervousness, outbursts of anger, impulsive or reckless behaviour, or apathy about appearance or health.

¥ Frequent irritability or unexplained crying.

¥ Lingering expressions of unworthiness or failure.

¥ Lack of interest in the future.

¥ A sudden lifting of spirits, when there have been other indicators, may point to a decision to end the pain of life through suicide.

Myth

If a person attempts suicide and survives, they will never make a further attempt.

Fact

A suicide attempt is regarded as an indicator of further attempts. It is likely that the level of danger will increase with each further suicide attempt.

Myth

Once a person is intent on suicide, there is no way of stopping them.

Fact

Suicides can be prevented. People can be helped. Suicidal crises can be relatively short-lived. Suicide is a permanent solution to what is usually a temporary problem. Immediate practical help, such as staying with the person, encouraging them to talk and helping them build plans for the future, can avert the intention to attempt or complete suicide. Such immediate help is valuable at a time of crisis, but appropriate counselling will then be required.

Myth

People who threaten suicide are just seeking attention.

Fact

All suicide attempts must be treated as though the person has the intent to die. Do not dismiss a suicide attempt as simply being an attention-gaining device. It is likely that the young person has tried to gain attention and, therefore, this attention is needed. The attention that they get may well save their lives.

Myth

Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

Fact

Talking about suicide provides the opportunity for communication. Fears that are shared are more likely to diminish. The first step in encouraging a suicidal person to live comes from talking about feelings. That first step can be the simple inquiry about whether or not the person is intending to end their life. However, talking about suicide should be carefully managed.

Myth

Suicide is hereditary.

Fact

Although suicide can be over-represented in families, it is not genetically inherited. Members of families share the same emotional environment, and the completed suicide of one family member may well raise the awareness of suicide as an option for other family members.

Myth

Only certain types of people become suicidal.

Fact

Everyone has the potential for suicide. The evidence is that predisposing conditions may lead to either attempted or completed suicides. It is unlikely that those who do not have the predisposing conditions (for example, depression, conduct disorder, substance abuse, feelings of rejection, rage, emotional pain and anger) will complete suicide.

Myth

Suicide is painless.

Fact

Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of the pain.

Myth

Depression and self-destructive behaviour are rare in young people.

Fact

Both forms of behaviour are common in adolescents. Depression may manifest itself in ways which are different from its manifestation in adults, but it is prevalent in children and adolescents. Self-destructive behaviour is most likely to be shown for the first time in adolescence and its incidence is on the rise.

Myth

All suicidal young people are depressed.

Fact

While depression is a

contributory factor in most suicides, it need not be present for suicide to be attempted or completed.

Myth

Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over.

Fact

The opposite may be true. In the three months following an attempt, a young person is at most risk of completing suicide. The apparent lifting of the problems could mean the person has made a firm decision to suicide and feels better because of this.

Myth

Once a young person is suicidal, they will be suicidal forever.

Fact

Most young people who are considering suicide will only be that way for a limited period of their lives. Given proper assistance and support, they will probably recover and continue to lead meaningful and happy lives unhindered by suicidal concerns.

Myth

Suicidal young people cannot help themselves.

Fact

Whilst contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around

them, young people can gain full self-direction and self-management in their lives.

Myth

The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.

Fact

All people who interact with suicidal adolescents can help them by way of emotional support and encouragement.

Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.

Myth

Most suicidal young people never seek or ask for help with their problems.

Fact

Evidence shows that they often tell their school peers of their thoughts and plans. Most suicidal adults visit a medical doctor during the three months prior to killing themselves. Adolescents are more likely to 'ask' for help through non-verbal gestures than to express their situation verbally to others.

Myth

Suicidal young people are always angry when someone intervenes and they will resent that person afterwards.

Fact

While it is common for young people to be defensive and resist help at first, these behaviours are often barriers imposed to test how much people care and are

prepared to help. For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.

Myth

Break-ups in relationships happen so frequently, they do not cause suicide.

Fact

Suicide can be precipitated by the loss of a relationship.

Myth

Suicidal young people are insane or mentally ill.

Fact

Although suicidal adolescents are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most are not legally insane. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need psychiatric help.

Myth

Most suicides occur in winter months when the weather is poor.

Fact

Seasonal variation data are essentially based on adult suicides, with limited adolescent data available. However, it seems adolescent suicidal behaviour is most common during the spring and early summer months.

Myth

Suicide is much more common in

young people from higher (or lower) socioeconomic status (SES) areas.

Fact

The causes of suicidal behaviour cut across SES boundaries. While the literature in the area is incomplete, there is no definite link between SES and suicide. This does not preclude localised tendencies nor trends in a population during a certain period of time.

Myth

Some people are always suicidal.

Fact

Nobody is suicidal at all times. The risk of suicide for any individual varies across time, as circumstances change. This is why it is important for regular assessments of the level of risk in individuals who are 'At risk'.

Myth

Every death is preventable.

Fact

No matter how well intentioned, alert and diligent people's efforts may be, there is no way of preventing all suicides from occurring.

Myth

The main problem with preventive efforts is trying to implement strategies in an extremely grey area.

Fact

The problem is that we lack a complete understanding of youth suicide and know more about what is not known than what is fact.

Further Information

Other information sheets are:

How Can I Help

Statistics on Suicide Among Young People in Australia

Suicide Bibliography

The Myths of Suicide

What Are Suicide Risk Factors

What Are the Warning Signs

What Causes People to Commit Suicide

Youth Suicide Prevention Activities

and are available from:

Mental Health Library

1st Floor, Clinical Services Centre

Royal Park Hospital

Park Street

Parkville, Victoria 3052

Tel: (03) 9342 2574/5

Fax: (03) 9342 2578

E-mail: Mhealth@Vicnet.net.au

August 1996

What Are the Suicide Risk Factors

The following factors predispose young people to attempt or complete suicide. The risk is greater when more than one factor is present. The risk factors include:

Some personality traits.

Social and cultural factors.

Family stresses.

Psychiatric disorder.

Prior suicidal behaviour.

Behavioural factors.

Biochemical and genetic factors.

Exposure to attempted or completed suicides.

~ *Stressful life events.*

Personality Traits

Young people at risk have displayed withdrawal, perfec-

· tionism, poor impulse control, aloofness, aggression, lack

· of trust, rigidity and hopelessness. Dysfunctional person-

ality traits are not psychiatric disorders. However, in

tandem with depression, conduct disorder or substance

abuse, they add to the danger of an individual attempting

or completing suicide.

Social and Cultural Factors

Mental Illness

These do not explain suicide, but there is a direct correlation

with the increase in the rate of youth suicide. They must

There are many psychiatric disorders that can increase

the risk of suicide. These include depression manic therefore, be considered as risk factors, and include:

· Increased rates of violence accompanied by decreased depressive disorders, conduct disorders and schizophre levels of concern.

nia. Those who are intent on suicide are unlikely to

· Marriage dissolution, remarriage and changes in family recognise their own emotional state. structure.

· Increased mobility, with disruption of friendships and

social networks.

People who have previously attempted suicide are at risk

· Uncertainty through changes in employment residence and access to education.

· Changing roles of men and women

· Larger and less personal communities.

Family Stresses

If considerable difficulties exist in childhood, there is more

Behavioural risk factors include:

risk that the young person will attempt or complete suicide

Other family risk factors include:

· Death of a parent, caregiver or another family member

· Partnership dissolution and separation.

Behavioural Factors

Behavioural risk factors include:

Inappropriate use of alcohol, drugs or solvents

Writing suicide notes and choosing suicide methods

Variations in work performance of daily lifestyle

· Behaviour indicating feelings of rejection, humiliation,

Further Information

hopelessness or isolation

Other information sheets are:

· Impulsive behaviour and other conduct disorders,

How Can I Help

including rage anger and hostility.

Statistics on Suicide Among Young People in Australia

Suicide Bibliography

Biochemical and Genetic Factors

The Myths of Suicide

Studies have established that there is an association

What Are Suicide Risk Factors

between reduced brain activity and subsequent suicide or
What Are the Warning Signs
violent suicide attempts. It is unclear whether this activity
What Causes People to Commit Suicide
alone has a direct effect on suicidal behaviour or whether
Youth Suicide Prevention Activities
it is mediated through specific psychiatric disorders. No
and are available from:
direct relationship between genetic inheritance and
Mental Health Library
suicide has been established.
1st Floor, Clinical Services Centre

Royal Park Hospital

Park Street
Exposure to Attempted or Completed
Parkville, Victoria 3052
Suicide

Tel: (03) 9342 2574/5

This can be in a number of ways:

Fax: (03) 9342 2573

- Seeing the person who completed suicide and being
E-mail: Mhealth@V'cnet.net.au
involved in the aftermath.
- Having talked with or seen the person on the day of the
August 1996
suicide.
- Belonging to the family of the deceased.
- Being a close friend.
- Being in the same class or group.
- Being a friend of the family.
- The attempted or completed suicide of a role model.
- Reading or hearing about the death in the media.

Stressful Life Events

Environmental stressors include events that engender feelings of rejection, humiliation, rage, shame or a desire to get even, including sexual and physical abuse.

Statistics on Suicide Among

Young People in Australia

In Australia today, more than 2000 deaths per annum are recorded as suicides. International reports show that increasing suicides among young people are also a problem in several other industrialised nations.

Youth Deaths Due to Suicide

Increasingly, male rates account for all of this upward

In 1993, suicide was the recorded cause of death of

trend, with the rate for females showing a slight downward

2081 Australians. By far the majority of these deaths

trend during the same period.

involved males (1687 or 81 per cent of the total number of

suicides), and of these, 345 (20 per cent) were young

Graph 1 shows the trends for males and females overall for

men 15 to 24 years of age.

the last 12 years (that is, 1982-93)

together with those for

males and females in the 15 to 24 age group.

Among females, deaths by suicide are much lower, and

the age distribution is more even.

Table 1 shows the number and rate of deaths attributed to

suicide for males and females for all age groups in 1993.

Trends in Suicide Deaths

Any analysis of trends in suicide over time needs to take

account of overall population changes in Australia during

the same period. For this reason, the number of deaths

per 100,000 population (that is, the crude death rate in

statistical terms) is used for comparative purposes.

The overall rate was relatively stable throughout 1973-

1985, with a figure of around 11 deaths per 100,000

during that time. More recently however the picture has

changed.

Table 1: Suicide deaths—numbers (and rates per 100,000 of population), Australia, 1993

Comparison with Other Causes of Death Statistics for Selected Industrialised Among Young People Countries

The youth suicide rate in Australia is high by international

standards. Table 3 shows Australia's position among a wider range of countries.

Graph 2 shows the trends for the three leading causes

of death for 15 to 24-year-olds for the period 1982-93.

The seriousness of suicide in Australia today is illustrated

The text and data contained in this information sheet have by the fact that it is now approaching motor vehicle

been sourced from the Commonwealth Department of accidents as the leading cause of death among young

Human Services and Health 1995, *Youth Suicide in Australia: A Background Monograph*, Australian Government

Publishing Service.

The third leading cause of death in this age group is 'other injuries', including non-motor vehicle accidents, poisonings and drownings. Deaths from this cause have

Further Information

remained relatively constant throughout the period.

Other information sheets are:

How Can I Help

Urban/Rural Differences in Youth Suicide

Statistics on Suicide Among Young People in Australia

Suicide Bibliography

Comprehensive statistics showing the differences between

The Myths of Suicide

suicide deaths in urban and rural areas have only been

What Are Suicide Risk Factors

available since 1986. These data indicate that, as a

What Are the Warning Signs

population group, males living in rural areas have a

What Causes People to Commit Suicide

consistently higher rate of suicide than their urban counter

Youth Suicide Prevention Activities

parts in every year for which data are currently available

and are available from:
(see table 2).

Mental Health Library

1st Floor, Clinical Services Centre

Royal Park Hospital

Park Street

Parkville

What are the Warning Signs

The ability to predict suicidal behaviour is still relatively poor. It is difficult to distinguish those likely to attempt suicide from those who will complete suicide.

However, in approximately 80 per cent of cases, young people who complete suicide have communicated suicidal thoughts and feelings and their intent to kill themselves to someone prior to the suicidal act.

Although it is not possible to prevent every suicide, it is possible to recognise changes in behaviour and the existence of common crises that may precipitate suicidal behaviour. Those who are likely to come into contact with young people can help.

Knowledge of the warning signs and risk factors may help people to intervene in the potentially destructive process in which a young person is enveloped and take action to alleviate it.

The more of the observable signs, the more stressful episodes and chronic life stresses that a young person shows, the more at risk of suicidal behaviour they generally are. It is important to note the duration and

intensity of these factors and to consider any changes in observable behaviour in the light of the individual concerned rather than necessarily comparing one person with another. Depressed mood and drug or alcohol abuse is a particularly deadly combination.

Observable Signs of Suicide Risk

Classroom Behaviour

¥ Marked decline in school performance and levels achieved.

¥ Skipping classes and opting out of school activities generally.

¥ Poor concentration, sleepiness, inattentiveness.

¥ Unusually disruptive or rebellious behaviour.

¥ Death or suicide themes dominate written, artistic or creative work.

¥ Loss of interest in previously pleasurable activities.

¥ Inability to tolerate praise or rewards.

Interpersonal Behaviour

¥ Giving away prized possessions.

¥ Sudden changes in relationships, for example, exhibiting disruptive behaviour.

¥ Withdrawing from friends and social involvements.

¥ Not wanting to be touched by others.

Other Behavioural Signs

¥ Apathy about dress and appearance.

¥ Sudden change in weight.

¥ Running away from home.

¥ Risk-taking and careless behaviour.

¥ 'Accident proneness'.

¥ Sudden and striking personality changes and changes in mood.

¥ Overt signs of mental illness (for example, hallucinations).

¥ Loss of sense of humour or sudden compulsive joking.

¥ Sleeping pattern changes.

¥ Self-mutilation behaviours.

¥ Noticeable increase in compulsive behaviour.

¥ Development of extreme dependency.

¥ Sudden happiness after a prolonged period of depression.

¥ Impulsive tendencies.

¥ Depressive tendencies.

¥ Unrealistic expectations held of self.

Verbal Expression of Suicidal Intent or Depression

¥ Direct statements, for example, 'I wish I were dead', 'I am going to end it all'.

¥ Indirect statements, such as, 'No one cares if I live or die', 'Does it hurt to die?'.

Episodic Stressful Precipitants (Stressful Episodes)

School and Society

- ¥ In trouble with school authorities or police.
- ¥ Loss or disappointment in school.
- ¥ Change of school and/or address.
- ¥ Strong demands from adults for show of strength, competence and effectiveness.

Interpersonal and Physical Problems

- ¥ Loss of an important person through death or divorce.
- ¥ Recent suicide of friend or relative.
- ¥ Breaking up with boyfriend or girlfriend.
- ¥ Exposure to violence, incest, rape.
- ¥ Abusing drugs or alcohol.
- ¥ Feared pregnancy.
- ¥ Refusal by significant other to provide anticipated help, support or love.
- ¥ Major disappointment or humiliation.
- ¥ Major family dysfunction.

Chronic Stressful Life Situations

Home Life

- ¥ Chronic depression or mental illness in parent(s).
- ¥ Incest or child abuse.
- ¥ Severe parental conflict.
- ¥ Family involvement with drug or alcohol abuse.
- ¥ Poor communication with parents.
- ¥ Pressures for high achievement to gain parental approval or acceptance.
- ¥ Exposure to suicide, suicidal behaviour or violent death of relatives or friends.

Interpersonal Relations

- ¥ Involvement in physical violence.
- ¥ Inability to relate well to peers.
- ¥ Sexual promiscuity.
- ¥ Inability to enjoy or appreciate friendships or to express affection openly.
- ¥ Mood swings and occasional outbursts.
- ¥ Feelings of worthlessness, being a burden or having let parents or others down.
- ¥ Feelings of guilt, failure, having no control over their lives.

Further Information

Other information sheets are:

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Youth Suicide Prevention Activities

There are many different approaches being used at Government and community level in an endeavour to reduce current high rates of youth suicide. The following is a summary of research, strategies, programs and services for youth suicide prevention in Victoria.

Research

Coroner's Working Party on Youth Suicide

It is anticipated that when the data analysis is completed it will facilitate:

¥ Identification of particular 'At risk' groups, constellations or clusters.

¥ An attempt to develop strategies in prevention, targeting at risk groups.

Victorian Adolescent Cohort Study

The project, undertaken through the Centre for Adolescent Health, began in 1992 with a cohort of 2000 Year 8 students in 44 Victorian schools. The results provide epidemiological information on the causal factors in three major antecedents of youth suicide - adolescent depression, substance abuse and deliberate self-harm. This information will be used to develop prevention strategies.

Uniting Church Study

The Uniting Church, in conjunction with the Cairnmillar Institute, has released a register of services available throughout Victoria providing crisis counselling, postvention (programs dealing with the aftermath of suicide - concerned with survivors and the creation of safe environments) and other services related to youth suicide. (Phone: (03) 9723 5266).

Direct (Primary) Interventions

Psychiatric Services, Human Services

Child and Adolescent Mental Health Services (CAMHS)

The Child and Adolescent Mental Health

Service provides a network of multidisciplinary teams in all Human Services regions, providing intake and crisis responses, assessment and treatment services to meet the needs of children and adolescents up to the age of 18. CAMHS have also established 'outreach' into the community,

providing information and consultation on an ongoing basis.

Community Mental Health Services
Community Mental Health Services, are available to those 16 years and over, if not more appropriately seen at a CAMHS, through:

¥ Mobile Support and Treatment Services, which provide assertive outreach, intensive long-term support, treatment and rehabilitation of a client group known to be at high risk.

¥ Crisis Assessment and Treatment Services which provide a rapid, 24-hour response to people in crisis, including those exhibiting suicidal intent and high risk behaviours.

¥ Community Mental Health Centres, which provide a range of community-based assessment, treatment and consultancy services and a single point of contact for access by other services.

Early Psychosis Prevention and Intervention Centre (EPPIC)

EPPIC has successfully piloted a programmatic approach to the treatment of first episode psychosis, which has a high risk of recurrence. The older adolescents suffering such episodes have also been identified as being at high risk of suicide. The outpatient program provides a comprehensive service based on an explicitly documented recovery and preventive philosophy.

Child, Adolescent and Family Welfare (Human Services)

Juvenile Justice

Juvenile Justice clients comprise an adolescent population of 1200 and, within this, a smaller group at greater risk of self-harm and suicide - those who are on protective orders prior to coming into Juvenile Justice, have depressive disorders, have made prior suicide attempts, are drug and alcohol abusers or have a previous psychiatric illness.

Interventions are targeted to both groups by:

¥ Mandatory training for all generalist youth officers in self-harm prevention.

¥ A referral mechanism for the smaller identified at risk group to the Juvenile Justice Specialist Support Services or to CAMHS or other mental health services for the more severe cases.

Within the residential centres at Parkville, Melbourne Juvenile Justice Centre and Malmsbury, additional prevention strategies are:

¥ Increased environmental control to limit access to methods of self-harm and

training of staff in management methodologies to reduce potential stress factors in at risk groups.

¥ Strengthened quality assurance mechanisms to ensure best practice case management.

¥ Introduction of postvention strategies to prevent contagion (or 'copycat').
Protective Services

Protective services' clients comprise 12-17 year olds who have been subject to physical abuse, sexual abuse and neglect. Common among this client group of 1220 children and adolescents on protective orders are substance abuse, previous self-harm, and unstable domestic arrangements with a concomitant inability to establish stable relationships. Once risk is identified, several responses are available through:

¥ Behaviour Intervention Support Teams.

¥ Referral to CAMHS.

¥ Referral to Secure Welfare with professional mental health input.

¥ Adolescent Support Program which provides assistance through 12 non-government organisations

¥ Streetwork.

¥ Families First.

¥ Intensive Youth Support Service.

Primary Care (Human Services)

Community Health Centres (CHCs)

Some CHCs have specific programs to work directly with young people, whilst general counselling is available at all 77 CHCs. The Innovative Health Services for Homeless Youth Program, administered by Primary Care, has funded a broad range of services for youth, the majority of which are delivered through CHCs in rural and metropolitan regions. Programs deal with issues such as crisis management, substance abuse, sexual abuse, psychiatric and psychological disorders. They also establish linkages with other service providers, such as schools and youth workers.

Telephone Counselling, Information and Referral Services

There are 24 telephone counselling, information and referral services operating in Victoria. All professionally run telephone counselling services deal with issues of relevance to young people at risk.

Approximately five to six per cent of all calls relate to suicide, although the number of calls from young people to these generalist services tends to be relatively small. Ballarat Lifeline has therefore established a dedicated and specifically

trained Youthline.

Sexual Assault Services

Centres Against Sexual Assault (CASAs) target victims of sexual abuse and their families.

Regional and statewide services provide crisis care, specialist counselling and support services, as well as providing consultation services to relevant agencies.

Other Auspices

Kids Helpline Telephone Counselling Service Available throughout Australia on a 008 number for the 5-18 age group, it has developed an extensive register of local services for referral. In Victoria, in the year to February 1995:

¥ 1410 calls (9 per cent of State total) related to the broad category of 'emotional problems'.

¥ 5837 calls (37.4 per cent of State total) related to failure of interpersonal relationships.

Private Clinicians and Clinics

Australian Funeral Directors Association

Non-Government Organisations

Secondary Interventions

General

Youth Suicide Prevention Working Party

Established by VicHealth in 1993 comprising representatives from government departments, non-government organisations, academic institutions, service agencies and the three education sectors.

Youth Suicide Intersectoral Collaboration Project

The project aims to develop intersectoral cooperation between service providers in one rural and one metropolitan region, assisting workers from the health, education, welfare, youth, law enforcement and local government sectors whose job brings them into regular contact with young people.

Anticipated outcomes will be:

¥ Development of formal protocols between hospitals and primary health care services.

¥ Development of strategies for teachers to identify those at risk and to provide support.

¥ Establishment of a more confident workforce.

¥ Establishment of better knowledge of where to seek help.

¥ A manual to assist communities to develop a youth suicide prevention strategy.

¥ Development of an authoritative, formalised network to meet on a regular basis.

Transport Accident Commission Victoria

A 'Learn and live' campaign for drivers and

learner-drivers covers issues of risk-taking, self-esteem, relationships and lifeskills, via:

¥ Television advertisements.

¥ A 12-part television series targeted at youth, covering themes including suicide.

¥ School-based curriculum on crash prevention delivered via professional development of teachers.

¥ Simulator for driver education.

Counselling, Support and Consultancy

Coroner's Court Counselling and Support

Services/Lifeline Victoria Joint Project

The Coroner's Court Counselling and Support

Services are to develop protocols for professionals in the post-suicide phase. This

will be linked with funding for Lifeline

Victoria to establish self-help groups for

those affected by a suicide

Homeless Agencies Resource Project (HARP)

Three HARP projects currently operate in

Melbourne through the Austin, Western and

Maroondah Hospitals Child and Adolescent

Mental Health Services. The target population

is 12-24 year olds using housing and

residential services. HARP deals with broad

mental health issues, providing an early

intervention strategy and postvention

responses, aiming to improve delivery of

mental health via an interdependent approach

of consultation and education.

Local Rural Initiatives

Local initiatives around the State, such as

the Central Highland Youth Network in

Ballarat, East Gippsland Youth Suicide

Project in Bairnsdale, Central Gippsland

Regional Youth Network (Moe, Morwell and

Traralgon), Loddon-Campaspe Regional Suicide

Awareness Group and Kyneton Youth Development

Network, are attempting to develop local

networks for support, referral and education,

protocols with local hospitals, programs for

students in local schools and provision of

information pamphlets targeted to those

affected by suicide.

Training

'Imminent Risk assessment' Workshops

Working with teachers, clergy, social

workers, psychologists, drug and alcohol

workers and youth/housing workers is a key

part of the suicide prevention strategy, as

it is often workers' fear of over-reaction or

being seen by others to be over-reacting,

which prevents them from becoming proactive

in intervention. The program provides

knowledge and develops skills in problem

solving and increasing the sense of self-

esteem, belonging and worth in young people.

Centre for Social Health

Conducts training workshops on a range of social health issues including:

¥ Youth Suicide Prevention for Primary Care Workers (including community health, social, youth and welfare workers, teachers and direct care workers).

¥ Youth Suicide Prevention Policy and Procedures, for managers and senior staff responsible for development and implementation of suicide prevention policies and work practices.

Human Services Staff Development Branch
Psychiatric Services Training and Development Unit offers two-day workshops for clinical staff in public mental health inpatient and community settings. These workshops which aim to increase participants' knowledge of suicide, risk factors contributing to suicide and principles of management.

Child, Adolescent and Family Welfare Training Unit conducts a range of courses related to risk management, adolescent suicide and self-harm, drug and alcohol abuse, separation and loss and other topics relevant to the mental health of young people.

National Youth Foundation/Suicide Prevention Australia Training Package

A comprehensive professional training program and Train-the-Trainer manual, funded by the Commonwealth Department of Health, has been developed to assist teachers, youth workers, nurses, counsellors and those working with young people in the high risk group.

School-Based Interventions

Primary Care Community Support Fund Project
Directorate of School Education (DSE) and Human Services to explore the possibility of two pilot projects covering a network of primary and secondary schools, in one metropolitan and one rural area, to provide:

¥ In-service training of teachers to improve knowledge of mental illness, its early detection and management of disruptive behaviour disorders.

¥ Secondary consultation on how to deal with behavioural problems.

¥ Tertiary consultation on dealing with particular students with behavioural problems.

¥ School-based assessment and counselling services.

¥ Support to children experiencing grief, trauma, loss, parental discord or mental disorder.

Victorian Board of Studies, 'Healthy families' Project

Will work with 120 primary schools in six

areas, over two and a half years, to promote good mental health in schools.

Options - Promoting Mental Health and Human Rights in Schools

The project aims to analyse school culture in 19 core schools to reduce school violence, bullying and racism to promote healthy relationships between students and schools. Since bullying can lead to alienation, low self-esteem and lack of social relationships with peers and adults, it may also lead to a higher risk of suicide. The project will develop and trial:

¥ Resource kit for schools on preventing bullying, ('Stop bullying').

¥ Curriculum package for Years 5 - 9, ('Healthy Relationships, Healthy schools').

Drug Education Support for Schools (DESS)
The project has assisted 130 schools to develop policy and programs to reduce drug use by young people. The DESS Project has been funded to develop a strategic plan for drug education for the next five years, including recommendations for teacher professional development, parent involvement and strategies for identifying and monitoring 'At risk' students and developing referral networks. A resource package, consisting of curriculum and policy materials and drug-related student welfare information, will be made available to school communities.

Teaching Pro-Social Behaviours to Adolescents
The Australian Guidance and Counselling Association is conducting the project to consider and evaluate programs in 21 schools in Victoria, South Australia and New South Wales. These programs address issues of violence and the development of pro-social behaviours in adolescents. Successful programs will be identified, best practice determined and the results will be published as a database on the range of programs being used by schools across Australia. Behaviours targeted by the programs include bullying, violence and other harmful behaviours.

Community Relations in Education
Targeted in 16 schools in Bairnsdale, Broadmeadows and Dandenong, with a focus on staff development, this project aims to help reduce harassment, discrimination and violence in schools. The project has involved the wider community through reference groups in each focus area and a youth forum.
Extra Edge Project (Student and Youth Services Coordination Project)

This three year project focuses on students in secondary school at risk of leaving early, especially those at risk of homelessness and

subsequent substance abuse and self-harm. The aim is to bring various supports together, by including an 'Extra edge' coordinator for each of the 16 schools in the project with a brief to act as a link in bringing all players together.

Further Information

Other information sheets are:

How Can I Help

Statistics on Suicide Among Young People in Australia

Suicide Bibliography

The Myths of Suicide

What Are Suicide Risk Factors

What Are the Warning Signs

What Causes People to Commit Suicide

Youth Suicide Prevention Activities

and are available from:

Mental Health Library

1st Floor, Clinical Services Centre

Royal Park Hospital

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August 1996

What Causes People to Commit Suicide

It is generally recognised that the factors linked to youth suicide are numerous and complex. Research in the area has not been comprehensive and unravelling causal factors is extremely difficult. Current thinking suggests that individual predisposition and risk factors together determine vulnerability. This is then affected by protective and precipitating factors which can form a threshold leading to suicidal behaviour.

Adolescent Suicide Differs from Adult Suicide in That It Is More Likely to Be

¥ Motivated by revenge.

¥ An act of anger or irritation.

¥ Impulsive.

¥ Romantically and idealistically driven.

¥ Related to low self-esteem.

There Are Two Broad Schools of Thought in Regard to Suicide Causation

¥ The depression model is a medical model in which the problem is conceptualised as belonging to the individual. Under this model the individual is treated for their illness, so the remedy involves mental health interventions.

¥ The stress model points to the social framework in which suicide occurs as being of most importance. The way in which society

influences the individual is seen as vital in explaining suicidal behaviour, so the remedy involves discerning the influential social factors and introducing social change to alleviate their impact on individuals. Popular opinion among lay and professional people favours the view that, adolescents today are under more and different types of stress, compared to young people from earlier generations.

Commonly Expressed Reasons for the Increase in Suicidal Behaviour Include

¥ Increased pressures of modern society and technological change.

¥ High youth unemployment.

¥ Denial of educational opportunities.

¥ Increased social and family disruptions.

¥ Decreased resources for family support (neighbours and extended families).

¥ Isolation of family units.

¥ Increased access to means of self-harm (for example, firearms, drugs, cars and so on).

¥ Increased recognition of youth suicide, creating greater acceptability of it as an option.

¥ Culture of violence in the media, which makes it difficult to talk problems through.

¥ Increased use of alcohol, drugs and medication.

Another view is the standard of living and quality of life for young people in Western countries has improved. Young people have more education, better physical health, more possessions and leisure. So, they have fewer external sources to blame for their misery. This increases their psychological distress and may lead to suicide. It is suggested that the way to counter this is to involve adolescents in activities they find meaningful and fulfilling.

Another Classification of Suicidal Causation Focuses on Motives

¥ Revenge - anger and hostility, combined with the desire to create guilt in significant others and the

tendency of adolescents towards impulsivity.

¥ Isolation - socially isolated young persons who feel unable to fit in, that no one cares or will grieve if they are gone.

¥ Hopelessness - feeling trapped in situations they have no control over and cannot escape (for example, pregnant teenagers or young people from families where there is abuse, alcoholism or divorce).

¥ Failure - self-perceived rather than

actual, in relationships, school or personal achievement. Such people are frequently overachievers.

¥ Loss - seen as the most important cause of suicide. The loss can be real (for example, a relationship, a person who dies or leaves); more obtuse (for example, self-worth or a goal in life); or it can be imagined. Depression affects behaviour, emotions, thinking and even bodily functions and can be caused by biological/genetic factors or psychological factors. It is considered to be the single highest predictor of suicidal behaviour in adolescents. It is not uncommon for adolescents to go through mood swings; indeed many people would consider this an expected feature of adolescence. However, what distinguishes depression from a normal mood swing is the duration and intensity of correlated symptoms.

The American Psychiatric Association's Diagnostic and Statistical Manual (DSM) requires that a minimum number of associated symptoms that lead to functional impairment be evident for a two-week duration. The prevalence of depression increases with age, with significantly more adolescents than children being depressed. Since many depressed adolescents are found to develop mental illnesses as adults or end their lives prematurely, adolescent moodiness cannot simply be dismissed as a passing phase. A working model of adolescent suicide taken from Western Australian Ministry of Education 1993, Youth Suicide Prevention: Resource Package for Student Services Personnel, p.32. (adapted from Shaffer et al, Mattison and Blumenthal & Kupfer) is presented below.

Acknowledgements

The materials in this Kit have been compiled with reference to the following resources: Queensland Department of Education 1991, Dealing with Death and Suicide in the School Community.

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Further Information

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August 1996

Suicide Bibliography

The Mental Health Library is located on the first floor of the Clinical Services Centre, Royal Park Hospital, Park Street, Parkville, Victoria. It is a specialist collection on psychiatry, mental health and related disciplines available to workers in the field across the State.

The Suicide Prevention Collection comprises a reference resource of current books, journals, kits and videos on adolescent suicide prevention as well as helping skills, mental illness, trauma, debriefing, loss and grief, and other related health issues.

The library is open to the public with provision for user pays photocopying, CDROM searching, private study carrels and video previewing facilities. Staff will assist library users to find the most appropriate material for their needs.

The library lends material only to Department

of Human Services employees, staff working for mental health non-government organisations and psychiatry departments in general hospitals. It is possible for people to access materials through other libraries, for example, students through their own tertiary library, members of the public through their local library. Further enquiries should be directed to the Senior Librarian.

The Child and Adolescent Suicide Bibliography lists books and journal material from the collection. Material can be copied at the Mental Health Library and any further requests for specific access to material should be directed to the library. The bibliography can also be regarded as a current awareness bulletin. Some of the material may be found at other libraries. The bibliography will be updated quarterly and those wishing to receive a copy should contact the library.

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Adolescent and Child Suicide

- May 1996

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- Further Information
Other information sheets are:
How Can I Help
Statistics on Suicide Among Young People in Australia
Suicide Bibliography
The Myths of Suicide
What Are Suicide Risk Factors
What Are the Warning Signs
What Causes People to Commit Suicide
Youth Suicide Prevention Activities and are available from:
Mental Health Library
1st Floor, Clinical Services Centre
Royal Park Hospital
Park Street
Parkville, Victoria 3052
Tel: (03) 9342 2574/5
Fax: (03) 9342 2578
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