Focus

Guidelines for youth suicide prevention

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This article contains excerpts from the evidence-based guidelines for primary care providers: *Detection and management of young people at risk of suicide* produced by the RNZCGP. Guideline development involved literature review and consensus by a multidisciplinary group. There is comparatively little high quality evidence available for many issues surrounding youth suicide, so sections have been based on expert opinion. As with all guidelines they are designed as a decision aid to complement expertise and not as a substitute for clinical judgement.

Key points

- New Zealand has one of the highest rates of youth suicide among developed countries
- GPs should be aware of risk factors for suicide in the young
- 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
- Threats of suicide should never be dismissed as gestures or attention-seeking measures
- Management strategies aim to assess and minimise risk of suicide while those at high risk should be referred to specialist mental health services

Despite increasing rates of youth suicide locally, suicide is still rare and a far less frequent occurrence than suicidal ideation and suicide attempt behaviour in young people.

Suicide in young people

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

1. We have one of the highest rates of youth suicide among developed countries.
2. There has been a marked increase in suicide rates among young people in this country during recent decades. In 1997, a total of 142 young people aged 15-24 years died by suicide.

Despite increasing rates of youth suicide locally, suicide is still rare and a far less frequent occurrence than suicidal ideation and suicide attempt behaviour in young people.

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

- up to one quarter will experience suicidal thoughts and ideas, with the majority not acting on these
- up to one in 10 will make a suicide attempt, with most being of minor medical severity and not requiring medical attention
- up to one in 500 will make a serious suicide attempt requiring hospitalisation
- one in almost 4000 will die by suicide.

Risk factors

Suicidal behaviour in young people is frequently the end-point of a multicausal process in which risk factors accumulate to influence risk. The risk factors with best research evidence include the following.

(1) Mental disorders are the strongest risk factors for suicidal behaviour. Studies of suicidal behaviour in young people con
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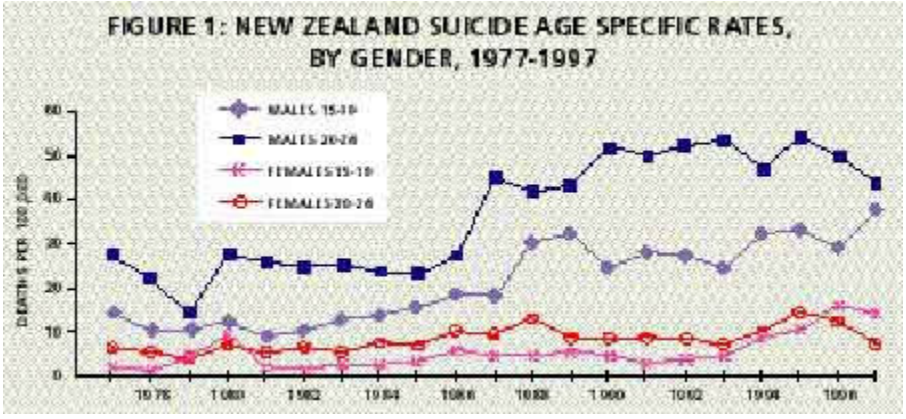

sistently indicate that the majority (80-90 per cent) who die by suicide

or make serious suicide attempts have at least one recognisable mental disorder at the time of their attempt.

(2) Young people at risk of suicide tend to come from socially disadvantaged backgrounds characterised by low socioeconomic status and limited educational achievement.

(3) Research evidence suggests increased rates of suicidal behaviour in young people are associated with a wide range of adverse family factors. These include parental disharmony, parental separation and divorce; parental psychopathology, 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.

(4) There is considerable evidence to suggest 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 only when they occur in individuals vulnerable to suicidal behaviour.

Recognising a significant risk

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.

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 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 required to reduce this risk.

Some opening questions to help primary care providers recognise that a young person may be at risk:

- how are you going generally?
- do you ever feel miserable?
- how are things at home (or where you live)?
- many young people use alcohol and drugs; how about you?

Make time - you may not get another chance

Box 1 lists the risk factors for suicide. 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.

BOX 1: RECOGNISING RISK FACTORS FOR SUICIDE

CONSIDER	RECOGNISE	LOOK FOR
Background risk factors	Individual risk factors	Protective factors ('resilience')
Genetic/biological Social and educational disadvantage Family and parental disadvantage Cultural issues	Previous suicide attempt Prior mental health care Current mental disorders Coexisting disorders Personality factors – Axis II personality disorders Stressful life events – Relationship breakdowns Unemployment Gay, lesbian, bisexual orientation Accumulative risk factors Warning signs	Dispositional attributes of the young person – Social/problem solving skills – Life affirming beliefs – High self-esteem – Internal locus of control Family cohesion – Support/warmth – Absence of discord/ neglect External support Belonging to a social group of peers Having a strong cultural identity

Assessing suicide risk

Box 2 lists ways to assess suicide risk. Pay particular attention to the viability of
If you have a suspicion that a young person is potentially suicidal this may be the most important
consultation of your day

BOX 2: ASSESSING SUICIDE RISK

EVALUATE	EVALUATE	ASSESS
Personal difficulties	Positive resources	Suicide risk
Stressful events Mental disorders Alcohol and substance abuse Coping behaviour Risk taking Ongoing life difficulties Cultural issues	Family and friends Lifestyle Communication of thoughts and active help seeking	Previous suicide attempt Recent suicide among family or friends Suicidal ideation Suicide plans Lethality of method Means to carry out Likelihood of being discovered ***No direct questioning: this will not increase risk***

any suicide plan, the lethality of the method, any impulsivity and your intuition. 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.

Managing suicide risk

Box 3 lists strategies for managing risk. However, it is not possible to eliminate risk entirely. Even using the best assessment and

management methods, a young person may still commit suicide. The objective is to minimise this risk.

Management of underlying factors

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

For management of **non-primary care disorders**, eg, psychosis, severe major depressive disorder and personality disor
der, it is recommended that referral be made to specialist mental health services.

For **high risk of suicide** it is recommended immediate referral be made to specialist mental health services.

For **medium or low risk of suicide**: (a) age 16 years and under, consultation with mental health services is recommended; (b) age 16 and over, consider trial management of precipitating factors, ongoing life difficulties or underlying mental disorders, including substance use disorders, according to the level of skill and expertise of the primary care provider. If there is low response, consultation or referral to mental health services is recommended (in the 16-18 group there should be a lower threshold for referral).

Guidelines

The guidelines were distributed to GPs in November 1999. To obtain a copy please contact Lynn Saul at the RNZCGP office, email: lsaul@rnzcgp.org.nz or Ph 04 496 5999. They are also available on the RNZCGP website (www.rnzcgp.org.nz).

BOX 3: MANAGING SUICIDE RISK

Reduce risk	Consult and refer	Manage underlying factors
Remove the means of harm Determine support Provide 24-hour backup support or refer to mental health team Devise a clear action plan with the young person, agree and record it	Discuss with a colleague or specialist mental health service Involve family/whanau Recommend appropriate agency or therapy Ensure there is a management plan Network with school/educational institution	Precipitating events Ongoing life difficulties Mental disorders Monitor and follow-up SEE TEXT