

Chapter 3:

Risk Assessment of Suicidal Behaviours in Young People

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Introduction

This chapter will cover the correlates of suicide risk particularly in relation to youth. Included in the chapter will be a description of a model that shows the relationship between risk factors and suicidal behaviours, processes for assessment, and suggestions for intervention. A case study will be used to illustrate the main points.

New Zealand has a relatively high suicide rate compared to most other OECD countries: 16.4 per 100,000 for males (all ages) and 5.2 per 100,000 for females in 2002 (ranking sixth highest amongst OECD countries). Suicide rates are higher in Māori than non-Māori: The age-standardised rate of suicide was 12.6 per 100,000 for Māori, compared to 10.1 for non-Māori (The Social Report 2004, Ministry of Social Development). People aged 25–34 years had the highest suicide death rate for any 10-year age group in 2002 (19.6 per 100,000, or 107 deaths), followed by people aged 15–24 years (17.0 per 100,000, with 94 deaths).

Prior to 2000, male and female youth (15-24 years) had the highest rates of suicide by gender of any age group in New Zealand. This resulted in an increased focus on the factors associated with suicidal behaviours among youth. Māori youth have higher suicide rates than non-Māori, older youth (20-24 years) have higher rates than those aged 15-19 years, and males have twice the suicide rate of females.

While a complex mix of factors influences the suicidal behaviour of males and females (Beautrais, 2002), the higher suicide rate amongst males is largely accounted for by their tendency to use more lethal methods of suicide (e.g. hanging, vehicle exhaust gas) than females.

A Model of Suicidal Behaviours

Typically, suicidal behaviours do not suddenly appear but develop out of the interplay between genetic, social and family circumstances, stressors, personality traits and mental health problems. Figure 1 summarises and

synthesises a large body of evidence about the pathways that lead to suicidal behaviours. The figure makes the following assumptions:

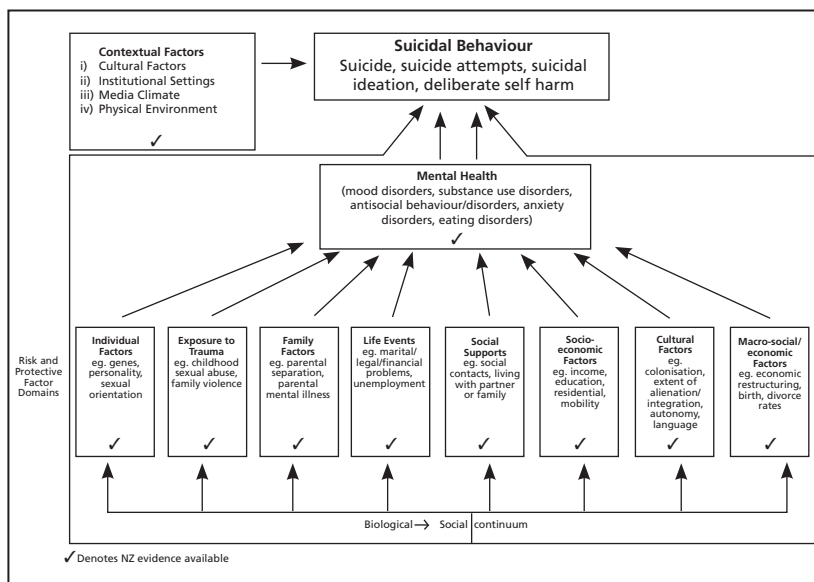
- 1) That the background causes of suicide span a number of domains of variables with these variables ranging from individual level factors (e.g. genes, personality, sexual orientation) to macrosocial factors (e.g. unemployment rates). The figure identifies a number of domains that span individual level factors, exposure to trauma, family factors, life stresses, social supports, socio- economic factors, cultural factors and macrosocial factors as contributing to suicidal behaviours. For each of these domains New Zealand evidence that identifies the role of these factors is available (Beautrais, Collings et al. 2005; Collings and Beautrais 2004).
- 2) That a major route by which background factors contribute to suicidal behaviours is by influencing individual susceptibility to mental health problems and, notably, such conditions as mood disorders, substance abuse, anxiety disorders and antisocial and offending behaviours. This assumption is justified on the grounds that there is consistent evidence to suggest that: (a) the majority of those dying by suicide or making suicide attempts have a recognisable mental health problem; (b) mental health problems (including in particular, mood disorders, substance abuse, and antisocial behaviours) account for well over 50% of suicides and suicide attempts (Beautrais, Collings et al. 2005). At the same time the model recognises that a range of background factors can also make direct contributions to suicidal behaviours. Thus, for example, exposure to unemployment may increase risks of depression, but, at the same time, may also provoke the onset of suicidal behaviour.
- 3) That, in addition to describing the factors that make a direct or indirect causative contribution to suicide, the model also recognises that contextual factors may contribute to this process. Two important contextual factors that may influence rates of suicide within a population are: a. the availability of methods of suicide, and, b. media climates.

The following case study will be used to illustrate factors included in the model, and where relevant, present New Zealand information that underpins the model. In this way it is hoped that the practitioner will see the advantage of such a framework when assessing a young person for suicide.

Case Study

Kirk is a 16 year old Māori male who had become increasingly distressed after his girlfriend of 8 months had ended their relationship 6 weeks ago. He had been making comments like “life sucks” and “what’s the point” to his friends and family. He had

Figure 1: Pathways to Suicidal Behaviour



(Fergusson and Beautrais, personal communication reproduced in its entirety here by permission).

also stopped going to the gym which he always had done on a regular basis, and had begun to increase his alcohol intake. Kirk's friends had become increasingly worried about him and took him along to see a counsellor at a Youth Health Centre.

In talking to Kirk, the counsellor was able to gather the following information. Kirk admitted to having suicidal thoughts most days which had been becoming more intense. He had begun to think about hanging himself and had worked out where there was a rope and where he would do it. The thought of the impact on his family and friends had stopped him acting on his thoughts although he had got close a couple of days ago when he had seen his ex-girlfriend with a new boyfriend. On this occasion he went out and got really drunk with his mates and thinks if he hadn't done this he probably would have gone through with his plan as he was feeling so angry.

Over the last month, Kirk had been having increasing difficulty with his sleep and was finding it harder to motivate himself to go to work. He was feeling really negative about himself and couldn't see that his life was going to get any better for him. He was drinking more alcohol and using cannabis in an attempt to try to improve the way he was feeling.

Other key information from Kirk

- *previous episode of suicidal ideation after previous relationship break-up*
- *history of depression on his mother's side of the family*
- *classmate at school last year had hung himself after relationship break-up*
- *one of his cousins had committed suicide*

Kirk's background indicated a positive relationship with his mother, however his father had been violent towards him and his mother which he had witnessed. His parents had separated when he was aged 10 and since then he had lived with his mother and had little contact with his father. Things had been quite difficult as there wasn't much money coming into the household. He was no longer at school which he described as a mixed experience. He had struggled with schoolwork but had generally got on with teachers and had a good group of friends who he still hangs out with. He was now attending a course and doing work experience which he had been enjoying up until the relationship break-up.

Kirk was able to recognise that things were not going well for him and that he needed help. He was feeling better now that he had told someone about how he had been feeling. He felt he was safe to return home that night and would be able to contact people if he became distressed and suicidal.

The counsellor also spoke to his friends who had brought him in. They described their increasing concerns for Kirk, in particular the comments he had been making around life being pointless, his increased alcohol and cannabis use and how he "just didn't seem to be himself".

Risk Factors to Consider in Assessment

Static Prevalence Factors

Kirk, being Māori, male and aged between 15 and 24 is in a high risk group for suicide in New Zealand. As presented in the introduction, this group within the population has a high risk of suicide compared to other socio-demographic groups.

Presence of Suicidal Behaviours

Kirk admitted to having suicidal thoughts most days which had been becoming more intense.

Thoughts of suicide appear to be relatively common among youth. Beautrais (2000) reports that almost a quarter of young people report having these. Suicide attempts are less common with estimates ranging from 4 to 8 percent of young people reporting that they have attempted suicide some time before they are twenty (Beautrais 2000). However, relatively few of these

result in some form of self harm serious enough to require hospital attention. People in the 20–24 years age group had the highest hospitalisation rate for intentional self-harm (300.5 cases per 100,000 population) with females in the 15-19 years age group having the highest rate at 428 per 100,000. Kirk has not had any previous attempts – Shaffer and Craft (1999) report that a previous attempt is the most potent predictor for males increasing the risk by more than 30-fold.

Method

He had begun to think about hanging himself and had worked out where there was a rope and where he would do it.

The likelihood of death is affected greatly by the means used and the likelihood of interruption. Most youth suicides in New Zealand occur in or near the young person's home. The variety of methods include commonly, hanging, and use of vehicle exhaust gas to suffocate. Much less common methods are jumping from a height, firearms, stepping in front of train or vehicle, deliberate motor vehicle crash, ingestion of poisons, drug overdose, stabbing and cutting, electrocution, and immolation. In New Zealand the first two methods are commonly used, highly lethal, readily available, and it is difficult to restrict access to both.

Availability, opportunity and cultural acceptability are the major factors that determine choice of method for suicide attempts. For example, in the United States where guns are widely available, 60% of all youth suicides are by firearms, whereas, in New Zealand, where gun legislation is more restrictive and rates of gun ownership are much lower, the major method of youth suicide is hanging (Beautrais 2002; Daigle 2005).

Mental Health and Suicide

He had been making comments like “life sucks” and “what’s the point” to his friends and family. He had also stopped going to the gym which he always had done on a regular basis, and had begun to increase his alcohol intake.

Over the last month, Kirk had been having increasing difficulty with his sleep and was finding it harder to motivate himself to go to work. He was feeling really negative about himself and couldn't see that his life was going to get any better for him. He was drinking more alcohol and using cannabis in an attempt to try to improve the way he was feeling.

It is not clear from Kirk's presentation that he has a mental health disorder but there are indications that a mood disorder may be present (specifically, he reported difficulty with sleeping, lack of motivation, low self-esteem, hopelessness about the future, increased alcohol and drug use) and that a fuller

assessment of his mental health and substance use is warranted. As such disorders are a major feature of assessing for suicide risk, their assessment is discussed under a separate heading below.

A large body of evidence indicates that mental health disorders are common among youth who attempt suicide and play a major role in placing youth at risk. Four disorders have been found to be particularly associated with suicide risk: mood disorders such as depression and bipolar disorder; substance use disorders; anti-social behaviour; and anxiety disorders. Studies suggest that up to 90% of those dying by suicide may have had at least one disorder when they died (Apter et al., 1993; Martunnen, Aro, Hendrikson & Lonnqvist 1991; Shaffer et al., 1996). The most common disorders are mood disorders.

Youth with mood disorders were found by Shaffer et al (1996) to be 10 times more likely to commit suicide than those without them and those with substance use disorders had odds of suicide that were over eight times more than those without them. Lower odds were found for anti-social disorders (three times that of those without the disorder) and a small but significant relationship has been found between anxiety disorders and suicide (Beautrais et al 1998a). The impact of mental health disorders appears to be cumulative – having more than one disorder increases suicide risk substantially. Beautrais (1996) estimated that youth with two or more disorders had odds of a suicide attempt that were 15 times those with no disorder.

Research by Beautrais, Joyce and Mulder (1998) revealed that 80% of young people making serious attempts in New Zealand had previous contact with medical, welfare and related services for mental health problems; 30% had previously been admitted to a psychiatric hospital prior to making suicide attempts. A major issue for youth is that depression is frequently undiagnosed and untreated or under-treated – fewer than 50% of youths with depression receive treatment before the age of 18 (Ryan 2005).

While limited to a small number of youth, psychosis is also a major risk factor for suicidal behaviours. Psychotic disorders include schizophrenia and psychotic depression, and bipolar disorder may involve psychotic episodes.

Mental disorders are also the strongest predictor of suicidal behaviour in adults. The risk of suicidal behaviour increases with increasing co-morbidity of mood disorders, substance-use disorders, antisocial behaviours and non-affective psychosis. Beautrais, Joyce and Mulder (1996) reported that those with two or more disorders were 90 times more likely to attempt than those who had none.

Social and Demographic Factors

Things had been quite difficult as there wasn't much money coming into the household. He had struggled with schoolwork but had generally got on with teachers and had a good group of friends who he still hangs out with.

Socioeconomic and educational disadvantage have also been linked to suicidal behaviour. As shown in Figure 1 factors such as low socio-economic status, limited educational achievement, poverty and their consequences are likely to impact on the risk of suicidal behaviours (Beautrais 1998, Fergusson et al 2000). Fergusson et al report that much of the association is mediated by linkages between socio-economic factors, family functioning and mental health.

Stress and Adversity

Kirk had become increasingly distressed after his girlfriend of 8 months had ended their relationship 6 weeks ago.

Kirk had a previous episode of suicidal ideation after previous relationship break-up

Stress and adversity appear to be strongly linked to suicidal behaviour. Studies suggest that in two-thirds of young people who have committed suicide, stressful life events could be identified (see for example, Martunnen, Aro & Lonnqvist, 1993). In New Zealand, Beautrais et al (1997) found higher levels of exposure to adverse life events amongst young people who attempted suicide than those who did not make suicide attempts. Two types of life event are common precipitants to suicidal behaviour: interpersonal losses and conflicts (for example, relationship break-ups and arguments) and offending related crises (such as being in trouble with the police or legal difficulties). It is likely that both the number and intensity of stresses may be higher for those who exhibit suicidal behaviours than for those who do not (Beautrais, 2000).

Particular groups of young people may be more at risk than others. Studies have suggested that gay, lesbian and bi-sexual youth have higher rates of suicide attempts and suicidal intent than heterosexual control groups. It has been suggested that this higher rate occurs “because a series of social processes centering around homophobic attitudes expose young gay, lesbian and bisexual youth to serious social and personal stresses that increase their likelihood of suicidal behaviour” (Beautrais, 2000).

Childhood Adversity

Kirk's background indicated a positive relationship with his mother, however his father had been violent towards him and his mother which he had witnessed. His parents had separated when he was aged 10 and since then he had lived with his mother and had little contact with his father.

The adverse effects of such childhood factors as physical sexual and emotional abuse and neglect, parental separation and divorce, family violence and contact with welfare agencies or institutional care are frequently

found among young people with suicidal behaviours. Beautrais (2003) lists a number of adverse childhood features which have been shown to be linked to both suicide and suicide attempts:

1. Parental separation and divorce (Andrews & Lewinsohn, 1992; Fergusson et al., 2000; Gould, Shaffer, Fisher & Garfinkel, 1998b; Groholt et al., 1998)
2. Parental psychopathology (Brent et al., 1996; Fergusson et al., 2000; Gould, et al 1996; Groholt et al., 2000; Pfeiffer, Normandin, & Kakuma, 1994)
3. Parental or family discord (Beautrais, Joyce, & Mulder, 1996; Fergusson et al., 2000; Pfeiffer, et al., 1994; Taylor & Stansfeld, 1984)
4. History of physical and/or sexual abuse during childhood (Beautrais et al., 1996; Briere & Runtz, 1993; Brown, Cohen, Johnson, & Smailes, 1999; Fergusson et al., 2000; Molnar, Berkman, & Buka, 2001; Silverman, Reinherz, & Giaconia, 1996; Wagner, 1997); and impaired or neglectful parenting (Beautrais et al., 1996; Brent et al., 1994; Gould, et al 1996; Hollis, 1996; Johnson et al., 2002; Lewinsohn, Rohde, & Seeley, 1993).

Genetic and Biologic Factors

There was a history of depression on his mother's side of the family and one of his cousins had committed suicide.

The presence of genetic pre-disposition to suicidal behaviour is supported by research evidence which finds high rates of suicide attempts in the children of those who have attempted suicide. Research suggests that this maybe a consequence of the mediation of psychiatric disorders such as depression, but may also be due to suicide itself being an inheritable trait. A family history of suicidal behaviours is therefore a strong risk factor (Mann et al 2005).

Personality Traits

He was feeling really negative about himself and couldn't see that his life was going to get any better for him.

There are a number of personality traits and cognitive styles that appear to act as predisposing risk factors for suicidal behaviour. Included among these are:

- Low self- esteem;
- High scores on measures of neuroticism;
- High external locus of control;
- High scores on measures of hopelessness, introversion, impulsivity, risk taking and aggressiveness (Beautrais, Joyce & Mulder, 1999).

Beautrais (2000) lists other personality traits such as passive, dependent, oral, obsessive and hysterical traits that have been linked to suicidal behaviour as have state and trait anxiety and anger, verbal aggression, impulsive violence, social inadequacy and reduced ability to evaluate the consequences of one's actions. Many of these factors are also risk factors for offending found in adolescent offenders. It is well recognised that these traits are associated with increased risk of psychiatric disorder and may increase suicide risk through this pathway. For example, passivity and hopelessness may lead to depression and thereby lead to suicidal behaviours. In addition, these personality traits and cognitive styles may indicate maladaptive coping strategies such that increased stress can lead to suicidal behaviours as a means of coping.

Contextual Factors

Kirk had a classmate at school last year who had hung himself after a relationship break-up.

There is a body of evidence that suggests that exposure to suicidal behaviour in friends or family members may increase the risk of suicidal behaviour in those vulnerable to such behaviour by increasing familiarity with suicidal behaviour and lowering the threshold for such behaviour. This process is sometimes referred to as a 'contagion effect' or as 'copycat' behaviour (Coleman, 2004).

There is also a substantial body of evidence that suggests that incautious media reporting and portrayal of fictional or actual suicidal behaviour has the potential to encourage imitative behaviour among vulnerable individuals. A famous example of this was the death of Marilyn Monroe. The widespread media coverage of her death by suicide resulted in a 12 % increase in suicides in the US in the month following her death.

Such observations have led to the development of guidelines that have attempted to encourage cautious and restrained reporting about suicide in the media (Ministry of Health, 1999).

Protective Factors

The thought of the impact on his family and friends had stopped him acting on his thoughts. On this occasion he went out and got really drunk with his mates and thinks if he hadn't done this he probably would have gone through with his plan as he was feeling so angry.

He had a positive relationship with his mother. He had generally got on with teachers and had a good group of friends who he still hangs out with. He was now attending a course and doing work experience which he had been enjoying up until the relationship break-up. The counsellor also spoke to his friends who had brought him in.

Despite the presence of many of the risk factors listed above not all youth engage in suicidal behaviours – it is clear that protective factors also play a role in whether suicidal behaviours will occur or develop. Some factors that are thought to increase resiliency include: adaptable temperament; internal locus of control; good self-esteem, self image, self-confidence, and self-efficacy; good social support and social networks; a good emotional relationship with at least one person in the family; positive school experiences; and spiritual faith (Beautrais, 2003).

The Christchurch longitudinal study of a cohort of 1000 births followed up for 21 years, has provided some evidence related to factors that affect risks of suicide positively or negatively. Fergusson, Beautrais and Horwood (2003) found that a family history of suicidal behaviour, childhood sexual abuse, neuroticism, novelty-seeking, self-esteem and peer affiliations mitigated or increased risk depending upon their levels. Specifically, an absence of family history of suicide, no sexual abuse, good peers, low novelty seeking, low neuroticism and good self-esteem, increased resilience, whereas a family history of suicidal behaviour, childhood sexual abuse, deviant peer affiliations, high novelty seeking, high neuroticism and low self esteem increased risk.

Assessing Suicidal Youth in Practice

The above description of risk domains for suicidal behaviour provides an example of how the framework in Figure 1 can help identify the risk factors that might be present for a given young person. It is not clear how these factors combine to increase risk except to say that generally, the higher the number of risk factors present the greater the risk. While some risk factors are historical, an assessment should focus upon those contextual and personal factors that would suggest current risk is increased. For example, the presence of low mood, suicidal ideation, preparation or planning for suicide, current substance abuse, interpersonal conflict and so on will exacerbate the risk posed by childhood adversity and historical abuse.

Assessment of suicide risk is a challenging area. Often someone who is a non mental health professional (e.g. teacher, school counsellor, or social worker) is in the best position to be able to identify the presence of suicidal behaviour. Having a framework to enquire and pull together the information around risk will guide the professional in establishing a plan that is needed to manage the risk and enable the young person to access the appropriate level of assistance. The following section will focus on issues related to the application of the framework presented earlier with an emphasis on helping the practitioner.

When to Assess

The question of when a suicide assessment should be conducted is a vexing one for most non-mental health practitioners. Routine contact with young people in General Practice (for doctors and nurses), or in schools (for teachers and school counsellors) will not always require a suicide assessment; however there are occasions when such assessments should occur. Frequently these are when indications of changes that can be distressing to the young person are observed. They may or may not be accompanied by changes in the young person's attitude and behaviour. Practitioners should be aware of any symptoms indicative of mood disorders or mental health issues.

Intake into hospitals, Child Youth and Family care and protection or residence, or prison are clearly occasions when consideration of suicide should occur. The changes that occur in such circumstances can be particularly distressing and some form of screening for risk of suicide or self harm should occur for every young person.

Another instance in which assessment should occur is if an indication of suicide threat, ideation or attempt is known. Frequently, self harming will be at a level low enough to avoid hospitalisation and so if indications of cutting are observed by a teacher, counsellor, social worker or other person assessment of suicide risk should occur. This may not occur through the young person themselves revealing it to a practitioner as young people are often poor at seeking help for themselves. However, a friend or family member may have this information supplied to them and provide it to a practitioner. Such disclosures should always be taken seriously and followed up with an assessment of the young person themselves. The lack of young people seeking help means that support people around the young person should be made aware of risk factors and seek help on the young person's behalf should these increase.

What to Consider During Assessment

Assessing young people is often a challenge as the young person may not be forthcoming with information; it is important to ask direct questions rather than relying on the young person to be up front with information. It can also be useful to use prompts to help clarify information e.g. *Are the suicidal thoughts there everyday? 1-2 per week?, occasionally?* Observations of the young person and information from other sources such as friends and family are also important in clarifying information around risk. Such support people may be critical in identifying at risk young people, as many, particularly young males do not refer themselves when facing distress or difficulties.

A common concern from non-mental health professionals is whether asking about suicide will put such ideas into a young persons mind. As

described above thoughts of suicide are common in young people and asking about suicide will not put thoughts into their mind (Gould et al 2005).

Exploring the level of risk includes an assessment of the current risk i.e. what is the likelihood of an attempt in the immediate/ short-term in combination with information on background risk factors and protective factors.

When considering current risk, in essence

- the greater the extent of planning
- the more lethal the method chosen
- the more available the means

the greater the current level of risk.

An interview can be based on the following structure. When questioning about the intensity of thoughts or feelings it is possible to ask the young person to rate the intensity between 1 (not at all) and 10 (most intense ever experienced) to gauge levels.

Enquiring into Presence of Suicidal Thoughts - Build Up Questions From the General to More Specific

- Any thoughts that “life not being worth living”/“life sucks”?
- Any thoughts of suicide, if so frequency (number per day, week etc) and intensity (rate between 1 and 10)?
- Have they thought about what method/s they would use?
- What is the extent of the planning for each of the methods they have chosen (if they intend to hang themselves have they identified a location, have they selected a time when detection might be lowest and so on)?
- How available are the means to carry out the plan (e.g. have they got a rope or know where they can get one)?
- What has stopped them acting on thoughts/plans?

If the Person Has Made an Attempt

- What occurred and where it occurred?
- The level of planning involved vs being impulsive?
- Presence of risk factors such as alcohol or drug use, peer influence, arguments, particular distressing events (e.g. relationship break up) and so on that might have contributed to the attempt?
- What their intent was at the time i.e. did they want to die or think that what they had chosen would result in death?
- Had they told anyone of their intentions?
- How they feel about being alive?

Additional Information to Explore

- Any past attempts, if so what occurred, when they happened, what were precipitants?
- Have they had friends/family make suicide attempts/die by suicide?
- Are there signs of low mood? Does the young person report feeling sad, irritable or angry, how often is there low mood and how long does it last, is there disturbance to motivation, energy levels, appetite (weight gain or loss), sleep disturbance, frequent crying, hopelessness or helplessness, changes to memory and concentration, a loss of interest or pleasure in previously enjoyed activities, reports guilt or poor decision making, a negative view of self and future?
- Level of current alcohol and drug use?
- Has the young person been isolating themselves
- Has performance at school, sport or work unexpectedly reduced
- Has the young person been giving away personal effects or prized possessions?
- Has there been a sudden apparent resolution of the above symptoms, a sudden apparent happiness or calmness that may indicate they have made the decision to attempt suicide?
- What would / will the young person do if they have further thoughts about suicide? Do they have a plan to cope/
- What access to coping strategies and resources (including people) does the young person have available to them?
- Any involvement, past or current, with mental health services? If so, what was the outcome, has follow-up been arranged?

The factors described in the framework shown in Figure 1 can be seen as underpinning the interview with the young person and family/whanau members. Much of the historical information related to family mental health and suicide attempts may not be known to the young person themselves and only becomes apparent when relatives or others are questioned. It is important to remember that the young person's behaviour is occurring in a social and cultural context – understanding these contexts is an important component of determining both the current risk and what elements might need to change to reduce that risk.

In addition to an interview, various scales and psychometric inventories and tests have been developed to assess suicide risk (for an extensive description and discussion of these scales see Goldston, 2003). Some of these are only available for use by professionals with specific training and/or qualifications (e.g. Clinical Psychologists). A number of such instruments have been shown to be valid in identifying young people at increased risk

for suicidal behaviour, see for example, The Columbia Suicide Screen, CSS, (Shaffer D, Scott M, Wilcox H et al 2004); The Kessler Suicide Risk Screen, (Kessler et al, 2002).

Regardless of how young people are identified as being at risk for suicidal behaviours, it is only the first step in providing appropriate help to reduce risk. The following section outlines intervention for suicide prevention.

Interventions for Suicide Prevention

The material presented thus far identifies the areas in which interventions could be expected to have an impact on suicidal behaviours. As stated, mental health issues make the greatest single contribution to suicide risk and therefore addressing them should form the major component of any intervention strategy. Detection, particularly of mood disorders, previous suicidal behaviour and prior mental health problems, is a key element of prevention.

At an individual level, consideration of the risk factors that are present for the young person must occur with a clear risk management strategy developed to reduce these. Such a plan should indicate what the level of risk is perceived or assessed to be, what the strategy for managing the risk should be, who is responsible for actioning the strategy, when the action will occur and when the plan will be re-assessed or reviewed. These components will be described further below.

Identification of Risk Factors

As described above the factors that influence suicide risk are well known. However, risk factors will need to be determined for each individual. A discussion should occur with the young person and their family/whanau which includes questions such as those listed above under “assessment”. The information from such a discussion can be used to develop a risk management plan. It should also be noted here that frequently young people are considered to demonstrate suicidal behaviours as a “cry for help” and some people may minimize the potential risk for future suicidal behaviour. Shaffer & Pfeffer (2001) note that *“even the most skilled clinician can find it difficult to differentiate between benign and ominous suicidal behaviour. Many adolescents who have made a medically serious attempt will never do so again, while others who have made what seemed like only a mild ‘gesture’ may eventually commit suicide. The term ‘gesture’ ... is therefore misleading.”*

Managing Risk

The details of how suicide risk will be managed will be largely specific to the individual young person and their circumstances but could include such elements as: consideration and prioritisation of immediate risks (for example access to means for suicide or self harm) with longer term planning to consider those factors which increase risk but do not immediately contribute to suicidal behaviour (e.g. historical sexual abuse or unresolved grief).

Immediate or Acute Risks That May Need to be Managed Include:

Removal of means for self harming or suicide such as weapons, sharp objects, medication and drugs, rope etc; referral to a mental health professional for further assessment of suicidal ideation and/ or the presence of mental health problems, for example, the abuse of substances, presence of symptoms of depression and offending behaviours; ensure a suicidal young person is closely monitored and is not left alone for any extended period; ensure that the young person is encouraged to talk about suicidal thoughts or impulses; provide safe alternatives to self harm and expression of despair, or anger, for example physical activity, art, writing or contact with positive people.

Longer Term Options for Managing Risk Could Include:

Consideration of the environmental stressors that might be contributing to distress and suicidal behaviours, for example, relationship problems with family members, difficulties at school, ostracism by peers and abuse; ongoing monitoring of suicidal ideation and other factors known to 'trigger' or increase risk for the young person such as hopelessness; regular cross sector liaison with other relevant agencies involved in the management of the young person such as school counsellors, therapists, social agencies, mental health and welfare agencies; consideration of unexpected events that may challenge the young person's coping abilities for example loss of a significant relationship such as partner or best friend; have an agreed strategy with the young person about who to contact and what to do when such events occur; help develop positive peer relationships and mentor type relationships.

Many of these strategies involve having effective engagement with the young person and their family or caregiver. These people may be crucial in both the development of suicidal behaviours and their management. Providing them with support and information about what to look for in terms of signs of suicide risk, ensuring a safe living environment and who to contact are important elements for increasing safety. If family/ whanau are a factor in the suicidal behaviour of the young person arranging for family therapy

may also be a necessary component of a risk management plan. Involving the family in the development of the risk management plan may also help ensure both its feasibility and the likelihood of 'buy-in'.

While many components of the plan will be focused on addressing the issues facing the young person the risk management plan should also enhance the strengths and positive resources available to the young person. It should also be regularly checked to see whether the elements of the plan are being adhered to – as previously mentioned young people can be poor at complying with such plans. If medication is prescribed ensuring that a caregiver dispenses the medication and sees that it is taken by the young person would be a better means of managing the risk than relying on the young person to take the medication themselves. Similar involvement of other support people available to the young person can significantly enhance the likelihood of success for the risk management plan.

The plan should also be cognisant of the dynamic nature of risk and be reviewed regularly to ensure that elements are being carried out and that other factors that emerge are being included. A major risk factor is the tendency for things to settle down and for monitoring to decrease to the extent where sudden crises are not identified and dealt with. When risk is considered to have been addressed and the young person considered to no longer need to be monitored a closure plan should be developed which ensures that strategies for preventing relapse are well known and for awareness of what signs would indicate an increase in risk and what should be done in these circumstances.

Risk Management Plan for Kirk

Once the counsellor gained the information from Kirk and his friends, an assessment of Kirk's level of risk needs to occur that in turn informs what needs to be put in place to address this risk.

The counsellor identified that there were a number of factors that indicated that Kirk's current level of risk is at the high end of the continuum, namely

- suicidal thoughts with plan and choice of method of high lethality
 - symptoms suggestive of depression, in conjunction with family history of depression
 - increased alcohol and cannabis use which could lead to increased impulsivity and disinhibition.
 - Recent exposure to a suicide of a classmate
- Factors which decreased his immediate risk were
- his sense of current safety and willingness to engage in help
 - supportive friends

Risk Management Plan

Immediate

1. Contact Kirk's mother and inform her of the concerns and ascertain her ability to monitor Kirk overnight
2. Provide information on safety of the home environment, in particular ensuring that Kirk would not have ready access to means of suicide, in particular items that he may use to hang himself
3. Provide her with information on services available if she becomes concerned for his safety e.g. Psychiatric Emergency Service, Police and has Youth Health counsellors contact details and information on availability
4. Identify other key supports and also ensure they have this information
5. Arrange a follow- up appointment with Kirk the following day to review the situation and review level of current risk.
6. Ensure that the rope that Kirk had planned on using is removed and unavailable to him
7. Develop a safety plan with Kirk identifying strategies if he became distressed and more suicidal
 - who he would contact
 - possible distraction strategies e.g. listening to music, reading a book, playing computer games, talking to a friend
 - not using alcohol and cannabis
8. Make a referral for a psychiatric assessment with local mental health service ensuring all the information gathered to date is communicated to those doing the assessment
9. Continue to have regular contact with Kirk until he has his assessment
10. If any signs of immediate risk, to access emergency psychiatric assessment
11. Provide support to Kirk's mother and other key support people by maintaining contact and keeping them informed.
12. Liaise with course tutor and ensure they are aware of the current situation and who to contact if concerned.

Ongoing

1. Liaise with mental health service and ensure that information from their assessment is obtained especially their assessment of his level of risk, mental health concerns and their intervention plan
2. Clarify the nature and extent of their ongoing role with Kirk and follow through on any specific recommendations made from this assessment

3. Consultation with mental health regarding
 - need for further evaluation of drug and alcohol use
 - need for counselling regarding recent relationship break up
 - need for counselling regarding issues related to his earlier physical abuse and exposure to violence
4. Continue to liaise with services involved with Kirk and ensure that there is clarity around the roles and responsibilities of each service and any information indicative of increased risk to be passed on to all services involved.

In addition to working with individuals at risk of suicide there are also interventions that have been aimed at changing wider group and societal influences on suicide risk.

Public Health Interventions

Prevention of suicidal behaviour does not occur simply at an individual level; strategies can also be developed for reducing the level of risk across societies at a population level. Such strategies can include hotlines, suicide awareness programmes, proactive support to families considered to be at risk and designed to reduce infant and early childhood experiences of abuse and disadvantage, and ensuring primary health care practitioners and those likely to come into contact with suicidal people know how to screen and refer those they suspect might be at risk.

However, a recent review of specific suicide-prevention interventions revealed that few have been adequately evaluated. Based on current research there was evidence that two approaches are effective in preventing suicide:

- i) Educating doctors about better identifying and treating those at risk of suicidal behaviour;
- ii) Restricting access to lethal means of suicide.

There is promise of effectiveness for a number of other interventions including public education, screening programmes, suicide education but these require more evaluation.

Early childhood interventions have been trialled in New Zealand as a means of reducing the number of young people who are vulnerable due to adverse histories of social disadvantage and family dysfunction. Early Start and Family Start are two examples of such programmes in New Zealand; evaluations of their effectiveness in reducing such adversity are still awaited and the impact on longer term suicide risk will still take many years. Beautrais (2003) also notes that recent New Zealand research has shown that children in welfare care are at increased risk of suicidal behaviour compared with

those not in welfare care. The department of Child Youth and Family Services has developed a programme specifically aimed at providing clinical support to Social Workers who have suicidal clients on their case loads. The Towards Wellbeing Programme has been piloted as a joint development by CYF and the Wellington Medical School and is now part of CYF operations. Publication of the efficacy of the programme has not yet occurred.

Conclusion

New Zealand has a relatively high rate of suicide among young people compared to other countries, and the full range of suicidal behaviours including suicidal ideation, suicide attempts and self harming are common enough to warrant the awareness of such issues for those working with young people in a therapeutic or social work manner.

The model of suicidal behaviours provided indicates a complex interaction of biological, psychological and social factors. Genetic and biologic factors, social factors, childhood adversity and personality factors are considered to affect a person's vulnerability or resilience to suicidal behaviours in a broad 'distal' fashion. Such factors influence the impact of mental illness and stressful life-events which are considered to be proximal determinants of suicidal behaviour.

Consideration of these factors when working with young people at risk can help the practitioner in deciding whether referral to acute emergency services is warranted. Eliciting relevant information about these factors can inform the development of a risk management plan specifically addressing the risks identified. The importance of monitoring risk on an ongoing basis, liaising effectively with other agencies involved, and inclusion of family/whanau, positive peers and mentors have also been highlighted.