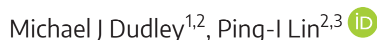
Preventing suicide by young people requires integrative strategies

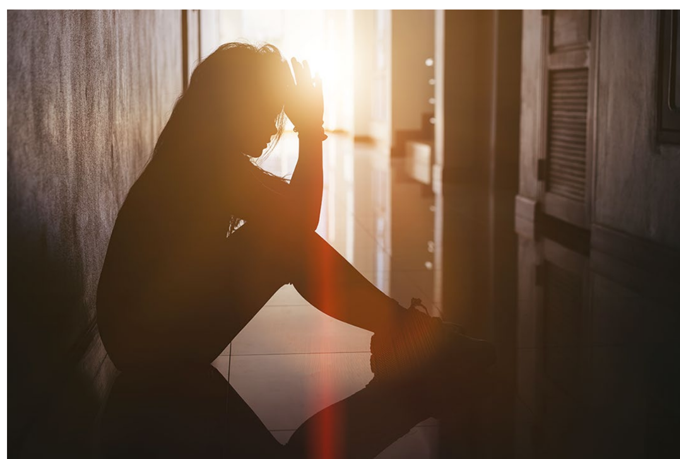

Michael J Dudley[1,2], Ping-I Lin[2,3]

We need more robust strategies with targeted, customised approaches, and funding for evidence-based interventions

Suicide is the leading cause of death of young people in Australia,[1] despite extensive research into risk factors for self-harm. In this issue of the *MJA*, Hill and colleagues[2] report their analysis of National Coronial Information System (NCIS) data for the 3365 young people (10–24 years old) who died by suicide in Australia during 2006–2015. Most were boys or young men (74%); many had diagnosed or possible mental health problems (57%), but fewer than one in three had been in contact with mental health services. A large proportion (38%) were not employed or in education or training at the time of their deaths; 14% were Indigenous Australians, 8% resided in remote locations, and 38% lived in the socio-economically most disadvantaged regions of Australia.[2] Although Hill and her co-authors could not assess causal relationships between these factors and suicide, their statistics suggest potential targets for focused prevention.

Clearly defining risk factors can inform preventive strategies for groups at particular risk. For example, suicide by young Indigenous people is related to transgenerational trauma caused by dispossession, colonisation, racism, and child removal to erase Indigenous culture and identity by assimilation,[3] and to ensuing disadvantages related to early child development, health, education, economic participation, and high imprisonment rates.[4] An effective suicide prevention strategy for Indigenous Australians requires intergovernmental support for initiatives designed and managed by Indigenous people, participatory action and research, and culturally appropriate care for people who have attempted suicide, as well as technological tools for prevention (such as the IBobbly app[5]), and listening by non-Indigenous Australians. Indigenous Australians have collectively highlighted the centrality of truth-telling, justice, and self-determination for improving their children's futures.[6]

Risk is compounded by the interaction of several factors. For instance, rates of suicide by Indigenous people and by males are higher in remote regions, characterised by disadvantages that include climatic extremes, lower literacy, underemployment, occupational hazards, sparser population and fewer resources, greater mental health burdens, less access to health services, higher transport costs (including for food), poor internet coverage, isolation, and greater access to firearms. Poor health literacy and excessive self-reliance may further increase risk.



Effective prevention therefore requires synergistic approaches. Rural and remote Indigenous communities, for example, might benefit from a national rural mental health policy that includes improving internet access.[7,8] Socio-economic support for the disadvantaged should be reformed, as young people report increasing concerns about sustained poverty, unemployment, and discrimination.[9] Fixed sub-subsistence Newstart allowances and the Robodebt scheme engender feelings of hopelessness, burdensomeness, and expendability.[10] Practical and social support, including outreach services, social housing, and adequate unemployment support, should replace austerity and punitive welfare policies that undermine suicide prevention.[11]

Just as Hill and colleagues[2] found that many young people who died by suicide had mental health problems, other recent research has found that mental disorders are unequivocally major risk factors,[12] notwithstanding the importance of socio-cultural context, psychosocial stressors, and first person accounts for understanding suicide.[13] However, 83% of Australian children with mental disorders do not receive treatment, and one-third of their carers have limited knowledge about mental health services.[14] Enhancing patient engagement with mental health care services should therefore be a priority in suicide prevention strategies.

Clinical and socio-cultural solutions must complement each other. This requires a National Mental Health Commission with statutory authority, intergovernmental coordination (as achieved for COVID-19), the continuing engagement of service users, and investment in the reform of mental health care delivery and policy.[15] Community-based child and adolescent mental health services, including dedicated emergency services, must be expanded in view of the rising numbers of emergency department presentations by young people in crisis[16,17] and the inadequate support that can be provided by mental health specialists.[18,19]

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Linked, targeted, and school or community-based activities (eg, School-Link, mental health screening, gatekeeper training, hotlines and online help, onsite clinicians[20-22]) can strengthen resilience, particularly in young people who have had experiences with long term impacts that increase the risk of self-harm, including maltreatment, bullying, school absenteeism, and mental disorders. Structured support for general practitioners and nurses managing depression and self-harm in children should include family and peer support. Despite limitations, encouraging results have been reported for diverse interventions in clinical, educational, workplace, and community settings.[23,24] People who have attempted suicide require effective, culturally appropriate care, both prior to and for three months after discharge from emergency care.[25]

Finally, reducing access to common suicide methods has reduced suicide rates in some countries by 30–50%.[26] Ligatures and attachment points that can be used for hanging oneself are widely available, and the feasibility of requiring face-to-face sales for rope, cable, and similar items could be considered.[27]

In conclusion, suicide prevention strategies should recognise the complex interplay of multiple risk factors. The tragedy of suicide by young people demands that we develop more robust strategies with targeted, customised approaches, and provide funding for evidence-based interventions and peer-reviewed evaluations.[18]

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