7.0 Suicide prevention

Despite considerable research into suicide prevention, the evidence base does little to identify a clear and definitive approach to preventing suicide amongst homelessness population.[55] While it is clear that more evidence demonstrating the effectiveness of particular approaches in reducing suicide is needed, many studies have been unable to demonstrate such effects.[56] It has been suggested that research efforts should focus on the reduction of risk factors associated with suicide. This is because there is a growing evidence base for suicide prevention efforts that focus upon the reduction of suicide risk factors such as treatment uptake, depression and self-harming behaviours.[56] A number of strategies, described below, have demonstrated effectiveness in reducing suicide in the broader population.

Education

General awareness raising public health campaigns advocating for suicide prevention have shown moderate effectiveness on improving attitudes towards suicide. However, limited evidence exists to suggest that they can elicit a reduction in suicidal behaviours.[57, 58] Targeted suicide intervention training such as gatekeeper and Applied Suicide Intervention Skills training (ASIST), described in detail in Section 10, have demonstrated contextual positive outcomes.[55]

Screening

Screening individuals for risk of suicide or depression and directing them to appropriate treatment services has been shown to result in increases in treatment for depression as well as decreases in suicide rates.[57, 59] Debate exists upon how to accurately identify individuals at risk of suicide. Current evidence suggests a movement away from standardised risk assessment tools that characterise people as low, medium or high risk, to an approach that involves gathering a comprehensive picture of the unique individual and tailoring an approach that meets their needs.[60]

Reduce access to means

Reducing access to lethal means such as guns and poisons has shown to reduce suicide rates.[39, 57] This approach does not always see a reduction in overall suicide as a substitution of a method may occur. Nevertheless, reducing access to means has been shown to be one of the most effective suicide prevention strategies available.[57]

Clinical interventions

Clinical interventions including Cognitive Behavioural Therapy (CBT) and medications such as anti-depressants have demonstrated promise in eliciting reductions in suicide.[57, 61, 62] However, clear links between other clinical interventions and suicide reductions have not been established.[30, 61, 63] Providing information on clinical interventions is outside the scope of this report. To find out more about the evidence for clinical interventions for suicide and mental health disorders visit ***www.griffith.edu.au/health/australian-institute-suicide-research-prevention***, ***http://www.headspace.org.au/what-works/evidence-maps***, ***http://www.thelancet.com/series/suicide***, ***http://www.livingisforeveryone.com.au/Research-and-evidence-in-suicide-prevention.html*** *or* ***https://www.sane.org/information/research***

Follow-up care

Increasing support provided by health services to at risk groups, in particular through the provision of follow-up care is thought to decrease suicide re-attempts and encourage treatment compliance.[39, 57, 64, 65] Follow-up contact should be provided on a long term basis and at regular intervals.[66] Service providers should provide follow-up contact in a positive, empathetic and personal way.[66]

Crisis lines

Crisis lines have demonstrated effectiveness in reducing suicide rates and suicide related feelings in callers.[66] Suicide specific training can improve call centre operators response to people at risk of suicide resulting in reductions in feelings of depression and suicide ideation.[67]

For a list of crisis lines suitable for young people visit ***www.yacwa.org.au/youthworkertoolkit/suicide-prevention*** *and search emergency services. YACWA's Pling app is available for Apple and Android devices.*

School based interventions

School based suicide prevention efforts have shown to increase suicide related knowledge and diversionary skills.[55] However, evidence of the efficacy in reducing suicide rates varies between studies.[55, 66] Interventions that trained school staff in suicide prevention demonstrated the greatest impact on suicide rates in this age group.[66]

For more information on suicide prevention in schools visit ***http://www.mindmatters.edu.au***

http://www.beyondblue.org.au/resources/schools-and-universities/secondary-schools-and-tertiary *or* ***http://www.headspace.org.au/what-works/school-support***

Responsible coverage of suicide in the media

Evidence shows that media reporting of a suicide can lead to increased suicide rates.[68] Changes towards responsible reporting of suicide in the media have seen a reduction in suicide related behaviours.[68]

For more information on appropriate ways of communicating and reporting in relation to suicide visit ***http://www.mindframe-media.info***

Box 4:
Suicide and self-harm prevention in young people

A recent review of the evidence surrounding suicide and self-harm prevention in young people. concluded that the lack of evidence is hindering best practice efforts as current approaches to treatment and prevention do not have a strong evidence base.[69] Approaches considered as promising including Cognitive Behavioural Therapy (CBT), interpersonal psychotherapy, attachment-based family therapy and interventions undertaken in a school based environment when a skills based approach is taken.[69]

A recent study concluded that for young people, four strategies have demonstrated effectiveness in reducing suicide.[66] These include:

- *training adults to respond to suicide within a school environment;*
- *educating students on how to deal with depression and suicide;*
- *crisis phone lines; and*
- *follow-up care for those who have attempted suicide.*

To find out more about the evidence surrounding suicide prevention visit www.griffith.edu.au/health/australian-institute-suicide-research-prevention, http://www.headspace.org.au/what-works/evidence-maps, https://www.sane.org/information/research http://www.thelancet.com/series/suicide, or http://www.livingisforeveryone.com.au/Research-and-evidence-in-suicide-prevention.html

8.0 Improving the mental health of young homeless people

Specific intervention studies that focused on suicide prevention in young homeless people were lacking in the literature. However, seven intervention studies were identified that had mental health related outcomes and will be discussed in this section. A summary of these studies is provided in Appendix A. Four of these studies were specifically mental health focused.[70-73] The remaining three had both a mental health and substance misuse focus.[74-76] Due to the small sample sizes and heterogeneity between these interventions, it is concluded that there is no compelling evidence linking specific strategies to positive outcomes in the mental health of homeless young people. However, what these studies do demonstrate is that the mental health of homeless young people can be improved through targeted interventions.

Two studies utilised a Community Reinforcement Approach (CRA) with the aim of decreasing alcohol and drug use and improving mental health outcomes in homeless young people.[74, 75] The CRA is primarily employed with problem users of alcohol and other drugs and is based on the understanding that aspects of a person's environment can influence behaviour. CRA works with an individual to substitute aspects of the environment that have supported the use of alcohol and or other drugs with aspects that support recovery. The positive impact of CRA therapy on both substance use and mental health that were reported in these studies, suggest that CRA may be effective in supporting homeless young people with co-occurring substance use and mental health issues. These findings are supported by Barker et al[77] who concluded that integrating the treatment of co-occurring alcohol and other drugs with mental health issues is more effective than treating each in isolation.

Alternatively, other intervention studies that had been explored identified Cognitive Behaviour Therapy (CBT) as an effective option in treating several suicide risk factors.[72, 73] This skills based treatment centres on restructuring thinking patterns that are linked to thoughts and beliefs that are maladaptive.[78] Hyun et al[72] reported that depression decreased and self-efficacy increased significantly through CBT. In addition to this, Taylor et al[73] reported that a range of mental health issues improved including depressed mood and levels of aggression with the integration of CBT. Interestingly, CBT also significantly decreased self-harming behaviours. These reductions in self-harming behaviours through CBT interventions have not been replicated in other interventions aimed at young people.[78] However, CBT has been shown to be effective in treating depression and generalised anxiety in young people, two key risk factors for suicide.[78]

McCay et al[70] and Stewart et al[76] suggested that intervention studies utilising social support may be of benefit to suicide interventions.[70, 76] Stewart et al[76] developed a network of peers and professionals for young homeless people to interact with. This resulted in improvements being exhibited in emotional and mental well-being, decreased loneliness, support-seeking and coping.[76] McCay et al[70] developed relationship-based group sessions to increase social support as well as a range of other emotional factors including positive self-concept, resilience and self-determination, which consequently reported increased levels of social connectedness and decreased hopelessness. The study undertaken by McCay et al[70] however, suggests no statistically significant difference was reported in resilience, self-esteem or mental health symptoms.

Another model identified during the literature review is that of a Social Enterprise Intervention (SEI) model which was implemented by Ferguson and Xie.[71] SEI aims to improve the mental health status and a variety of other outcomes for young homeless people through supporting engagement with vocational programs that provided mentoring, employment training, clinical services referral and harm reduction strategies. Ferguson and Xie[71] reported decreased depressive symptoms and increased life satisfaction, family contact and peer support as a result of utilising this model.