

## The role of the community psychologist in preventing youth suicide and self-harm

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*While a number of international guidelines and practice recommendations in relation to the clinical management of suicide and self-harm currently exist, resources to support community psychologist prevention efforts in both the clinical and community practice setting are limited. The aim of this paper is to provide an up-to-date summary of primary, secondary, and tertiary level prevention initiatives that can be delivered by community psychologists practising in both clinical and community-based settings.*

Approximately one in ten adolescents engage in self-harm, a term used in this paper to refer to any form of intentional self-injury irrespective of motive or intent (Hawton et al., 2003; NICE, 2011). Although most acts are not medically serious (self-cutting is the most common form; see Hawton et al., 2002; Madge et al., 2008; Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005), many young people who self-harm do so with some suicidal intent (De Leo & Heller, 2004; Evans, Hawton, Rodham, & Deeks, 2005; Hargus, Hawton, & Rodham, 2009; Hawton, Rodham, Evans, & Weatherall, 2002; Madge et al., 2008; Moran et al., 2012). It has been reported, for example, that approximately one in eight adolescents who self-harm in the community will require hospitalisation (Hawton et al., 2002; Madge et al., 2008). Globally, suicide accounts for 8.5% of all deaths for those aged 15-29 years (WHO, 2014) and is the most common form of death for females aged 15-19 years and the third most common form of death for male adolescents, after road traffic accidents and violence (Patton et al., 2009).

The risks of both self-harm and suicide in adolescence increase substantially when mental health problems are present. Elevated risk is not only associated with depressive disorders, but also a range of other diagnoses including bipolar, eating disorders, post-traumatic stress disorder, and schizophrenia (Belfer, 2008; Costello, Foley, & Angold, 2006; Esposito & Clum, 2002; Palmer,

Pankratz, & Bostwick, 2005). It therefore seems reasonable to expect psychologists to have a key role to play in the prevention of suicide and self-harm in young people. The aim of this paper is to provide an overview of the different types of prevention interventions that community psychologists might consider when working in both clinical and community-based settings.

Prevention is, of course, the foundational platform of the community psychology approach with community psychologists keenly focused on identifying and addressing systemic barriers to positive health and well-being (Gridley & Sampson, 2010). Primary prevention is a term used to refer to those interventions that aim to stop self-harm and suicide by focusing on universal factors that reduce opportunity and strengthen individual, family, community and social structures. Secondary prevention targets those individuals and/or communities which are identified as at risk, whilst tertiary prevention responses occur after self-harm has occurred. This public health framework provides a useful way to conceptualise the different roles that community psychologists can play in this area of practice (see Table 1), extending international guidelines and practice recommendations that have been published in relation to the clinical management of suicide and self-harm (ASCEM & RANZCP, 2000; Jacobs & Brewer, 2006; New Zealand Ministry of Health, 2003; NICE, 2004, 2011; Victorian

Department of Health, 2010) to include community-based health promotion and intervention programs.

### **Primary Prevention**

The major goal of primary prevention initiatives is to reduce the number of new cases of suicidal young people or young people who engage in self-harm. Community psychologists can contribute to this in four ways, as outlined below.

1. *Build and foster resilience among young people.* There is an ever-growing body of research highlighting the importance of strengthening those factors that have been shown to protect against suicidal and self-harm behaviours in young people (e.g., Eisenberg, Ackard, & Resnick, 2007; Fleming, Merry, Robinson, Denny, & Watson; Taliaferro & Muehlenkamp, 2014; Whitaker, Shapiro, & Shields, 2016). Resilience is a strength-based concept that emphasises exposure to adversity and “positive” adaptation (Fergus & Zimmerman, 2005; Luthar & Cicchetti, 2000) which acts as a life-long buffer to potential threats to wellbeing over time and transition, and has been shown to influence suicide risk for persons of all ages (Johnson, Wood, Gooding, Taylor, & Tarrrier, 2011).

A number of psychosocial factors have been shown to be associated with resilience to stress and stress-induced mood and anxiety disorders (Luthar & Cicchetti, 2000; Southwick, Vythlingam, & Charney, 2005), including positive emotions (such as optimism and humour), cognitive flexibility (positive explanatory style, positive reappraisal, and acceptance), meaning (religion, spirituality, and altruism), social support (role models), and active coping style (Southwick et al., 2005). Accordingly, interventions such as cognitive behavioural therapies that encourage young people to utilise more positive emotions, alter pessimistic explanatory styles of thinking, cognitively reappraise negative events, and find positive meaning in difficult circumstances (Southwick et al., 2005) can play an important role in the prevention of self-harm and suicide. Community psychologists are particularly adept at

identifying and responding to risk and protective factors and are well-placed to assist young people to develop and refine the problem-solving and conflict resolution skills which have been shown to also be protective against suicide (WHO, 2012).

2. *Encourage and facilitate social support and help-seeking behaviours.* Strong connections to family and community support have been found to be protective against suicidal behaviours in people of all ages (Kleiman, Riskind, & Schaefer, 2014; WHO, 2012, 2014). Social support not only buffers the relationship between depressogenic risk factors and depression, which is highly related to suicide (Charyton, Elliott, Lu, & Moore, 2009; Cohen, McGowan, Fooskas, & Rose, 1984; Cohen & Hoberman, 1983; Cohen & Wills, 1985), but also has been shown to alter negative appraisals of the self after the occurrence of negative events (Panzarella, Alloy, & Whitehouse, 2006) and reduce suicidal feelings (Johnson, Gooding, Wood, & Tarrrier, 2010). It is unsurprising then that the majority of interventions that have positive effects in reducing adolescent suicidal ideation, suicide attempts, and self-harm have some focus on family interactions or non-familial sources of support (Brent et al., 2013). Parental support and monitoring, in particular, has been shown to protect against suicidal behaviour (Resnick et al., 1997; Toumbourou & Gregg, 2002).

Help-seeking, a term used to describe how individuals utilise networks to gain support in coping with mental health problems, is also regarded as an essential link between the recognition of a problem and receiving the necessary care (Cauce et al., 2002; Srebnik, Cauce, & Baydar, 1996). A review of international community epidemiological studies examining help-seeking in young people (up to the age of 26) who experienced suicidal thoughts or had self-harmed concluded that the majority did not seek help for their difficulties (Michelmores & Hindley, 2012). This may be a consequence of the stigma surrounding seeking help for suicidal behaviours (Fortune, Sinclair, & Hawton, 2008; WHO,

**Table 1.** Primary, secondary and tertiary suicide/self-harm prevention strategies that may be utilised by community psychologists

PRIMARY PREVENTION	SECONDARY PREVENTION	TERTIARY PREVENTION
<p><b>Build and foster resilience among young people</b></p> <ul style="list-style-type: none"> <li>• Utilise cognitive behavioural strategies to teach young people to be more optimistic, use more positive emotions, alter pessimistic explanatory styles of thinking, cognitively reappraise negative events and find positive meaning in adverse circumstances</li> <li>• Teach young people techniques to assist them in managing stress</li> <li>• Teach young people conflict resolution and problem-solving skills</li> </ul>	<p><b>Increase awareness of young people who may be at-risk of suicide/self-harm behaviours</b></p> <ul style="list-style-type: none"> <li>• Community psychologists should be aware of the <i>current</i> physical, emotional, social and environmental factors that place some young people at greater risk of suicide or self-harm</li> </ul>	<p><b>Provide support to family, peers, and community members</b></p> <ul style="list-style-type: none"> <li>• Postvention care and support should be provided to bereaved families and friends of people who have died by suicide</li> <li>• Community psychologists must be alert not only to the mental health risks of those in proximity to the young person who died by suicide but also to the mental health risks of young people who may perceive similarities between themselves and the deceased</li> <li>• Community psychologists can assist family members of young people who self-harm by providing psycho-education, teaching communication and parenting skills, and by providing practical support</li> </ul>
<p><b>Encourage and facilitate social support and help-seeking behaviours</b></p> <ul style="list-style-type: none"> <li>• Encourage and facilitate the expansion of positive and emotionally meaningful sources of social support including family, friends, co-workers, and organisations</li> <li>• Develop interventions or programs designed to normalise help-seeking care for self-harm, suicidal ideation, or suicidal behaviours</li> <li>• Develop interventions or programs designed to decrease the stigma surrounding mental illness</li> </ul>	<p><b>Integration of suicide/self-harm screening into practice</b></p> <ul style="list-style-type: none"> <li>• All young people who may be at-risk should be screened for suicidal or self-harm behaviour (see WHO mhGAP recommendations)</li> <li>• Risk screening should be considered a <i>process</i> and may occur on multiple occasions over the course of young person's contact with the community psychologist</li> <li>• Risk screening tools should be used within the therapeutic context, in combination with clinical judgement and in communication and negotiation with the young person and their family</li> </ul>	
<p><b>Promotion of healthy lifestyle behaviours</b></p> <ul style="list-style-type: none"> <li>• Promote healthy behaviours such as adequate sleep, healthy diet, effective management of stress (including the use of meditation techniques), regular exercise (particularly aerobic exercise), and awareness of the health impact of alcohol and drug use</li> </ul>		
<p><b>Implement mental health literacy practices and policies in health care settings</b></p> <ul style="list-style-type: none"> <li>• Ensure that mental health literacy policies and practices are implemented within the health practice or organisation in order to encourage and facilitate health care access for young people who need assistance</li> </ul>		

2014), as well as fears that asking for help will result in other people finding out about their behaviour (Fortune et al., 2008). When young people do seek help, however, there is evidence that they prefer to turn to informal (i.e., non-professional) sources of support such as family and friends with whom they are familiar (Boldero & Fallon, 1995; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Community psychologists can play a key role in facilitating community-based social support and informal help-seeking by thoroughly assessing the extent of social networks and the level of emotional support that exists in the young person's life. Where necessary, they can encourage and facilitate the expansion of positive and emotionally meaningful sources of social support (Southwick et al., 2005). Psychologists can also increase access to care by reducing the stigma surrounding self-harm and suicide by normalising help-seeking (Fortune et al., 2008). More broadly, mental health awareness campaigns that encourage help-seeking in young people can have a positive impact on community attitudes and increase public dialogue on these issues (Klimes-Dougan, Klingbeil, & Meller, 2013; WHO, 2014). The most effective campaigns have a narrow focus on one or two mental health issues, utilise multimodal strategies, adapt messages where appropriate, and target specific populations at a local level (Matsubayash, Sawada, & Ueda, 2014; Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014). These interventions are examples of how a community psychology framework applied at both an individual level (encouraging social and familial support and connection) and at a broader level (through the raising of community awareness about mental illness) can build social support and encourage help-seeking behaviours among young people.

**3. Promotion of healthy lifestyle behaviours.** Given that prevention is the foundational platform of community psychology, community psychologists can also play a key role in the promotion of healthy lifestyle behaviours which are likely

to lead to good mental and physical health (Gridley & Sampson, 2010). This might include the promotion of adequate sleep, healthy diet, effective management of stress, regular exercise, and helping young people to consider the health impact of alcohol and drug use (Jane-Llopis, Barry, Hosman, & Patel, 2005). Aerobic exercise and meditation are, for example, both associated with resilience to stress and stress-related mental illness (Southwick et al., 2005) and young people who engage in frequent physical activity are likely to be more resilient than those who do not (Moljorda, Moksnesb, Espnes, Hjemdalf, & Eriksena, 2014).

**4. Implement mental health literacy practices and policies in health care settings.** Community psychologists are especially skilled and experienced at empowering consumers to make fully informed health decisions (Gridley & Sampson, 2010). Therefore, it is recommended that community psychologists employed in health practices and organisations accessed by young people, have comprehensible health literacy policies and practices in place, with mental health literacy a distinct part of these strategies (WHO, 2013). Mental health literacy consists of the knowledge and beliefs about mental disorders which aid their recognition, management, or prevention (Jorm et al., 1997). Mental health literacy strategies might include providing intelligible messaging to young people on available services, using clear and accessible language when engaging with young people, and ensuring that information is provided to help young people navigate the health system (WHO, 2014).

#### **Secondary Prevention**

Interventions at the secondary prevention level aim to decrease the likelihood of suicide attempts or self-harming behaviour among those considered to be at high-risk. At-risk young people include those with mental health problems (Fleischmann et al., 2005; Marttunen, Aro, & Lönnqvist, 1993), young people who have experienced a recent stressful life-event or trauma (Gould, Greenberg, Velting, &

Shaffer, 2003; Plener, Singer, & Goldbeck, 2011), as well as indigenous young people, same sex attracted young people, and young people incarcerated within (or recently released from) youth justice facilities (Gilchrist, Howarth, & Sullivan, 2007; King et al., 2008; McNamara, 2013; Reynolds, 2011). These particular groups of young people often experience acute and multiple forms of disadvantage which are frequently rooted in underlying social inequalities (World Conference on Youth, 2014). The primary goal for community psychologists in providing secondary prevention is to identify and assist young people before they engage in self-harm or suicidal behaviours.

*2.1 Increase capacity for suicide risk assessment and crisis intervention.* The factors associated with both suicide and self-harm among young people have been well documented (Hawton, Saunders, & O'Connor, 2012; WHO, 2014), and yet are not always assessed. Australian research has shown that younger, less experienced psychologists are more confident in their ability to treat someone who engages in self-harm (Gagnon & Hasking, 2012). A possible reason for this finding is that younger clinicians are more likely to have had recent training in suicide risk assessment and treatment strategies, thereby increasing their confidence when working with these individuals (Gagnon & Hasking, 2012). Psychologists often receive limited formal training in working with suicidal clients (Palmieri et al., 2008; Schmitz et al., 2012) and this is of particular concern in light of evidence that many young people who commit suicide have been in contact with primary health care and mental health care services in the year prior to their death (Luoma, Martin, & Pearson, 2002). Training of various health practitioners in the area of suicide prevention has been shown to improve knowledge, attitudes, confidence, and skills (da Silva Cais, da Silveira, Stefanello, & Botega, 2011; Jacobson, Osteen, Jones, & Berman, 2012; Smith, Silva, Covington, & Joiner, 2014) and thus represents an important secondary prevention initiative. There is also some evidence,

albeit limited, that training results in positive changes to healthcare practice by enhancing clinician interviewing skills and prompting change in clinic policies and procedures (Gask, Dixon, Morriss, Appleby, & Green, 2006; Oordt, Jobes, Fonseca, & Schmidt, 2009).

*2.2 Integration of suicide and self-harm screening into routine practice.* The early detection of suicidal ideation and self-harm behaviours is of great importance, yet screening tools are often underused (Patel, 2013). The WHO Mental Health Gap Action Programme (mhGAP) recommends undertaking suicide/self-harm screening with any person over the age of 10 years who has experienced self-harm/suicide, depression, alcohol use disorders, drug use disorders, bipolar disorders, psychosis, epilepsy, developmental and behavioural disorders, mild dementia, chronic pain, acute emotional distress, or any other significant emotional or medically unexplained complaint (WHO, 2008). The WHO mhGAP recommends that these people should be asked about thoughts or plans of self-harm in the past month and about acts of self-harm in the past year (WHO, 2008).

Screening tools are a reliable method for gathering key information; however they will not always predict future behaviour (Khan, 2011; Randall, Colman, & Rowe, 2011). One study, a systematic meta-analysis of controlled studies of suicide within a year of discharge from psychiatric hospitals, concluded that about 60% of patients who committed suicide were likely to be classified as 'low risk' (Large, Sharma, Cannon, Ryan, & Nielssen, 2011). However, risk screening may be better at identifying those who will attempt suicide, a far more common behaviour than suicide itself (Mann et al., 2006). Among young people, the risk factors for suicide are the same as risk factors for suicide attempts (Beautrais, 2000).

Screening should occur on multiple occasions over the course of a young person's contact with a service, and particularly when there has been some change in circumstance (De Gioannis & De

Leo, 2012; Donely, 2013; Wasserman, 2011). Community psychologists should ideally develop and utilise methods of screening which are appropriate to the context in which they practise (Fountoulakis et al., 2012) and only use screening tools in conjunction with clinical judgement, and in communication and negotiation with the young person and their family (Ryan & Large, 2013).

### **Tertiary Prevention**

Tertiary prevention targets those young people who have already been affected by suicidal or self-harming behaviours. This may involve responding to not just the consequences of the behaviour for the young person, but also to the needs of their network of family and friends.

3.1 *Provide support to family, peers, and community members.* The families of young people who engage in self-harming behaviour face particular emotional and practical challenges. Parenting a young person who engages in self-harm is deeply distressing and is frequently accompanied by feelings of isolation, fear, guilt, anger, frustration, and a lack of confidence, in response to their child's self-harm (Byrne et al., 2008; Raphael, Clarke, & Kumar, 2006). Given the significance of parental support, it is important that parents are provided with emotional support to manage their distress (Morgan et al., 2013). Community psychologists can also assist by providing psycho-education, teaching communication and parenting skills, and offering practical support in how to handle self-harm incidents (Byrne et al., 2008).

'Postvention' is a term used to describe the care and support provided to the families and friends of people who have committed suicide and is considered an essential component of any suicide prevention strategy given that these individuals are at increased risk of developing mental health problems such as depression and anxiety, or engaging in copycat suicidal behaviour (Bolton et al., 2013; WHO, 2014). It is possible, although rare, that a number of suicides occur following an initial death, with young people appearing to be more vulnerable to imitative suicide than adults, possibly because they

identify more readily with the behaviour and qualities of their peers (Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990; Insel & Gould, 2008). Therefore, community psychologists must be alert not only to the mental health risks of those in proximity to the person who committed suicide but also to those of other young people who may identify with the deceased (de Le & Heller, 2008).

Community psychologists are particularly skilled at empowering people affected by a tragedy such as suicide, to be actively involved in building stronger, healthier communities (Gridley & Sampson, 2010). Community psychologists can support the grieving process in those who are bereaved by either providing individuals with support or by facilitating access to other services that are able to provide support. The significant contribution that community psychology can make to postvention response to suicide is best illustrated by the Western Australian Active Response Bereavement Outreach (ARBOR) program, a program established, implemented and evaluated by a team of community psychologists (AnglicareWA, 2016; Gridley & Sampson, 2010). ARBOR utilises a peer-support model to actively engage individuals affected by suicide to work alongside professionals in supporting other families who have also experienced suicide. The knowledge, skills and experiences of those affected by suicide are therefore used to support others experiencing the same trauma, ensuring that the support provided is relevant to the needs of families while at the same time facilitating stronger community connections (AnglicareWA, 2016; Gridley & Sampson, 2010). Other research has also shown that the provision of outreach services to family member survivors at the time of suicide results in increased use of services that assist with the grieving process (Szumilas & Kutcher, 2011). Advice in helping bereaved children and young people, and for handling communication problems in the family is often needed (Andriessen, 2009; Dyregrov, 2002; Murphy, 2000; Wilson & Clark, 2005) as the bereaved often have a

desire for information about the medical aspects of the suicide, the grief process, and about how the death can affect family members and the family as a unit.

### Conclusion

The prevention of suicide and self-harm behaviour among young people presents significant challenges for community psychologists. However, they can play a key role in implementing interventions at the primary, secondary, and tertiary prevention levels. At the primary prevention level, they can work to strengthen factors that have been shown to protect young people against self-harm and suicide. The overarching goal here is to increase psychological wellbeing regardless of whether this is undertaken in the context of direct clinical care or through working with young people in the community. Programs or interventions to increase resilience, encourage and facilitate social connectedness and support, promote healthy lifestyle choices, and support psychological skills development should be the focus. Community psychologists should also encourage and facilitate access to health care by offering interventions that normalise and promote help-seeking and in doing so reduce stigma. Organisations should ensure that they have clear mental health literacy policies and practices in place. The main challenge for the community psychologist in the area of secondary prevention is to ensure that they are up-to-date and knowledgeable about the risk-factors for young people and skilled in suicide/self-harm screening. The degree and depth of this screening will depend very much on the scope of practice, but all community psychologists who work with young people can play a role in identifying those at risk and providing (or facilitating) care when necessary. Finally, community psychologists can intervene at the tertiary prevention level by containing the consequences of suicide, suicide attempts, or self-harming behaviour. In the wake of such acts, community psychologists can assist by providing postvention outreach care and support to the families and friends of young people, ensuring that they receive the information and crisis support that may

very likely be required at this time.

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