Suicide among Children and Young People

BACKGROUND

This Update is one of two produced by the Mental Health Foundation, which deal with suicide and deliberate self-harm respectively. The rates of suicide and deliberate self-harm among children and young people have increased dramatically over the past 20 years. They are a major source of human suffering and wasted opportunity for the individual, their families and communities.

Suicide and deliberate self-harm are closely related in practice:
- Suicide (self-harm, resulting in death)
- Attempted suicide (self-harm with intent to take life, resulting in non-fatal injury)
- Deliberate self-harm (self-harm without suicidal intent, resulting in non-fatal injury).

The difference between suicide and deliberate self-harm is not always so clear. For example, deliberate self-harm is a common precursor to suicide, and people who deliberately self-harm may kill themselves by accident. Nevertheless, in their separate forms suicide and deliberate self-harm differ in terms of the intent that lay behind the behaviours. This has implications for their presentation and for relevant policy and service responses.

FINDINGS

Data from the Office of National Statistics shows:
- In 1999 across the UK and Republic of Ireland, two people between the ages of 15 and 24 took their lives every day.1
- Suicide now accounts for 22% of all deaths among young people between the ages of 20 and 24.1

The act of suicide is typically undertaken as a last resort in response to problems that overwhelm an individual. A sense of hopelessness, in which the person sees no way out of their difficulties other than to end their life, often precedes the act. Children and young people face many challenges growing up in the modern world. For the majority, these herald periods of personal growth as they develop coping strategies. For an increasing number however, their experience of life can be too much to bear.
Many factors are associated with increased risk of suicide including biological vulnerability, social circumstances, life events, mental ill health and access to means.

**Biological vulnerability**

Young people who take their own lives often have a family history of suicidal behaviour although the relative importance of genetic and social factors is poorly understood. Rates of suicide in the young vary also according to gender with 80% being male.

**Social circumstances**

Increased risk of suicide among the young has been associated with family turmoil. Young unemployed men, who live alone perhaps as a consequence of family difficulties are considered particularly vulnerable, and young South Asian women (i.e. Indian, Pakistani or Bangladeshi) who report cultural conflict within the family are at increased risk of suicide compared with other women of their age. Bullying in school has also been associated with suicidal behaviour and there is evidence that suicide is increasing among students of higher education.

**Life events**

What to an adult may be one of life’s frustrations can appear as a problem of significant size that threatens to overwhelm a child or young person. Growing up can be one long life event in itself. Typically, people report interpersonal difficulties with their partners or family members as life events that lead to suicidal behaviour.

**Mental ill health**

Mental health problems in the young are strongly associated with suicidal behaviour. This is particularly true of mood disorders, including depression, and substance use disorders. One in three young people who take their lives are intoxicated at the time of death. Acts of deliberate self-harm in the past year are also markers for increased risk of suicide. Despite these associations three-quarters of all people who commit suicide are not in contact with mental health services.

**Access to means**

Hanging and self-poisoning are the main methods of suicide in England. The act is often associated with impulsivity in the young, which provides a rationale for restricting access to the means.

Most importantly, the majority of young people who attempt suicide frequently express their thoughts in the year before the act to professionals, relatives, partners or peers. Potential opportunities to intervene in order to save lives are therefore available to all those who have contact with children.

**POLICY**

A 20% reduction in suicide by 2010 was set as a national target in *Saving Lives: Our Healthier Nation*. This has subsequently been reinforced by the *National Service Framework for Mental Health* and is now supported by a *Suicide Prevention Strategy for England*. However, these policy documents are for adults of working age.
The promotion of children and young people’s mental well-being is included as an objective in England’s suicide prevention strategy, which is welcomed, but this group is not identified as being at high risk, which seems contrary to the evidence. Consequently there is no coherent policy response to suicide among children and young people, although the gravity of the situation should encourage the use of mechanisms established by related policy. For example, under the National Service Framework, local mental health services are required to have systems to audit suicide.

A National Service Framework for Children is currently in preparation by the Department of Health. It will need to articulate a clear strategic response to this problem incorporating a wide range of organisations and individuals involved in the care and education of young people.

**IMPLICATIONS**

In the absence of a specific mental health policy for children and young people, service provision for this group is patchy and inconsistent. Child and adolescent mental health services (CAMHS) are poorly developed and in some areas it can be difficult for young people and their families to access professional support. In addition to statutory provision it is important to be aware of voluntary organisations providing support in this area e.g. Youth Access and Childline.

Evidence based practice guidelines are presented in England’s suicide prevention strategy for adults of working age. A similar evidence base for children and young people is not currently available, but is much needed and would greatly benefit practice developments. Drawing on existing guidance we believe there are three key areas upon which practice and service developments could focus.

**Interpersonal approach**

The attitudes we hold toward people who attempt to take their lives can influence the course of their condition. The isolation that suicidal people feel can be reinforced by a judgmental approach in which their behaviour is viewed as manipulative or selfish. We need to step beyond our personal assumptions, show care and respect for the people behind the behaviours, and help them to talk about their feelings.

**Assessment and management of risk**

Children and young people who have attempted suicide, or who express suicidal ideas, need to be assessed for the degree of risk they pose to themselves. This procedure should include assessments of mental state and substance use patterns, and is therefore conducted by specialist mental health staff. However, evidence is drawn from as wide a range of sources as possible so that all those involved in the care and education of young people can be expected to contribute to this process, which should involve:

- Assessment of risk, including mental state and substance use patterns
- Agreement and documentation of crisis/contingency plans
- Nomination of a named care co-ordinator
- Dissemination of crisis/contingency plans to those involved in young person’s care/education
- Pro-active use of relevant referral pathways.
Prevention of suicide

Prevention of suicide in the young is not the exclusive responsibility of any one sector of society. The many and varied factors associated with this behaviour point to the significant contributions that can be made by a range of organisations and individuals. For example:

- School nurses/student counsellors: creating cultures in which young people feel it is healthy to talk through emotional and other difficulties.
- General practitioners: restricting the number of tablets prescribed to those at risk of overdose and educating parents/guardian on availability of medicines in the home.
- Accident and Emergency staff: ensuring all young people who have attempted suicide receive a specialist mental health assessment.

Though suicide among the young is a devastating occurrence, we can intervene in ways that save and improve the quality of a person’s life. By paying attention to the overall mental health of our children and young people we can reduce the likelihood that life will become too much to bear.

REFERENCES


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