# YOUNG VOICES: A BRIEF REPORT ON YOUNG PEOPLE'S LIVED EXPERIENCES OF SUICIDALITY AND HELP-SEEKING

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**Acknowledgement:** Research prepared for the National Suicide Prevention Adviser and the National Suicide Prevention Taskforce, commissioned through the Suicide Prevention Research Fund, managed by Suicide Prevention Australia.

**Suggested citation:** Robinson J, Bellairs-Walsh I, Thorn P, La Sala L, & Boland A. Young voices: A brief report on young people's lived experiences of suicidality and help-seeking. Orygen; June 2020.

# YOUNG PEOPLE'S LIVED EXPERIENCES OF SUICIDALITY AND HELP-SEEKING

## A BRIEF REPORT

## INTRODUCTION

In June 2020, the Suicide Prevention research team at Orygen conducted consultations (one-on-one interviews and a focus group/workshop) with 11 different young people regarding their lived experiences of suicidality and associated help-seeking.

All young people had lived experience of suicidality (e.g., suicidal thoughts and/or behaviours – including suicide attempts or a crisis), and associated help-seeking. The most recent experience of suicidality ranged from within the previous four weeks to between one and two years ago. Young people were recruited from across Australia and represented the states of Victoria, New South Wales, and Western Australia. They ranged from 17-25 years of age (*M* age = 21.27 years). Seven identified as female, three as male, and one as non-binary. Five of the young people identified as LGBTQIA+, including two transgender young people.

Most reported an onset of mental health problems during childhood and primary-school years. For some, feelings of suicidality were also present during this time. For others, suicidality began during high-school, just after high-school, or during University. Most had experienced multiple episodes of suicidality; all had experienced suicidal thoughts and ideation, the majority had engaged in self-harming behaviours, and over half had attempted suicide; a few reported having made multiple suicide attempts over their lifetime.

Young people were asked the following questions during the individual interviews:

1. What led you to feeling suicidal or thinking about suicide?
2. What helped you throughout those experiences?

For the focus group, activities were conducted around the following questions:

1. What did your help-seeking journey look like?
    a. Who were the people/places/settings along the way that you sought help from?
    b. What kind of response did you receive from them, and what was the impact of that response on you?

## WHAT YOUNG PEOPLE TOLD US

### FACTORS THAT CONTRIBUTED TO THEIR SUICIDALITY

Young people described a range of contributing factors to their suicidality, which were frequently described as cumulative and multiple. The most commonly reported factors were:

1. **Difficulties in interpersonal relationships with others**, including problems with family, friends, or partners. These included factors such as dysfunctional, controlling, and unstable family or parent relationships in the home setting, including siblings, difficulties with their friendship groups (such as being isolated from groups, bullying, and friendship breakups), and long-term relationship break-ups or problems with partners.

2. **Symptoms of mental illness and mental ill-health**, most commonly, depressive episodes, psychotic symptoms, and anxiety disorders including panic attacks, social anxiety, and agoraphobia. Mania, bipolar, Borderline Personality Disorder (BPD), eating disorders, Attention Deficit Hyperactivity Disorder (ADHD), and experiencing intrusive thoughts also contributed to feelings of suicidality.
3. **Identity struggles**, particularly for the five young people who identified as LGBTQIA+ – all of whom discussed their internal difficulties in coming to terms with their identity, and concern about a lack of acceptance and belonging from others.
4. **Emotional states and feelings**, including feelings of worthlessness, inadaquecy, poor self-esteem, loneliness, isolation, abandonment or feeling excluded, a sense of burdensomeness, feeling out of control, and overwhelming despair, sadness, frustration, and unhappiness.
5. **Academic pressures and stress**, including school or university pressures such as exams, failing subjects or assessments, and experiencing high expectations either from one's self, or from family, to perform.
6. **Financial and socioeconomic stressors**, such as being unemployed or losing employment, income stress, and experiencing homelessness or poverty.
7. **Experiencing traumatic events**, such as childhood sexual abuse, the suicide attempt of a sibling, and emotionally abusive relationships.
8. **The failure of support and interventions** designed to assist young people, including medications and therapy not working, not being heard by providers, receiving involuntary psychiatric treatment, and having a lack of early diagnosis, which resulted in a lack of understanding and explanation.

***"I WAS IN A RELATIONSHIP FOR THREE YEARS, AND WE BROKE UP… IT WAS A BIT MESSY. I THINK THAT WAS PROBABLY ONE OF LIKE THE LEADING FACTORS – EVERYTHING FELT LIKE IT WAS FALLING APART"*** **(P8, FEMALE, 23 YEARS).**

## WHAT LED YOUNG PEOPLE TO SEEK SUPPORT FROM OTHERS

### Types of support

Young people reported accessing and interacting with many different supports throughout their help-seeking journey.

The most common **formal supports** included psychologists, counsellors, therapists, or clinicians (whether in the private or public system, at school, university, headspace, or somewhere else). Others were psychiatrists, mental health nurses, telephone and online support services (e.g., Lifeline, Beyond Blue), CAMHS, GPs/doctors, paediatricians, school chaplains, sexologists, duty teams, headspace Access teams, programs and support services such as psychosocial services, outreach, specialist services, outpatient services, gender clinics, sexual assault services, and hospitals, Emergency Departments, and in-patient units and their staff, CATT teams, PARC's, and emergency services (paramedics/ambulance and police).

**Informal sources** of support for young people were most commonly friends and parents or caregivers. Others were siblings, partners, schools and universities, supervisors, online social support or interest groups, social media, and mental health advocacy/interest groups such as Youth Reference Groups and Youth Advisory Groups.

### How they accessed help

At the time of suicidality, some young people were already engaged with professional supports, whilst others weren't engaged in any form of help-seeking. Often, dealing with increasingly problematic and severe stressors led them to seek or receive help from others.

For some, **accessing help was self-directed**; i.e., they realised that something was wrong and that they needed assistance. Often young people approached their friends, family, partners, GPs, private psychologists or psychiatrists, school counsellors, university counselling services, online social

communities including social media, online mental health supports such as Beyond Blue online chat and e-headspace, and crisis lines such as Lifeline, in these instances. For others, problems and **difficulties were identified by others**, either through disclosure by the young person themselves, or through the young person's expressions of distress or crisis. Often those who identified distress in the young person were teachers, friends, parents, school chaplains, psychologists, and care teams, who intervened and alerted others, and/or enacted linkage and referral processes to professional supports as needed.

***"I CRIED… I TOLD MY MOTHER… 'I THINK I NEED TO SEE A GP', BECAUSE TO ACTUALLY BREAK DOWN WAS KIND OF A MASSIVE RED FLAG FOR ME, LIKE THAT'S NOT MY STYLE AND IT HAS NEVER BEEN, TO REALLY LOSE CONTROL IN THAT SENSE"*** **(P10, FEMALE, 21 YEARS).**

## THE HELP-SEEKING JOURNEY

Once linked and engaged with formal support, young people's help-seeking journeys were often arduous, disrupted, and complicated, with **multiple 'drop-off' points** along the way. The most prevalent theme in young people's journeys related to **service access and care continuation** issues. When these occurred, young people were often left without formal support for long periods – sometimes many years. Issues along the journey included the following:

- **Running out of sessions;** being limited to 10 sessions with a Mental Health Care Plan (MHCP) meant that young people were often unable to continue treatment aside from receiving 'episodic care', had to go through multiple MHCP renewals, and were often left without support whilst waiting for their allowed number of sessions to restart. Once these plans expired, young people faced significant financial costs to continuing to access regular professional assistance.
- **Criteria of services or clinicians impacting acceptance or maintenance of treatment;** access and continuation was limited by complicated and often hypocritical criteria, which included complexity, severity, and functionality levels (despite risk), and age. Many young people experienced a 'merry-go-round' journey, where they were turned away from professionals and services who deemed them too complex and severe; despite being dismissed elsewhere for not meeting severity criteria. Adding to these difficulties, young people were often unable to access the long-term care required for more complex issues with limited MHCP sessions. They were also often discharged from treatment too early and felt to be not adequately recovered.
- **Failure of services and clinicians to transfer information, communicate with one another, and maintain continuity;** this meant that young people were given poor treatment, weren't followed up on, slipped through the cracks, and had to restart their journey and retell their story over and over. Many young people had clinicians leave or change throughout their treatment once they had already established a positive relationship with them. A lack of care continuity during periods of change was especially apparent and often led to disengagement.
- **Long waitlists;** both public and private services (e.g., headspace, private psychologists, ED wait times, and inpatient admission) had extensive wait periods, leaving young people without care for long periods of time.
- **Interventions or therapies being ineffective or unhelpful;** young people experienced poor therapeutic relationships at times, unhelpful techniques, or inappropriate treatments, which led to disengagement. They had often tried multiple different things along the way; different interventions, therapies, medications, dosages, clinicians, and services, yet experienced little to no relief for long periods.
- **Problems going unrecognised or unnoticed;** often young people's problems weren't identified by others in the first place, and concurrent disorders and issues were missed or ignored during treatment, leading to ineffective treatment and disengagement.

The above problems led to **multiple engagements, disengagements, and re-engagements**, and experiences of **having be linked in over and over again.** Feelings of discouragement and hopelessness were common, and journey 'drop-offs' were seen to extend suffering and negatively impact recovery. Despite these difficulties, many young people still **shared hope for their future and recovery**, highlighting that **recovery is not linear**, and that their mental health journey requires ongoing work and dedication. They expressed determination to pursue recovery, no matter how many relapses or setbacks they faced.

***"THERE WAS NO CUSHION, AND THERE WAS NO ASSISTANCE, IT WAS JUST A BIG OLD DROP-OFF… THERE'S A LOT OF DROP-OFF POINTS, THAT COULD'VE MADE THIS 10-YEAR JOURNEY LIKE 4 YEARS"* (P2, MALE, 18 YEARS).**

## EXPERIENCES OF SEEKING HELP

### Helpful responses

From **formal sources** of support, taking a holistic and individualised approach to treatment, going at the young person's pace, and providing space and autonomy were helpful. Personable, warm, and patient approaches were valued. Medication enactment and adjustment and making and suggesting referrals where young people needed increased support, were helpful. Receiving a formal diagnosis was validating and enabled young people to manage their problems more easily.

Young people **valued supports from psychologists, counsellors, therapists, and clinicians** very highly, and felt they assisted in a multitude of ways. These included:

- Learning practical strategies to deal with emotions, problems, and crises, which provided hope for the future and opportunities to move forward. Skills to cope and problem-solve, to manage negative and suicidal thoughts, and to address safety were helpful.
- Gaining insight into symptoms alongside a professional who was objective and offered expertise.
- Providing a therapeutic relationship, a space to be listened to and talk about problems, and being trusting, validating, and understanding.
- Being there through the worst it and not giving up on them – providing hope and reassurance for recovery.
- For LGBTQIA+ young people, helping them to come to terms with, and supporting, their identities.

Positive responses from **informal sources** included being supportive, reassuring, accepting, trustworthy, and taking the young person's problems seriously. Friends doing whatever they could to assist the young person during crisis – such as coming to their aid (particularly physically), calling emergency services, and attending ED with them – was helpful. Young people found value in interacting with others who had shared lived experience, as they felt they could genuinely understand and empathise. Responses from parents that were patient and not over-reactive to crises were helpful, and young people valued their parents' advocacy during their treatment and help-seeking journeys.

***"COUNSELLING WAS DEFINITELY A GREAT HELP IN UNDERSTANDING THAT THERE ARE OTHER WAYS TO DO THINGS"* (P3, TRANSGENDER MALE, 17 YEARS).**

### Unhelpful responses

A major unhelpful response from a range of **formal sources** of support involved not knowing how to deal with or respond to a young person in crisis. This was experienced from clinicians, GPs, psychiatrists, hospital/inpatient/ED staff, and first responders such as police and ambulance. Young people felt that often professionals were untrained or ill-equipped to deal with a person in crisis, weren't able to approach them as a person, and felt 'treated like a criminal'. These responses only served to make the young person themselves feel increasingly scared or defensive, and failed to

reassure their hope for recovery. Professionals were also often untrained to support LGBTQIA+ issues in young people. Responses from formal sources of help that were dismissive, invalidating, minimising, or judgmental were also notably unhelpful. Young people also reported poor experiences of being unheard and listened to during involuntary treatment periods.

Similarly, unhelpful responses from **informal sources** were unsupportive and unaccepting interactions with parents, friends, and partners. Again, responses that were dismissive or invalidating towards the young people's mental health problems were felt quite keenly. Once more, not knowing how to handle or deal with a young person in crisis – particularly for schools – was a common thread, and young people felt schools were often ill-equipped to support and manage crisis situations. One young person reported how their school suspended them for self-harming behaviour, and another detailed how their school failed to act after a student died by suicide; missing a valuable opportunity to intervene and to open the conversation about mental health in this setting.

***"WE TEND TO GET TREATED LIKE, I WOULD SAY CRIMINALS IN A SENSE SOMETIMES, IF PEOPLE ARE IN CRISIS. FOR ME, I HAVE BEEN PROBABLY QUITE TRAUMATISED… WE MAY BE UNWELL, AND WE MAY BE NOT BE THE BEST PERSON TO DEAL WITH, BUT YOU'VE GOT TO BE PATIENT"*** **(P9, FEMALE, 21 YEARS).**

## SUMMARY AND KEY LEARNINGS

In summary, young people described a range of cumulative contributing factors to their experiences of suicidality, most commonly interpersonal relationship stressors, symptoms of mental ill-health, identity struggles for those whom identified as LGBTQIA+, negative emotional experiences, and academic stressors.

They utilised a variety of both formal and informal supports throughout help-seeking, such as psychologists and other types of counsellors/therapists/clinicians, psychiatrists and doctors, other allied health services, specialist services and programs, emergency care in hospitals including ED and inpatient units, and parents or caregivers and friends. Often increasingly complex and severe stressors led young people to accessing support, and this was either self-directed, or other-directed, where distress was identified by others.

Young people's help-seeking journeys were frequently difficult and complex, and contained many 'drop-off' points influenced by service access and care continuation issues. These resulted in a lack of support for long periods, multiple disengagements, feelings of hopelessness and discouragement, and impeded recovery. Young people experienced a variety of negative responses from sources of support, and most commonly these involved supports being ill-equipped to deal with young people in crisis, and responding in ways that were dismissive, invalidating, or judgmental.

However, young people also experienced a variety of helpful responses, including supportive, validating, and accepting attitudes, genuine care and empathy, holistic and individualised approaches, and supports going out of their way to assist. Young people found value from formal supports that focused on therapeutic interventions, which assisted with practical skills to manage problems, and provided positive therapeutic relationships.

Overall, help-seeking journeys for young people were complex and strained, and many factors associated with service access and continuity of care require addressing in order to improve these experiences. Formal and informal sources were important in helping a young person recover from suicidality, however, these supports need to be better equipped to identity, manage, and respond to young people in ways that are validating and helpful.

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