Pacific youth follow-up after a suicide attempt presentation to Middlemore Hospital Emergency Department

A mixed method study combining quantitative and qualitative methods

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Findings from my dissertation submitted in fulfilment of the requirements for the degree Bachelor of Nursing Honours, the University of Auckland, 2018

Background

- **Internationally,** suicide is one of the top 20 leading causes for death for all ages and each year close to 800,000 people die by suicide, averaging to one person every 40 seconds and many more attempt suicide (World Health Organization, 2018b).
- In 2015, suicide was the second leading cause of death among 15 – 29 year olds (World Health Organization, 2017). It is indicated that for each suicide, there are likely to have been more than 20 others attempting (World Health Organization, 2018a).
- **In NZ** the number of people dying by suicide was around 500 per annum, averaging ten people per week. The latest Coroner's report showed that 685 people died by suicide in NZ in the year 2018/2019 which is an increase from 500 per annum. A rate of 13.92 per 100,000 population (Coronial Services of New Zealand, 2019).

Background

- 150,000 people think about taking their own life
- 50,000 make a plan to take their own life
- 20,000 attempt suicide

(Ministry of Health, 2017a).

- Male have higher suicide rates compared to females
- The highest rate of suicide in NZ was found in youth between 15 years and 24 years, a rate of 16.9 per 100,000 people (Ministry of Health, 2017b).
- A UNICEF report that measured the rate of suicide in adolescents aged 15 – 19 years across 41 countries of the European Union (EU) and the Organisation for Economic Co-operation and Development (OECD) found that the NZ suicide rate for this age group was the highest in the developed world (UNICEF Office of Research, 2017). This was a rate of 15.6 suicides per 100,000 people which was twice the rate of Australia and United States and nine times higher than the rate in Portugal (UNICEF Office of Research, 2017).

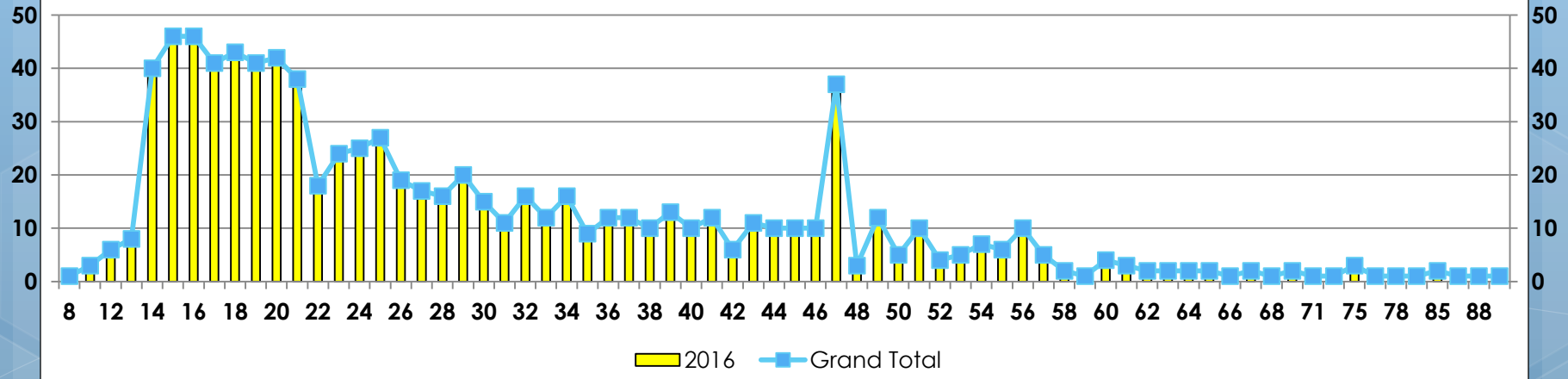
Background – Pacific

- While Pacific people's suicide rates occur at a lower rate compared to the general population; Pacific people have higher rates of suicidal ideation, suicidal plans and suicide attempts than all other ethnic groups (Teevale et al., 2016).
- Pacific youth, in particular age 12-18 years, are more likely to attempt suicide compared with NZ Europeans (8.6% compared with 2.7%) (Tiatia-Seath, Lay-Yee, & Von Randow, 2017).
- Pacific people access health services less than others (Tiatia, 2012). People who attempt suicide are also at high risk of making further non-fatal suicide attempts and dying by suicide (Tiatia, 2012).

Background

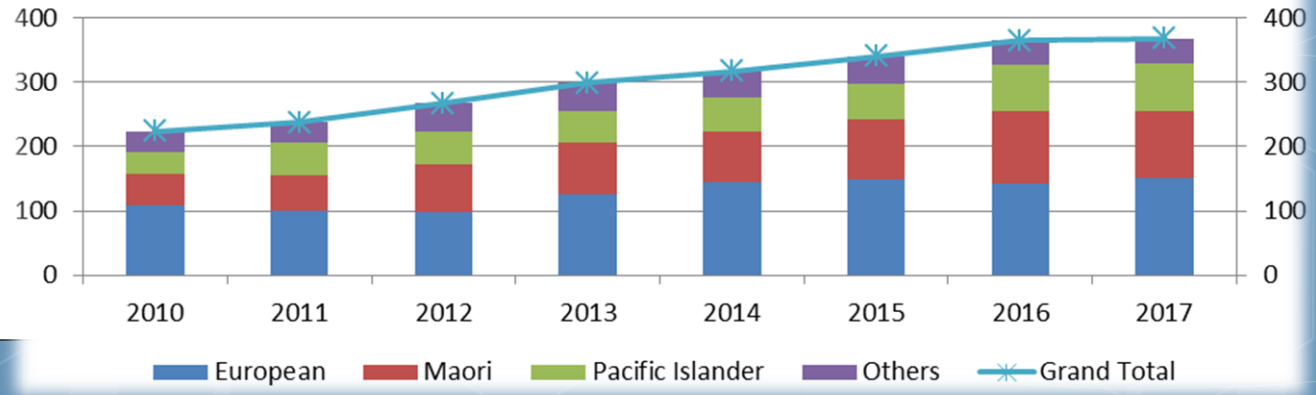
Suicide attempt presentations to MMH ED in 2016 – by age

1. Total number of suicide attempt presentation by age



Suicide attempt presentations to MMH ED for 15 – 24 year olds over the past eight years

2. Total number of episodes 15-24 years old by ethnicity



Aims & Objectives

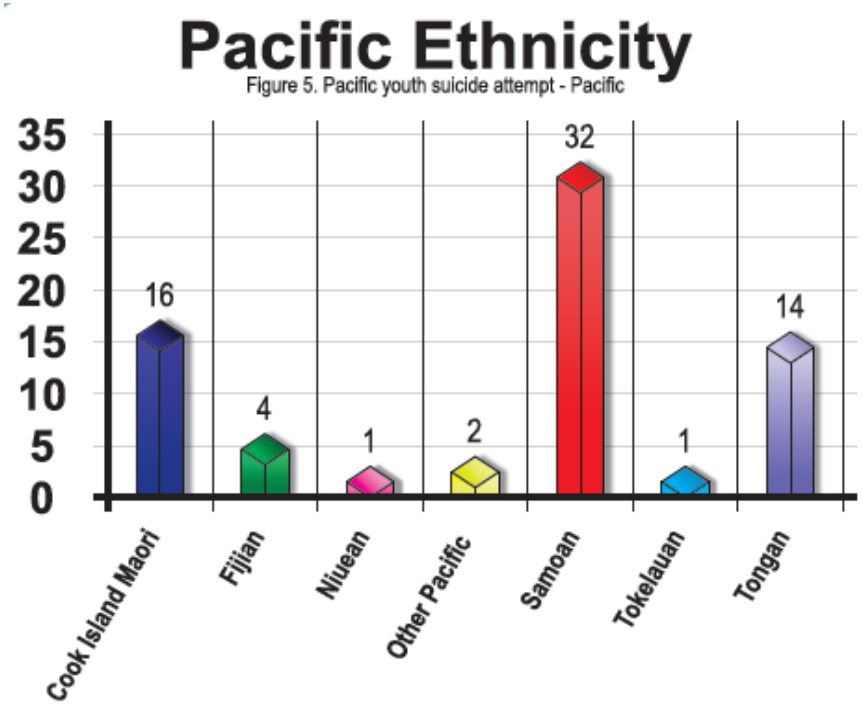
Phase 1 Quantitative

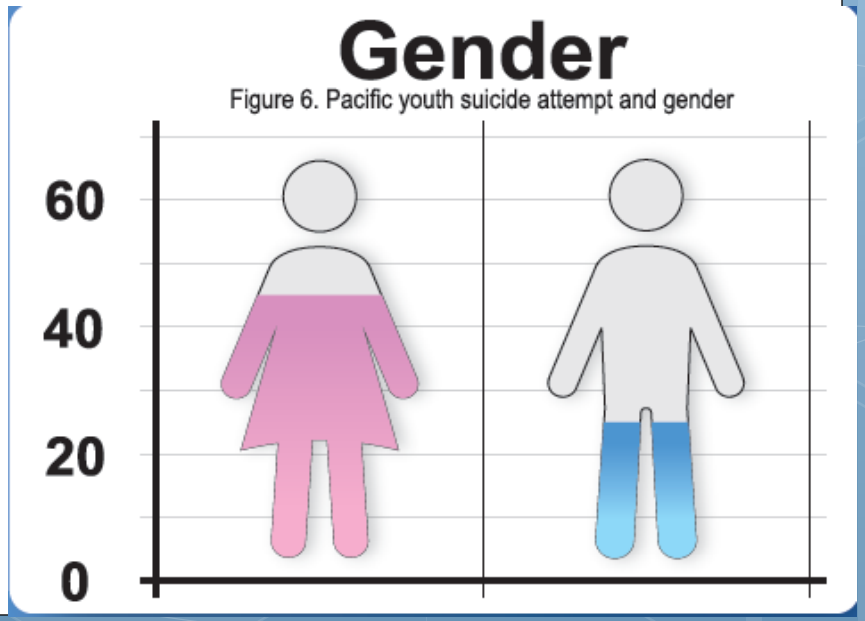
- To provide a descriptive analysis of recent patterns of Pacific youth presentations to MMH ED after a suicide attempt.

Phase 2 Qualitative

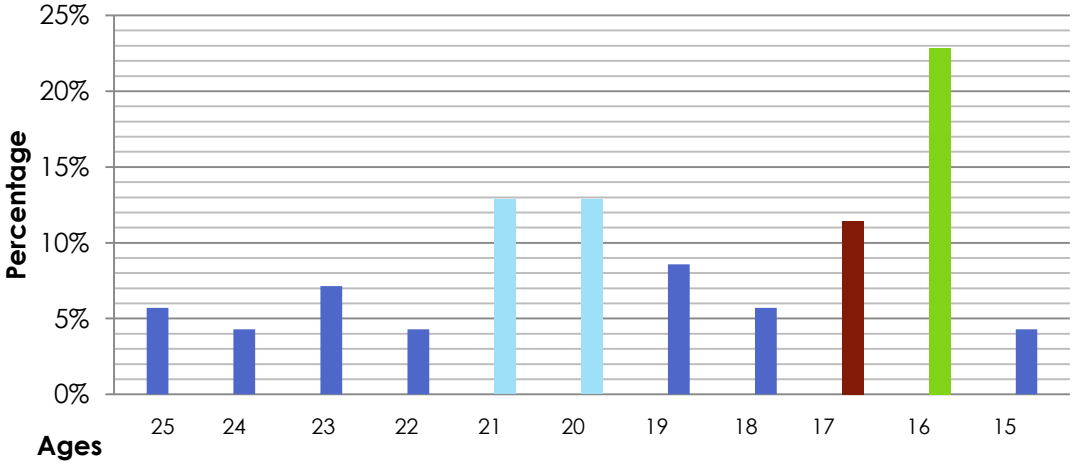
- To explore views of health professionals on follow-up strategies for Pacific youth after a suicide attempt.
- Looking at their experiences of what follow up is being provided, what is working and what they would recommend for future follow up.

Findings – Quantitative

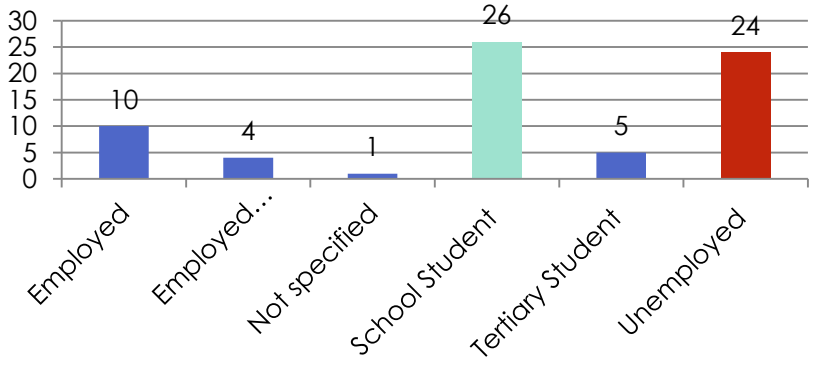




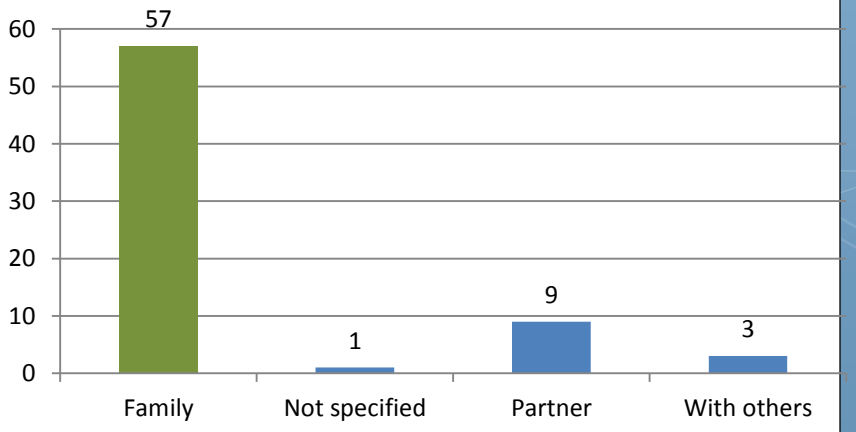
Findings – Quantitative



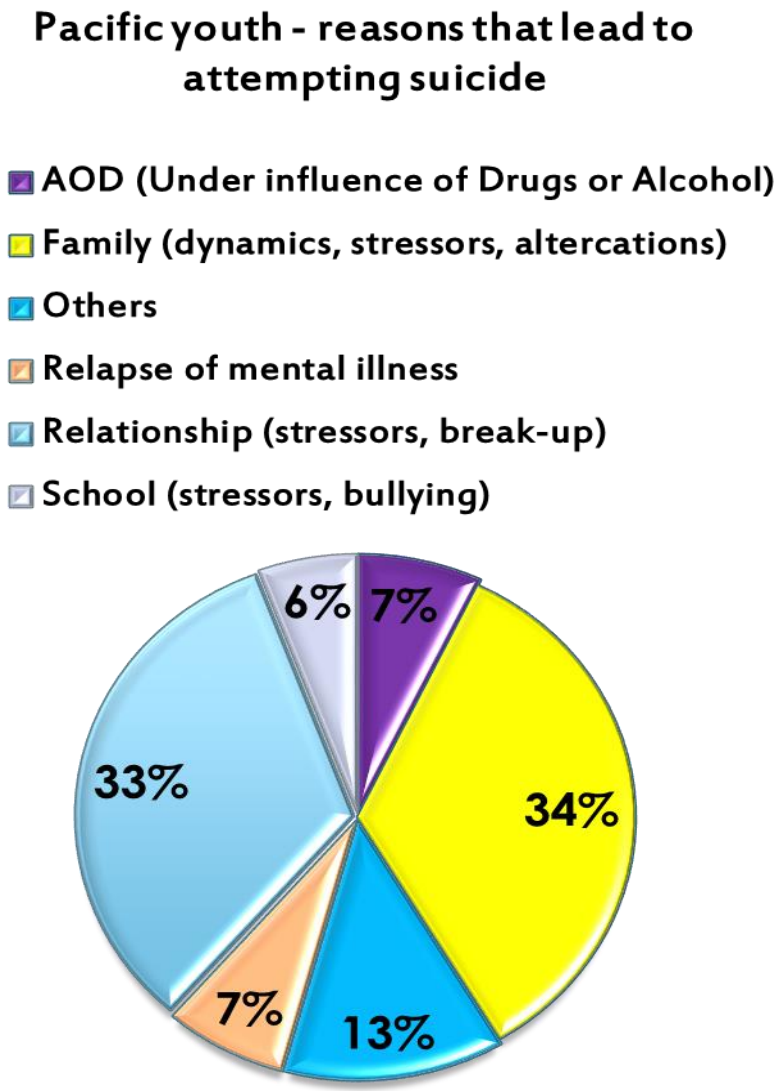
Occupation



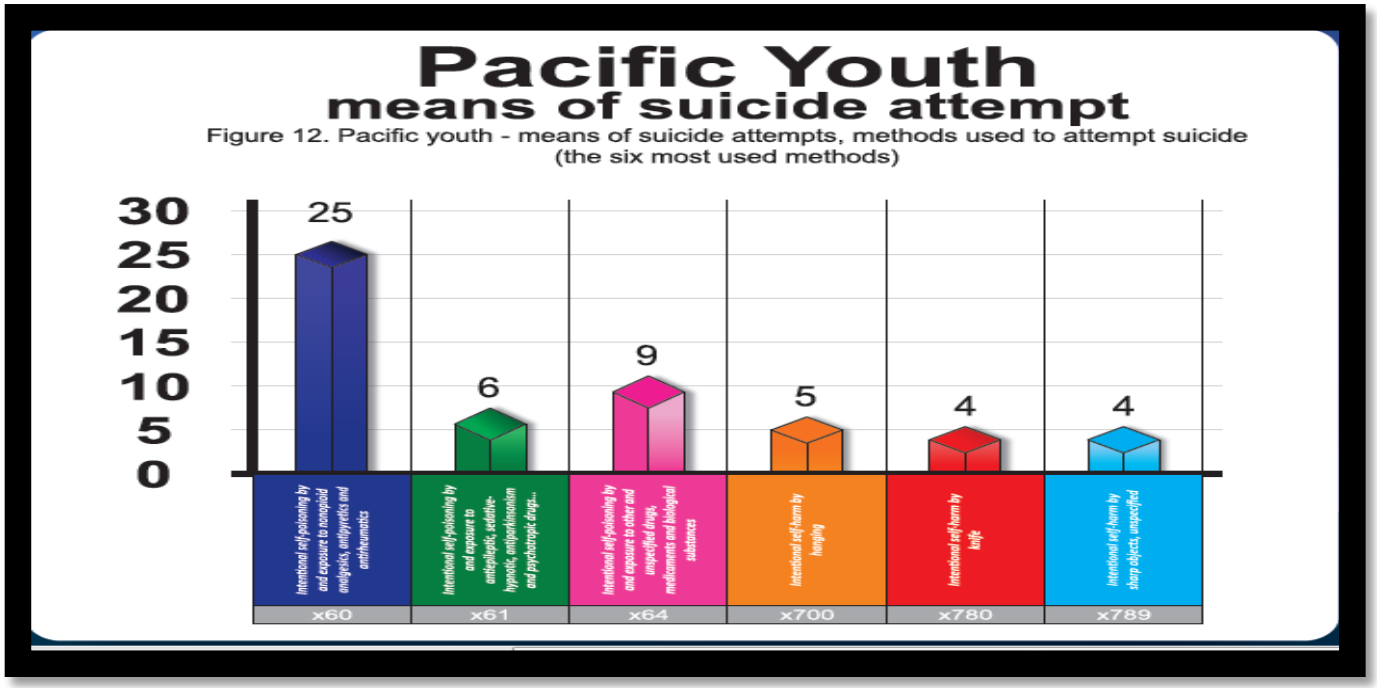
Living situation



Findings – Quantitative

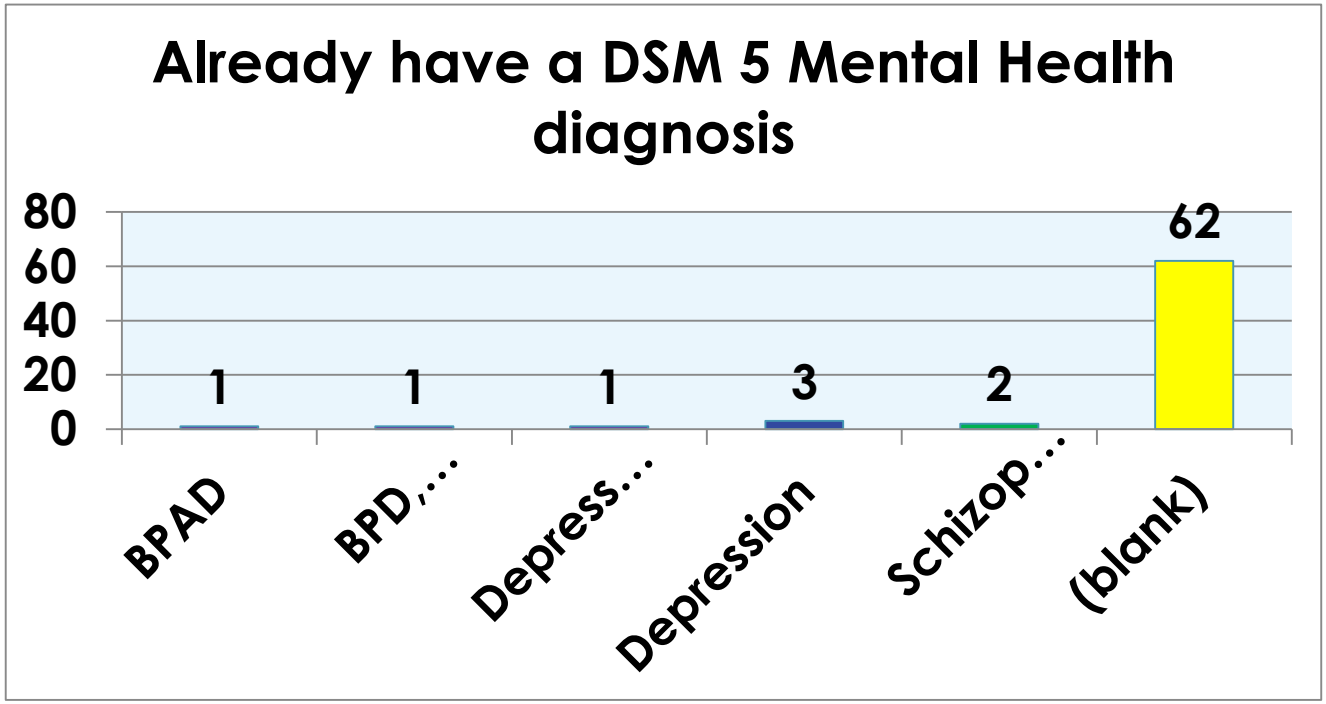


Findings – Quantitative



This study found that the most used method to attempt suicide was intentional self-poisoning

Findings – Quantitative



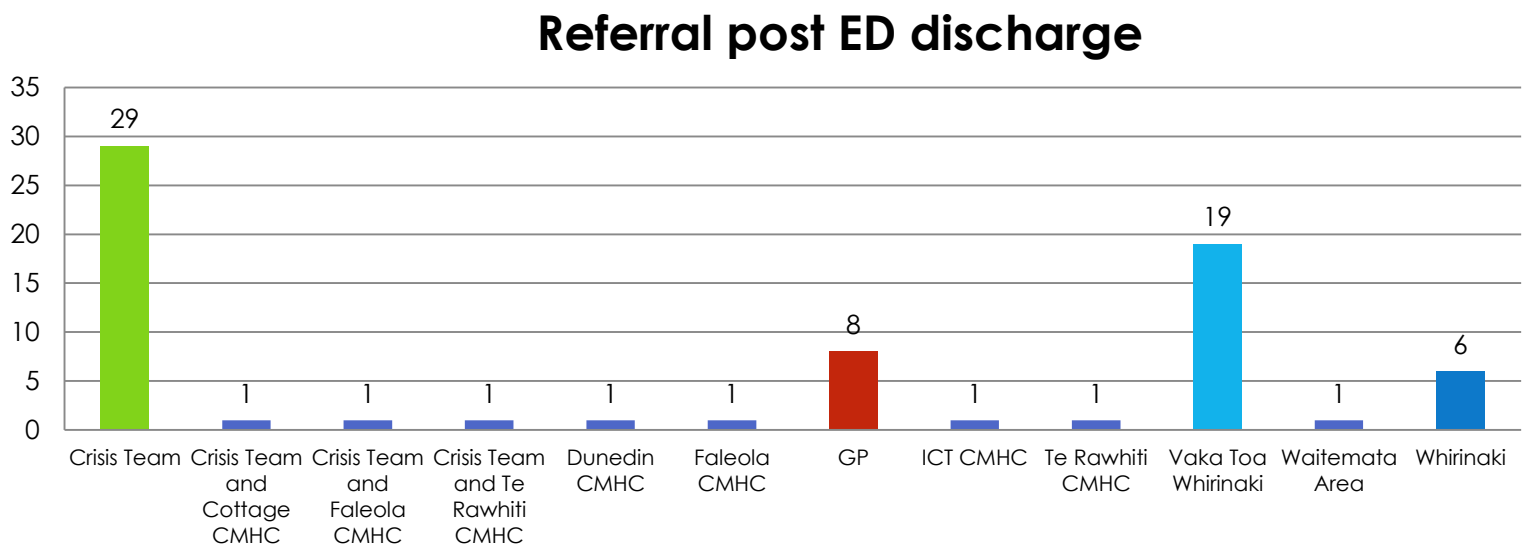
Of the 70 that presented within this year 2016, 62 (89%) did not have a DSM mental health diagnosis.

Findings – Quantitative

Intervention and recommendations provided in ED after Psychiatric assessments

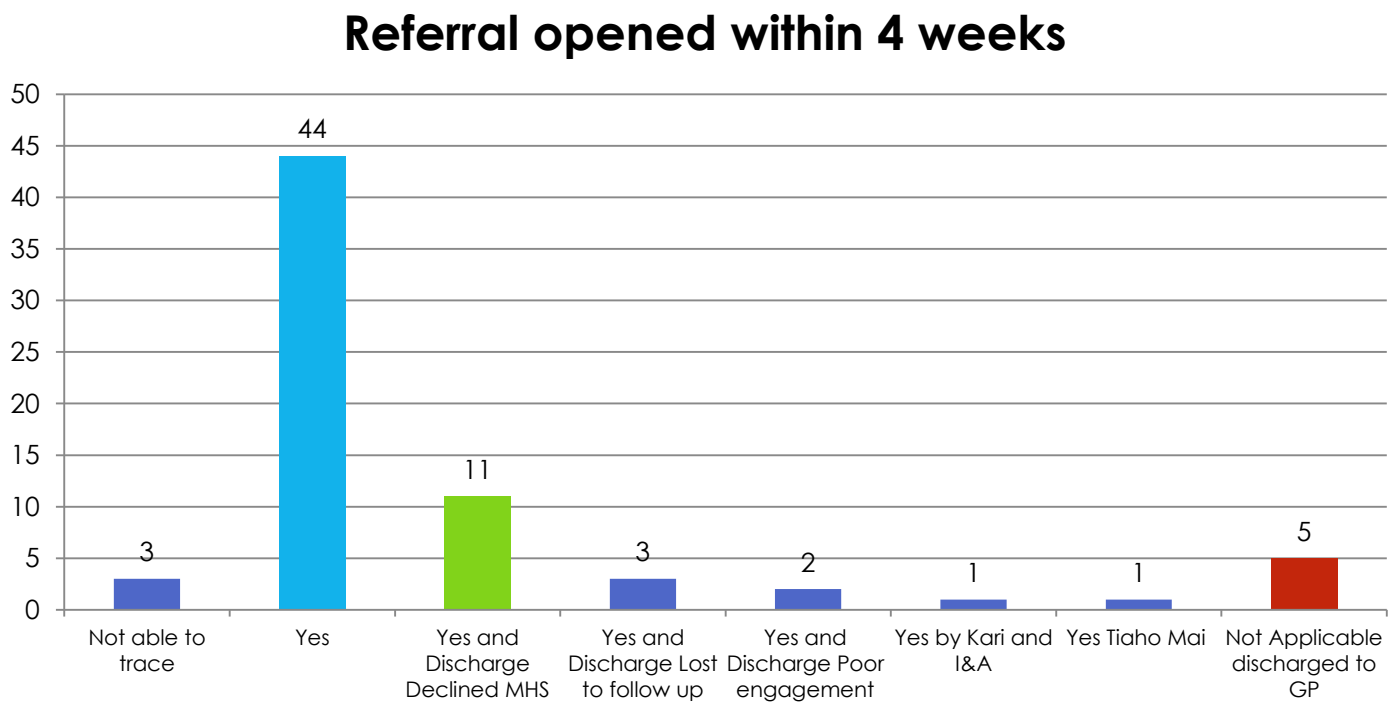
- Provided with contact numbers
- Psychoeducation
- Family discussions
- Mental health team follow-up initiated
- Recommendations of programs
- Referrals to other services

Findings – Quantitative



- Referrals after ED discharge. All referrals (in mental health teams) were opened within timely manner (within a month)
- Majority followed up by Mental Health Crisis Teams (called Intake & Acute Assessments and Home Based Treatments)
- Teams -
  - Mental health crisis teams
  - Pacific child and adolescent mental health
  - Mainstream Child and adolescent mental health
  - GP

Findings – Quantitative



Findings – QUALITATIVE

Theme 1 – Intervening

"to check their mood, their safety, their engagement with their GP. Find out again who their GP is. Have they made an appointment, we need you to make an appointment. To kind of you know, your GP now knows, because they would have had a discharge summary from ED saying you'd tried to hurt yourself." (Participant 4)

"*Majority is around relationships breakdown, whether it's between families or boyfriend, girlfriend. That seems to be the common that comes through from our Pacific people"* (Participant 6)

"But the younger they are the more they seem to have impulsivity and think that, 'well I'll kill myself today and I'll go to school tomorrow'. They don't have that reality of you're going to be dead forever" (Participant 4)

Theme 1 – Intervening

- *"It doesn't work for everybody, you know yourself if you get a phone call and you're busy, so you are like, 'yep, yep, okay, yeah, oh no, I'm fine, yep, yep, I'm busy'. It doesn't really get into the heart of the matter, face to face is a lot better"* (Participant 2)

- *"education can be around mental illness, why people present the way that that they do, medication , looking at relapse planning. You know, there's preference for written information that we have, which we can give to them. I also encourage using You Tube as well, podcasts and stuff like that which they can access. Certainly that's what we do as clinicians"* (Participant 3)

Theme 2 – Engaging

"Follow up is very individual on what the client's needs are.....They should also have ongoing, particularly for the young people because they're that high risk group. And negotiating with them, some want to stay with Pacific services and like to then have their counselling through their church"
(Participant 4)

I ask them, "Do you want me to be politically correct or do you want me to talk straight to you". People usually like; prefer you to be straight and honest with them. So I talk straight and honest to people about what's happening"
(Participant 4)

"Sometimes you have the actual person engaged, but if they haven't got family supporting that engagement and they're harassing the nurses, like "he doesn't need your medicine or", "whatever, 'cause, yeah,". What we do, though, is we get in someone, a clinician of like of their culture, like whether it's Tongan, Niuean, Samoan or whatever, we get in someone because that's the only way they're going to actually accept this is a serious business" (Participant 1)

Theme 2 – Engagement (Barriers)

" "I've got one person at the minute the family is saying "No, no we don't want this person to be referred there. We don't want them to be there. They don't need follow-up. Part of it I think is lack of understanding around mental illness, so someone presents well, but as we all know people do mask how they are actually feeling because they don't want to worry parents or other family members, so they put a brave face on. So then mum, dad: "Oh that's fine. They've been prescribed tablets so that's fine"
(Participant 3)

"There is stigma about mental health and mental health services and even about Pacific cultural services. [People think that] If cultural services know about the young person, that knows that whole community, Pacific community is going to know"
(Participant 6)

"I think some of the barriers for our people are not having the right cultural professional in ED, because sometimes there are language barriers with families" (Participant 6)

"Again, sometimes with the young people, some people that you're having to use interpreters for, they're very reluctant because they've known from experience how some of the interpreters don't keep things confidential because they 're in their community and the chatter goes on" (Participant 4)

Theme 3 – Referrals & Recommendations

- *"We might look at Pro-care (a primary health organisation) counselling from their GP. Might look at moving on to a CMHC and going with psychology or just whatever is needed. If needed, but it wouldn't be necessary at that time, but we might need quite a few visits it's all depending on the client and the nature of what happened"* (Participant 2)

- *"Unfortunately, not every young person that comes through ED has a mental illness, so some of them may be due to behaviour or relational, which is not a mental health issue. So a lot of our … some of them kind of fall through the gaps with regards to the … because they're not under us, we don't see them"* (Participant 6)

Theme 3 – Referrals & Recommendations

"I feel as if it's almost become a way of life, the lack of dealing with distress. Maybe schools might be a good place to start. Resilience, when things have gone wrong. Such a sad way, when things go wrong, what you do, it's so tragic and then the ripple effect. Yeah, teach some sort of resilience, to teach that there are ways, there are other ways to cope when things go wrong, cause they do go wrong, they all go wrong, all our life things go wrong"

(Participant 2)

Findings – QUALITATIVE

- Resilience building – to commence in primary schools, high schools is too late to intervene
- Mental health literacy – raising awareness in Pacific communities and schools
- Stigma

Discussions & Literature

- Covered three EDs in three DHBs 2001 (Total 56 presentations vs 70 presentations) One ED and DHB
- Age group difference
- People that attempted suicide did not have a mental health diagnosis Wei etl al. (2013)
- This follow-up increased the linkage of young people to recommended community appointments with services by (92% compared to 76%) (Asarnow et al., 2011).
- Stigma
- Education
- Consistent results – Ethnicity, Gender, Means of suicide

Implications & Recommendations

1. Indicated that the number of Pacific youth suicide attempts is rising in the Auckland region. Further research and action is needed to address this problem.

2. A high proportion of Pacific youth who attempted suicide were students and almost 90 percent did not have a mental health diagnosis. Further research and action is needed to address the needs of young people who experience distress but do not come to the attention of mental health services.

3. This present study collected data on methods used by young people to attempt suicide. These are different from those reported by the Ministry of Health which only include methods used by young people in completed suicides. This suggests a gap in information that could inform future policy and services.

Implications & Recommendations

4. This study found that barriers to engagement with Pacific young people were due to lack of understanding, stigma and shame. These factors have been found in previous studies with Pacific people who use mental health services.

5. Mental health clinicians recommended counselling and other support services should be available in the community. Cost was a barrier. The implications are that services need to be more widely available and cost effective.

6. The study found that all young people are assessed and all referrals are followed up by mental health services within one month but engagement can be difficult when there are not enough culturally-specific or child and youth specialists'.

Limitations

- Sample of this study
- Role of researcher and potential for bias
- Time constraints

Conclusions

- Numbers increasing
- Previously unavailable information
- CMH MHS provide systemic follow-up but more could be done with better resources
- Programs in primary care and schools to build resilience in young people
- Provide early interventions