IN THE MATTER OF THE BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

JOINT SUBMISSIONS FROM THE STATE OF QUEENSLAND, THE WEST MORETON HOSPITAL AND HEALTH SERVICE BOARD, THE METRO SOUTH HOSPITAL AND HEALTH SERVICE BOARD, METRO NORTH HOSPITAL AND HEALTH SERVICE BOARD (The Applicants)

RELATING TO CONFIDENTIALITY OF PATIENT RECORDS; NON-PUBLICATION AND CLOSED HEARINGS

1. The following Applicants make application for orders pursuant to sections 16 and 16A of the *Commissions of Inquiry Act 1950* ("**COI ACT**"):

   (a) The State of Queensland;

   (b) The West Moreton Hospital and Health Service Board ("**West Moreton**");

   (c) The Metro South Hospital and Health Service Board ("**Metro South**");

   (d) The Metro North Hospital and Health Service Board ("**Metro North**").

2. The Applicants note Practice Guideline 1 of 2015 which states:

   - Subject to the Commissioner's discretion to exclude the public or any portion of the public from any of its sittings, the Commission's hearings will be open to the public and live-streamed via its website.[1]

   - Subject to the Commissioner's determination of any application for confidentiality, all information, witness statements (including exhibits to those statements), documents or submissions provided to the Commission may be published on the Commission's website or otherwise made publicly available.[2]

   - Any person who provides a witness statement or any other document to the Commission, and who wants to apply for confidentiality and/or non-publication orders in relation to the fact of the material being provided or in relation to the whole or any part of the material:

     - If they consider it necessary to address confidentiality *before* providing any material, should contact the Executive Director to discuss arrangements that might be made in that regard;

[1] Paragraph 5
[2] Paragraph 30

- subject to any arrangements made under (a) above, should provide the material to the Commission under cover of a written notice stating:
    - the part of the information or material in respect of which confidentiality is sought;
    - whether confidentiality is sought in respect of the world at large or subject to acceptance of publication to some person or categories; and
    - the grounds on which such confidentiality is asserted to be necessary and appropriate despite the public nature of the inquiry;
- subject to alternative arrangements being made with the Executive Director, should organise the material provided in such a way as to indicate on its face where confidentiality is sought.[3]

- Where confidentiality is applied for in relation to material provided to the Commission, either:
    - The Commissioner shall decide the application on the papers and notify the person or their nominated legal representative accordingly. If confidentiality is refused, the material or information in question will nevertheless be kept confidential for seven days from notification of the decision; or
    - The Commission shall notify the person or their nominated legal representative that they will be required to appear before the Commissioner on a date to be advised for further consideration of the application. The material or information in question will be kept confidential until (and in accordance with) the Commissioner's decision following that appearance.[4]
- Nothing in the guideline should be taken as limiting the Commissioner's powers, whether at the request of any person or on her own initiative, to treat any material or information as confidential and to take any steps appropriate for the preservation of that confidentiality.[5]

[3] Paragraph 31
[4] Paragraph 32
[5] Paragraph 33

3. In respect of material and hearings relevant to the matters within the following terms of reference: ("**the subject matter**")

- For BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (**transition clients**);

    i. How care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (**transition arrangements**); and

    ii. The adequacy of the transition arrangements; (3(d));

- The adequacy of the care, support and services that were provided to transition clients and their families; (3(e))

- The adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients; and (3(f))

- Whether any contraventions of the *Mental Health Act 2000* or other Acts, regulations or directions have occurred with regard to patient safety and confidentiality. (3(i))

The Applicants jointly submit for blanket orders by the Commissioner,

(a) Pursuant to section 16 of COI Act which will:

    i. Wholly preserve the confidentiality of the records relevant to the care of patients, such that they are not made accessible publicly;

    ii. Prevent media publication of matters relevant to the care of patients; and

(b) Pursuant to section 16A of COI Act, that all hearings in relation to these matters be conducted in closed session;

to operate unless and until there is an order of the Commissioner, in any given matter, to the contrary.

Relevant provisions in the Commissions of Inquiry Act 1950 ("COI Act")

4. Section 16 of the COI Act provides:

> A commission may order that any evidence given before it, or the contents of any book, document, writing or record produced at the inquiry, shall not be published.

5. Section 16A of the COI Act provides:

> A commission shall not refuse to allow the public or any portion of the public to be present at any of the sittings of the commission unless in the opinion of the commission it is in the public interest expedient so to do for reasons connected with the subject matter of the inquiry or the nature of the evidence to be given.

Basis for the application

6. The reason for the requested order rests wholly in a concern for the protection of current and past patients, and other at-risk individuals within the community who may be inclined towards "copycat" self-harm / suicide.

7. Attached to this submission are expert reports from clinicians in the field of adolescent psychiatry who were commissioned to express their opinions on the risks to past patients of the Barrett Adolescent Centre and at risk youth generally of:

   (a) The conduct of public hearings in this Inquiry (including web streaming of those hearings);

   (b) Media publication of matters relating to the patients who are the subject of the terms of reference of this Inquiry;

(c) Public disclosure of confidential personal medical records.

8. Dr Sean Hatherill, is the clinical director of the Child and Youth Academic Clinical Unit, Metro South Addictions and Mental Health Service. His qualifications are MBChB (University of Cape Town, South Africa), MRCP (London), MRCPsych (London), FCPsych (South Africa), Cert Child Psych (South Africa), MPhil Child Psych (University of Cape Town, South Africa), FRANZCP (Australia and New Zealand).

9. In his report, he states:[6]

> I have a concern about the impact of public, web-streamed hearings, relating to recent youth suicides on both the young people who were transitioned out of the BAC and the wider youth community.
>
> [redacted]
>
> As we approach the anniversary of the closure of the BAC, I have concerns in relation to the deleterious impact on those young people's mental state and the risk of suicide contagion effects if they are exposed to media coverage or web streaming of the Commission hearings.
>
> I also have some concerns in relation to the disclosure of confidential personal medical records of the young people who were patients of the Barrett Adolescent Centre. Even with the best attempts to de-identify records, much of the information contained in these records may still be identifiable to the young people themselves, family and friends. Information contained in these personal records may well be exquisitely sensitive, relating to histories of trauma, neglect, abuse, and personal experiences hopelessness and suicidal thinking. My concern is that disclosure of these records, even in the de-identified format, may have the potential to destabilise the mental states of the young people concerned, and may also have a deleterious effect on the family members.

[6] At paragraphs 7 – 11

While I have particular concerns for those young persons transitioned from the BAC, I also have a concern in relation to the risk of suicide contagion effects in the wider youth community if the media coverage is not very carefully managed or if there is publicly accessible web streaming. The potential for youth suicide contagious effects is a real, well documented risk. In that respect I refer to the following:

> Gould, M, Jamieson, P, and Romer, D. Media Contagion and Suicide Among the Young. American Behavioural Scientist, May 2003; Vol. 46 N. 9, 1269 - 1284 (copy **attached** as annexure 2 to Dr Hatherill's report); and
>
> Abrutyn, S and Mueller, A. Are Suicide Behaviours Contagious in Adolescence? Using Longitudinal Data to Examine Suicide Suggestion. American Sociological Review, 2014, Vol 79(2) 211-227 (copy **attached** as annexure 3 to Dr Hatheril's report).

10. The Abrutyn and Mueller study considers whether suicidal behaviours are contagious in adolescence. The authors conducted an analysis of longitudinal data to examine suicide suggestion. They concluded:

> ...suicides, like other behaviours, can spread through social relationships via suicide suggestion. Friends' and family members' suicide attempts may trigger the development of suicidal behaviour, suggesting that exposure to role models is a powerful way that drastic and deviant behaviours, like suicide, become normalized. Notably, the relationship to the role model conditions the experience of suicide suggestion. Furthermore, adolescent girls appear more susceptible than boys to adopting the suicidal behaviours they observe through social relationships. This study provides important information for the evolution of the sociology of suicide, but our findings also have vital policy implications for public health officials attempting to prevent adolescent suicide. Namely, policies and practitioners need to be sensitive to the importance of suicide attempts (and not simply suicides), particularly among peers and for girls. Additionally, the increased risk of suicidality associated with friends' suicide attempts may last a year or more, which is longer than previously thought.[7]

11. Gould, Jamieson, Romer consider the impact of, *inter alia*, media reporting on suicide rates. They state:

[7] *Abrutyn and Mueller,* at page 225.

- Research continues to demonstrate that vulnerable youth are susceptible to the influence of reports and portrayals of suicide in the mass media. The evidence is stronger for the influence of reports in the news media than in fictional formats.[8]
- Recent content analysis of newspapers and films in the United States reveal substantial opportunity for exposure to suicide, especially among young victims.[9]
- There is ample evidence from the literature on suicide clusters and the impact of the media to support the contention that suicide is 'contagious'.[10]
- The magnitude of the increase in suicides following a suicide story is proportional to the amount, duration, and prominence of media coverage.[11]
- Furthermore, studies based on real suicides in contrast to fictional stories were 4.03 times more likely to find an imitation effect.[12]

12. A/Professor James Scott is a Child and Adolescent Psychiatrist at the Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service.

13. In his letter of 22 September 2015 he states:[13]

> 1. As a result of any inquiry, it is impossible to predict the responses of patients who received care whilst in the Barrett Centre and their families. It is likely that whilst the inquiry may bring relief to some individuals, it will engender distress in others.

[8] Gould, Jamieson and Romer, 1269
[9] Gould, Jamieson and Romer, 1269
[10] Gould, Jamieson and Romer, 1269. See also page 1270, where the authors state that "since 1990, the effect of media coverage on suicide rates has been documented in many countries" as well as the USA.
[11] Gould, Jamieson and Romer, 1271.
[12] Gould, Jamieson and Romer, 1271.
[13] At paragraphs numbered 1-7.

2. Following the closure of the Barrett Centre, information of the suicides and attempts of suicide was widely disseminated through social media as well as mainstream media.

3. [redacted]

4. On the balance of probabilities, the planned inquiry and dissemination of information arising from a hearing will likely cause distress in some patients and their families which may result in serious psychological harm.

5. In view of this risk, any inquiry into the closure of the Barrett Centre should handle information with the utmost sensitivity.

6. Information about any individual patients should be kept confidential.

7. It is unclear how other aspects of the inquiry best be managed. Clearly it is paramount that support is available for the patients who received treatment at the Barrett Centre and their families whilst this inquiry is undertaken so as to minimise the risk of psychological harm and suicide.

14. Dr Andrew Aboud (MB BCh BAO MRCPsych BSc FRANZCAP) is the Clinical Director, Prison Mental Health Services at The Park- Centre for Mental Health in the West Moreton Hospital and Health Service.

15. In his letter dated 24 September 2015 Dr Aboud states[14]:

> I recognise the potential concern that has been highlighted by West Moreton Hospital and Health Board about the potential effect, which disclosure and publicity of certain matters through the inquiry process may have on former Barrett Adolescent Centre (BAC) patients, their families and others. These effects may occur in the context of: patient confidentially not being maintained; public hearings (including web streaming); media publication of matters relating to the patients who are the subject of the terms of reference.

[14] At paragraphs 2-5.

> ... For some of these individuals, in particular former BAC patients, the inquiry process may be quite stressful and even lead to an increase in self-harm behaviour and suicidal urge. Compromised confidentiality may potentially make this process more traumatic and increase the risks. Those with pre-existing mental health problems will be most vulnerable, yet so might those without pre-existing mental problems, but harbouring risk factors for such.
>
> It is important to be aware that de-identification may not achieve true anonymity for individuals and sensitive material. Individuals and families and associates may well be able to identify such persons, based on material presented.
>
> ...
>
> It is my opinion that mechanisms should be put in place to: protect patient confidentiality; minimise potential risk to current patients, and other persons who were contemporary patients of those the subject of the terms of reference; minimise the potential for "copycat" self-harm/suicide by others at risk within our community. In my view such mechanisms would include holding closed, as opposed to open, court hearings and also consideration of placing appropriate boundaries on media reporting.

16. Dr William John Kingswell is the Executive Director of the Mental Health Alcohol and Other Drugs Branch within Queensland Health.

17. Dr Kingswell regards closed hearings to be '*critically important*'. In his report dated 24 September 2015 Dr Kingswell states:[15]

> ... As you know there is a literature that supports an association between media reporting of suicide and self-harm and a copycat or contagion effect. While I believe that is a risk, the more important risk is that sensitive personal and clinical information will be exposed in the public space. The BAC catered to a very small cohort and individuals will be readily identifiable amongst former patients, families and staff but also more broadly within the community. Some of these clinical records will note very sensitive information such as a history of physical or sexual abuse.
>
> The population accessing the BAG was particularly vulnerable to stress as evidenced by the three suicides that precipitated this

[15] At paragraphs 2-3.

> inquiry. Public exposure of a young person's medical and personal record and information provided by family carers and staff of a clinical or personal nature will be potentially highly embarrassing and stressful and worsen their already poor mental health and place the young person at risk of deliberate self-harm or suicide.

18. Associate Professor John Allan (MBBS FRANZCP PhD) is the Chief Psychiatrist of the Mental Health Alcohol and Other Drugs Branch, Queensland Health.

19. In his report dated 23 September 2015, Professor Allan expresses similar opinions to the other experts. He states[16]:

> Concerns about copycat suicide stimulated by media coverage have been present for many years and there is now considerable evidence relating to this. Mindframe, an Australian national media initiative which has been operating within the Hunter Institute of Mental Health for greater than 10 years, was set up particularly to address these issues. ... They suggest "There is strong support for the relationship between media reporting of suicide deaths and increases in completed and attempted suicide rates". ...
>
> There is also evidence that certain groups may be more vulnerable e.g. when the person identifies with the person who suicided, in young people, or when the person is already experiencing mental health issues. An important review, Suicide and the news and information media by Australians Jane Pirkis and Warwick Blood (2010) concluded that presentations of suicide in news and information media can influence copycat acts in circumstances such as "irresponsible" presentations in news and information media. They also note that suicide is a behaviour which is susceptible imitation which leads to suicide "clusters". "Clusters" may be another way of describing "copycat" events but usually refers to a group of suicide events that are in a limited geographical area or cultural subgroup. In Australia concerns have been raised about cluster suicides in groups of young people and particularly young indigenous people.
>
> There is also evidence that explicit descriptions of methods and places of suicide have led to increased suicide rates. Another report suggested that media depicting real suicide events rather than fictionalised ones can lead to a higher increase in rate. These are things that are likely to arise in the Commission's deliberations.

[16] At paragraphs 3-13.

...

Even with de-identification of witnesses and material there remain risks of potential self-identification with the suicide described, particularly by young people who have an existing mental health condition or who have previously been patients of that particular or any other mental health service. My conclusion is therefore that the evidence suggests there is an increased risk of copycat behaviour amongst vulnerable young people from the press coverage and particularly if the reporting is insensitive or sensationalised.

For persons with a mental health history who are appearing in the Inquiry, the stress could lead to deterioration in their mental state. I assume that any current or former patients and their family giving evidence will have access to dedicated concurrent and ongoing psychiatric support to deal with this. I want to point out however that publication of their stories can increase this stress even if de-identified. ..... the community of patients and families whose stories may be aired in this Inquiry is small and many know each other. Working out who is who may be much easier for those with some knowledge than the general public. It is likely that not everyone whose case will be examined in the Inquiry will welcome public scrutiny. The chances of further traumatisation by publicity similarly remain high.

It is also possible that former patients who hear reports of other's experiences may both identify with those stories and increase their risk or may misidentify the stories as their own and then feel aggrieved that their story is in the press.

My opinion is that the best way to protect this group of people would be for closed court hearing and limitations on media publications.

... Given the sensitivities for individuals and the potential risk, limitations around reporting on individuals and guidelines around sensible reporting of the general issues would be essential. Closed sessions where appropriate would decrease the risk of poor social media coverage.

Closed hearings for those affected would be very important in protecting the mental health of participants. Serious consideration needs to be given to the potential harmful effects on vulnerable people of uncontrolled or sensational reporting.

Submissions

20. The following observations of Dr Hallett are noted:

> Publicity is regarded as of fundamental importance to the success of an inquiry as a means of restoring public confidence, and as a means of independent scrutiny, into those areas of government administration where a problem has arisen. This is more than an expression of idealism.[17]

21. It is nonetheless respectfully submitted that, given the concerns expressed by the expert clinicians, the orders sought reflect an appropriate exercise of the discretions reposed in section 16 and 16A COI Act.

22. In particular, as to the operation of section 16A, it is submitted that it is "in the public interest expedient" to conduct the hearings *in camera* given the risks arising from public ventilation of the subject matter.

23. Some of the documents that will be produced in response to Requirements to Produce Documents issued by the Commissioner will include confidential records relevant to the care of patients of the Barrett Adolescent Centre (**Patient Records**).

24. It is submitted that the nature of Patient Records is such that any attempt to redact the records (to seek to protect the identity of the relevant patient) may not achieve the desired outcome as the un-redacted information could lead to the identification of that patient.

[17] Hallett, L, "Royal Commissions and Boards of Inquiry", The Law Book Company Limited, 1982, 173.

25. It is further submitted that any public disclosure of Patient Records carries with it the real risk of adverse harm to those patients and may impact their ongoing care and treatment.

26. In those circumstances it is submitted that a non-publication order of the nature set out in 3(a) above is an appropriate exercise of the Commissioner's discretion.

E S Wilson QC
Counsel for the State of Queensland

Instructed by:
Crown Law

J J Allen QC
Counsel for Metro North

Instructed by:

P W Ambrose
Counsel for West Moreton

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Corrs Chambers Westgarth

K A Mellifont QC
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Clayton Utz

25 September 2015

Queensland
Government

Addiction and
Mental Health Services
Metro South Health

Barrett Adolescent Centre Commission of Inquiry
PO Box 3601
George Street Post Shop
BRISBANE QLD 4003

Enquiries to: Sean Hatherill
Child & Youth Mental
Health Service CYMHS

Telephone: [redacted]

Date: 24 September 2015

Dear Sir / Madam

Barrett Adolescent Centre Commission of Inquiry ("Commission")
Private hearings

1. I am currently the clinical director of the Child and Youth Academic Clinical Unit, Metro South Addictions and Mental Health Service.

2. My qualifications are MBChB (University of Cape Town, South Africa), MRCP (London), MRCPsych (London), FCPsych (South Africa), Cert Child Psych (South Africa), MPhil Child Psych (University of Cape Town, South Africa), FRANZCP (Australia and New Zealand)

3. **Attached** as annexure 1 to this letter is a copy of my *curriculum vitae*.

4. I am informed that the Commission has the potential to conduct hearings in public with the additional possibility that those hearings could be live streamed on the internet.

5. I have been asked to provide my opinion on the risks of:

   (a) The conduct of public hearings (including web streaming of those hearings); and

   (b) Media publication of matters relating to the patients who are the subject of the terms of reference.

   (c) Public disclosure of confidential personal medical records

6. I have considered the above with respect to the potential impacts on both the past patients of the Barrett Adolescent Centre (**BAC**) and at risk youth generally.

7. I have a concern about the impact of public, web-streamed hearings, relating to recent youth suicides on both the young people who were transitioned out of the BAC and the wider youth community.

8. [redacted]

9. As we approach the anniversary of the closure of the BAC, I have concerns in relation to the deleterious impact on those young people's mental state and the risk of suicide contagion effects if they are exposed to media coverage or web streaming of the Commission hearings.

10. I also have some concerns in relation to the disclosure of confidential personal medical records of the young people who were patients of the Barrett Adolescent Centre. Even with the best attempts to de-identify records, much of the information contained in these records may still be identifiable to the young people themselves, family and friends. Information contained in these personal records may well be exquisitely sensitive, relating to histories of trauma, neglect, abuse, and personal experiences hopelessness and suicidal thinking. My concern is that disclosure of these records, even in the de-identified format, may have the potential to destabilise the mental states of the young people concerned, and may also have a deleterious effect on the family members.

11. While I have particular concerns for those young persons transitioned from the BAC, I also have a concern in relation to the risk of suicide contagion effects in the wider youth community if the media coverage is not very carefully managed or if there is publicly accessible web streaming. The potential for youth suicide contagious effects is a real, well documented risk. In that respect I refer to the following:

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    (b) Abrutyn, S and Mueller, A. Are Suicide Behaviours Contagious in Adolescence? Using Longitudinal Data to Examine Suicide Suggestion. American Sociological Review, 2014, Vol 79(2) 211-227 (copy **attached** as annexure 3).

Yours sincerely, [redacted]

[redacted]

Dr Sean Hatherill [redacted]
Consultant Child & Adolescent Psychiatrist
Clinical Director, MSAMHS Child & Youth Academic Clinical Unit

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Are Suicidal Behaviors Contagious in Adolescence? Using Longitudinal Data to Examine Suicide Suggestion

Seth Abrutyn[a] and Anna S. Mueller[a]

Abstract

Durkheim argued that strong social relationships protect individuals from suicide. We posit, however, that strong social relationships also have the potential to increase individuals' vulnerability when they expose people to suicidality. Using three waves of data from the National Longitudinal Study of Adolescent Health, we evaluate whether new suicidal thoughts and attempts are in part responses to exposure to role models' suicide attempts, specifically friends and family. We find that role models' suicide attempts do in fact trigger new suicidal thoughts, and in some cases attempts, even after significant controls are introduced. Moreover, we find these effects fade with time, girls are more vulnerable to them than boys, and the relationship to the role model—for teenagers at least—matters. Friends appear to be more salient role models for both boys and girls. Our findings suggest that exposure to suicidal behaviors in significant others may teach individuals new ways to deal with emotional distress, namely by becoming suicidal. This reinforces the idea that the structure—and content—of social networks conditions their role in preventing suicidality. Social ties can be conduits of not just social support, but also antisocial behaviors, like suicidality.

Keywords

suicide, social networks, suicide suggestion, Durkheim, gender, Add Health

Understanding suicide has been essential to the sociological enterprise since Durkheim ([1897] 1951) wrote his famous monograph, arguing that groups that integrated and (morally) regulated their members offered protective benefits against suicide. Durkheimian mechanisms remain highly relevant (cf. Maimon and Kuhl 2008; Pescosolido and Georgianna 1989; Thorlindsson and Bjarnason 1998), but emphasis on *suicide suggestion,* or the effect a role model's suicidal behavior has on an observer's suicidality, has become increasingly essential to the sociological understanding of suicide (e.g., Gould 2001; Phillips 1974; Stack 2003, 2009). Whereas Durkheim assumed that social integration protected individuals, suicide suggestion demonstrates that suicidality can spread through the very ties that Durkheim theorized as protective. This apparent contradiction is not such a problem for modern interpretations of Durkheim's theory that focus on the structure

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of social ties themselves, and how the networks individuals are embedded within produce the protective benefits Durkheim observed (Bearman 1991; Pescosolido 1990; Wray, Colen, and Pescosolido 2011). It is possible to imagine social ties as capable of both social support and social harm (Baller and Richardson 2009; Haynie 2001; Pescosolido 1990). Durkheim was right that collective solidarity is often protective, but we argue that the behaviors, values, and emotions embedded in network ties must be elaborated to truly understand how social relationships shape individuals' life chances.[1] This subtle shift provides an opportunity to integrate two equally important, but often unnecesarrily separate, realms in the sociology of suicide: the literature on suicide suggestion and the literature on social integration.

The existing literature on suicide suggestion demonstrates that concern over the emotions (suicidality) and behaviors (suicides) embedded in social networks is warranted. Suicides often occur in clusters, with spikes in suicide rates following media coverage of suicides (Stack 2003, 2005, 2009), so much so that a group of public health agencies (including the National Institute of Mental Health [NIMH]) issued guidelines for how the media should report on suicides so as to limit their spread (Suicide Prevention Resource Center [SPRC] 2013). Less research has examined how suicides spread through personal role models, but studies show a robust association between a friend's (and sometimes family member's) suicidal behavior and that of the person exposed to it (Bearman and Moody 2004; Bjarnason 1994; Liu 2006; Niederkrotenthaler et al. 2012; Thorlindsson and Bjarnason 1998). However, these studies often fail to address the critical questions of how, when, and for whom does suggestion matter?

With this study, we employ three waves of data from the National Longitudinal Study of Adolescent Health to examine these questions. By using longitudinal data rich in measures of adolescent life, we investigate the role suicide suggestion plays in the suicide process, independent of other measures of social integration and psychological well-being. We tease out nuances related to the harmful side of social integration by shedding light on four major gaps in the literature: (1) whether suicide suggestion is associated with the development of suicidal thoughts among individuals who reported no suicidal thoughts at the time a role model attempted suicide; (2) whether the effects of suicide suggestion fade with time; (3) whether the relationship between the role model and respondent matters; and (4) whether there are differences between boys and girls.

THEORETICAL BACKGROUND

The Spread of Suicide

Beginning with Phillips's (1974) groundbreaking work, suicide suggestion studies typically examine (1) the association between celebrity suicides and national and local suicide rates (Gould 2001; Stack 2003, 2005), (2) the association between fictionalized media suicides and national and local rates (e.g., Stack 2009), and (3) the apparent geographic and temporal clustering of suicides (e.g., Baller and Richardson 2002; Gould, Wallenstein, and Kleinman 1990). A few studies have also investigated the effect a role model's suicidal behavior has on friends or family members exposed to it. The logic of these studies is predicated on social psychological assumptions. Significant others or persons labeled as members of a reference group with whom we identify are far more likely to influence and shape behavior than are nonsignificant others or outsiders (Turner 2010). Additionally, direct ties infused with socioemotional meanings can act as conduits for the spread of behavioral norms (Goffman 1959) and positive *and* negative affect, which motivate the reproduction of these behavioral norms (Lawler 2006).

Suicide suggestion and the media. In a comprehensive review of the suicide suggestion literature, Stack (2005:121) estimates that about one-third of suicide cases in the

United States involve "suicidal behavior following the dissemintation of a suicidal model in the media." Models may be real celebrities like Marilyn Monroe or fictionalized characters such as those found in popular novels or television shows. The length of exposure and the status of the role model appear to matter: on average, publicized celebrity suicides produce a 2.51 percent spike in aggregate rates, whereas Marilyn Monroe's suicide, a high status and highly publicized suicide, was followed by a 13 percent spike in the U.S. suicide rate (Phillips 1974; Stack 2003). The evidence concerning effects of fictionalized suicides, such as those found occasionally in television series (Schmidtke and Hafner 1988), is less consistent (e.g., Niederkrontenthaler and Sonneck 2007), but a recent meta-analysis found youths are particularly at risk of suicide suggestion via fictional suicides (Stack 2009).

Spikes following celebrity suicides are confined geographically to the subpopulation exposed to the suicide—for example, local newspapers should only affect their readership, whereas nationally televised shows should reach more people. Furthermore, research shows that temporal effects of media exposure vary to some degree, typically ranging from two weeks to a month (Phillips 1974; Stack 1987). To date, these studies have had a difficult time determining whether suggestion plays a role above and beyond individuals' personal circumstances: finding an association between media and suicide rates "does not necessarily identify [suggestion] as the underlying mechanism" (Gould et al. 1990:76). If suicide suggestion plays a role in the suicide process, the question is: does it have an effect above and beyond other risk factors for suicide, such as suicidal thoughts or depression prior to exposure to media coverage of a suicide?

Suicide suggestion via personal role models. Like media exposure suggestion studies, studies of personal role models focus on demonstrating a link between a role model's and the exposed individual's suicidal behaviors. The majority of these studies focus on adolescent suicide, perhaps because adolescent suicide has tripled since the 1950s and thus represents a serious public health problem (NIMH 2003). Adolescents may also be particularly vulnerable to suicide suggestion: adolescents are particularly socially conscious—social status and social relationships are a major focus of their daily lives. Moreover, teenagers are greatly influenced by their peers' values and behaviors (Giordano 2003), which may increase their vulnerability to suicide epidemics. Finally, adolescents are unique in that their sense of self is still forming, so they are more malleable than adults (Crosnoe 2000; Crosnoe and Johnson 2011). Any insights into factors contributing to the development of suicidality are thus crucial to teen suicide prevention.

Generally, studies of personal role models show that having a friend or family member exhibit suicidal behavior is positively associated with an exposed adolescent's own suicidality (Bjarnason and Thorlindsson 1994; Bridge, Goldstein, and Brent 2006; Evans, Hawton, and Rodham 2004), even after controlling for other measures of social integration, regulation, and psychological distress (e.g., Bearman and Moody 2004; Bjarnason 1994). A few studies also demonstrate a positive association between exposure to suicidal behavior in role models and an individual's likelihood of attempting suicide (Bearman and Moody 2004). These studies add to our understanding of sociological influences on suicide, but they fail to examine who is most vulnerable to suggestion and how long effects may linger, and they are often limited by the use of cross-sectional data.

Three studies employ longitudinal data and thus shed further light on suicide suggestion within the adolescent suicide process. Brent and colleagues (1989) had the rare opportunity to collect data immediately following a suicide at a high school. Although they were unable to measure students' predispositions to suicide prior to a peer's suicide, their findings suggest that suicide suggestion can spread rapidly and then gradually lose some

of its effect. More recently, Niederkrotenthaler and colleagues (2012) found that young children exposed to a parent's suicidal behavior were far more likely to develop suicidal behaviors over time than were their counterparts. This work, however, is primarily epidemiological and fails to control for potentially significant confounding factors, such as social integration. Finally, Thompson and Light (2011) examined which factors are associated with adolescent nonfatal suicide attempts and found that role models' attempts significantly increase adolescents' likelihood of attempting suicide, net of respondents' histories of suicidal thoughts and many other factors. These studies provide insights into exposure to a role model's suicidal behavior, but questions of who is most vulnerable and how long that vulnerability lasts remain open, and the role suggestion plays as an aspect of social integration remains unacknowledged.

Similarity between individuals and role models. A primary limitation in the existing literature on suicide suggestion is its failure to determine whether the similarity between friends' or family members' suicidal behaviors is due to the tendency for individuals to form friendships with people they are similar to. This proverbial "birds of a feather" is often the case for teens, who select friends and peer groups based on how similar potential friends are to themselves (Crosnoe, Frank, and Mueller 2008; Joyner and Kao 2000). Research shows that adolescent friendships tend to be homophilous in terms of depression levels (Schaefer, Kornienko, and Fox 2011) and aggression (Cairns et al. 1988). The effect of suicide suggestion on an adolescent's suicidal behaviors may thus be due to unobserved preexisting similarities between friends. To address this limitation, we focus on the development of suicidal behaviors in a sample of adolescents with no documented history of suicidality, to avoid (to the extent possible with survey data) confounding the observed effect of suicide suggestion with selection into friendships. Answering this crucial question, whether suicide suggestion contributes to the development of suicidal behaviors, is a central goal of this study.

Temporal limits. In the process of discerning how suggestion shapes adolescent suicidality, it is useful to consider whether effects of suggestion via personal role models linger as time passes, and for whom. Given past research, suggestive effects likely have temporal limitations. Previous studies on effects of media exposure generally find that spikes in suicide rates last between two and four weeks (Phillips 1974; Stack 1987). Significant others tend to have a greater impact on individuals than do nonsignificant others (Turner 2010), so it is reasonable to expect effects of personal role models will last longer than suicides publicized in the media. We thus utilize the Add Health survey to test whether the impact of a role model's suicide attempt is observable after approximately one year and six years.

Family versus friends. Generally, studies of suicide suggestion do not distinguish between effects of a family member's versus a friend's suicide attempt on those exposed. Given that past research demonstrates that "the influence of friends surpasses that of parents" by mid-adolescence (Crosnoe 2000:378), and friends' influence is strongly linked with teen delinquency, health behaviors, and pro-social behaviors (Frank et al. 2008; Giordano 2003; Haynie 2001; Mueller et al. 2010), we would expect to see differences based on an individual's relationship to the role model. It is plausible, given the extant research on adolescents and peer influence, that a friend's suicidal behavior provides a more salient model for imitating than would family. We thus analyze the two types of role models separately.

Gender differences. The final aspect deserving greater attention is potential gender differences in suggestion and suicidality. Little research emphasizes potential gender differences in how adolescents develop suicidal behaviors, despite the fact that key differences exist in suicidal behaviors between

adolescent boys and girls (Baca-Garcia et al. 2008); for example, girls are more likely than boys to report nonfatal suicide attempts, whereas boys are more likely to experience fatal suicides. Another important reason to consider how suicide suggestion affects boys and girls stems from differences in boys' and girls' friendships. Girls tend to have fewer, but more intimate, emotionally laden friendships, whereas boys tend to maintain less emotional and more diffuse networks focused around shared activities (Crosnoe 2000). Moreover, girls tend to be more sensitive to others' opinions (Gilligan 1982) and are more easily influenced by peers than are boys (Maccoby 2002). These findings suggest girls may be more susceptible than boys to role models' suicide attempts.

In summary, this study shifts the sociological focus away from the protective nature of social ties toward the potential harm these ties can have on individuals. Specifically, we elaborate how exposure to suicidal behaviors shapes adolescent suicidality by identifying how, when, and for whom suicide suggestion matters. Our strategy includes (1) examining the development of suicidal behaviors in a sample of youth with no suicidal behaviors at Time I; (2) determining how long the effect of suggestion lasts; and if (3) the type of role model or (4) gender makes a difference in the process. Answers to these questions will help us understand how social relationships work in daily life to both protect and, sometimes, put individuals at risk of suicidality, thereby moving us closer to a robust sociological theory of suicide.

METHODS

Data

This study employs data from Waves I, II, and III of the National Longitudinal Study of Adolescent Health (Add Health). Add Health contains a nationally representative sample of U.S. adolescents in grades 7 through 12 in 132 middle and high schools in 80 different communities. From a list of all schools containing an 11th grade in the United States, Add Health selected a nationally representative sample of schools using a school-based, cluster sampling design, with the sample stratified by region, urbanicity, school type, ethnic composition, and size.

The preliminary in-school survey collected data from all students in all Add Health high schools (n = 90,118 students) in 1994 to 1995; from this sample, a nationally representative subsample was interviewed at Wave I (n = 20,745), shortly after the in-school survey. Wave II followed in 1996 and collected information from 14,738 Wave I participants. Some groups of respondents were generally not followed up at Wave II; the largest of these were Wave I 12th graders, who had generally graduated high school by Wave II. Wave III was collected in 2001 to 2002 and followed up the Wave I in-home respondents (including respondents excluded from Wave II) who were then approximately age 18 to 23 years. Additional information about Add Health can be found in Harris and colleagues (2009).

Sample Selection

We used several sample selection filters to produce analytic samples that allow us to assess suicide suggestion in adolescence. First, we selected respondents with valid sample weights so we could properly account for the complex sampling frame of the Add Health data. Second, we used longitudinal data analysis; as such, we restricted our sample to adolescents who participated in Waves I and II of Add Health for our analyses of Wave II outcomes, and Waves I, II, and III for our analyses of Wave III outcomes. Among respondents, 10,828 had valid sample weights and participated in all three waves of Add Health. Our third selection filter selected only adolescents with no suicidal thoughts or attempts at Wave I, so the time order of events is preserved such that we can determine whether suicide suggestion plays a role above and beyond preexisting vulnerabilities to suicidality. This restriction reduced our analytic sample to 9,309 respondents. With this sample restriction, our models are not estimating the

potential for role models to maintain or dissolve an adolescent's suicidal thoughts. Instead, our models estimate whether role models' behaviors at Wave I are associated with the development of previously undocumented suicidal thoughts and attempts at later waves. This also allows us to control for potential unmeasured factors that may shape both who adolescents choose as friends and their vulnerability to suicide (following the logic of classic ANCOVA; cf. Shadish, Campbell, and Cook 2002). Our final selection filter excluded adolescents missing any key independent variables.

These restrictions have the potential to bias our sample, but they also enable our analysis of critical aspects of suicidal behaviors in adolescence. To assess any potential bias, Table 1 presents descriptive statistics for the entire Wave I sample and our Wave II and Wave III analytic samples. The only substantial difference between the Wave I Add Health sample and our analytic sample is the lower incidence of suicidal thoughts and attempts at Waves II and III due to our restricting our analyses to adolescents with no suicidal thoughts at Wave I. Our analytic samples do not vary substantially from the entire Wave I sample in terms of average levels of emotional distress or demographic variables.

Measures

Dependent variables. We analyze two dependent variables: *suicidal ideation* and *suicide attempts* at Wave II and Wave III. *Suicidal ideation* is based on adolescents' responses to the question: "During the past 12 months, did you ever seriously think about committing suicide?" Adolescents who answered "yes" were coded 1 on a dichotomous outcome indicating suicidal ideation. Adolescents who reported having suicidal thoughts were then asked, "During the past 12 months, how many times did you actually attempt suicide?" Answers ranged from 0 (0 times) to four (six or more times). We recoded these responses into a dichotomous variable where 1 indicates a report of at least one suicide attempt in the past 12 months and 0 indicates no attempts. Adolescents who reported no suicidal thoughts were also coded 0 on *suicide attempts*. These variables were asked at all three waves.

Independent variables. Our first key independent variable, one of two ways we measure suicide suggestion, is *friend suicide attempt* and is based on adolescents' responses to the question: "Have any of your friends tried to kill themselves during the past 12 months?" Adolescents who responded "yes" were coded 1 on a dichotomous variable. This question was asked at all waves. For models predicting suicidal thoughts and attempts at Wave II, we rely on adolescents' responses at Wave I to preserve time order in these data. For models predicting Wave III dependent variables, we use adolescents' responses to this question at Wave II. Our second key independent measure of suicide suggestion is *family suicide attempt*. The treatment of this variable is identical to *friend suicide attempt* and is based on adolescents' responses to the question: "Have any of your family tried to kill themselves during the past 12 months?"

Our models also control for protective factors for suicide suggested by prior research. Following Durkheim's ideas about the importance of social integration as a protective factor for suicide, we measure adolescents' family integration, how close they feel to their friends, and their religious attendance. Our *family integration scale* (Cronbach's alpha = .769) is based on four items that measure how integrated adolescents are in their families (Bjarnason 1994). Adolescents were asked how much they feel their parents care about them, how much people in their family understand them, whether they have fun with their family, and whether their family pays attention to them. Responses were coded so that a higher value on the scale indicates a higher feeling of family caring. Our measure of adolescents' relationships with their friends, *friends care,* is based on adolescents' responses to the question, "How much do you feel that your friends care about you?" Higher

Table 1. Weighted Descriptive Statistics for Key Variables

	Full Wave 1 Sample (mean)		Wave 2 Analytic Sample (mean)		Wave 3 Analytic Sample (mean)	
	Boys	Girls	Boys	Girls	Boys	Girls
Suicide Ideation, W1	.103	.165	.000	.000	.000	.000
Suicide Attempt, W1	.021	.057	.000	.000	.000	.000
Suicide Ideation, W2	.083	.146	.052	.092	.051	.091
Suicide Attempt, W2	.019	.051	.009	.026	.006	.026
Suicide Ideation, W3	.068	.072	.060	.060	.057	.061
Suicide Attempt, W3	.010	.025	.008	.021	.009	.020
Age, W1	15.180	15.370	15.290	15.120	15.130	15.010
	(1.610)	(1.710)	(1.620)	(1.580)	(1.530)	(1.530)
White	.667	.676	.673	.680	.667	.673
African American	.138	.151	.138	.157	.146	.162
Asian American	.044	.038	.040	.036	.039	.035
Hispanic	.118	.109	.115	.105	.115	.108
Other Race/Ethnicity	.033	.025	.034	.022	.033	.021
Parents' Education	2.867	2.853	2.880	2.867	2.935	2.910
	(1.284)	(1.261)	(1.236)	(1.239)	(1.240)	(1.248)
Lives with Two Biological Parents	.581	.571	.594	.588	.590	.602
Same-Sex Attraction, W1	.075	.048	.065	.039	.066	.038
GPA, W1	2.727	2.925	2.751	2.972	2.780	3.001
	(.798)	(.764)	(.766)	(.747)	(.753)	(.740)
Emotional Distress, W1	28.933	30.813	28.110	29.423	27.910	29.110
	(6.868)	(8.137)	(5.910)	(6.990)	(5.830)	(6.800)
N	5,042	5,694	4,301	4,523	3,855	4,075

Note: Standard deviations are in parentheses.
Source: The National Longitudinal Study of Adolescent Health.

values on this measure indicate a higher feeling of caring friends. *Religious attendance* measures how often adolescents attend religious services. Responses range from "never" to "once a week, or more." Items were coded so that a higher value on this measure indicates more frequent religious attendance.

In addition to measures of social integration, we control for several known risk factors for suicide. These include adolescents' reports of *same-sex attraction* (at Wave I) or identity as gay, lesbian, or bisexual (which was only collected at Wave III). At Wave I, adolescents were asked whether they had "ever had a romantic attraction to a female?" or ". . . to a male?" These questions were used to identify adolescents who experienced some form of same-sex attraction (Pearson, Muller, and Wilkinson 2007). At Wave III, adolescents were asked to choose a description that fit their sexual identity, from 100 percent homosexual to 100 percent heterosexual (with not attracted to males or females as an option). Adolescents who reported being "bisexual," "mostly homosexual (gay), but somewhat attracted to people of the opposite sex," or "100 percent homosexual (gay)" were coded 1. Heterosexual, asexual, and mostly heterosexual adolescents were coded 0.

Because emotional distress may increase an adolescent's likelihood of becoming suicidal, we control for *emotional distress* in all models. *Emotional distress* is measured by a 19-item abridged Center for Epidemiological

Studies-Depression (CESD) scale (Cronbach's alpha = .873). Add Health, at Waves I and II, posed a series of questions asking respondents how often "you didn't feel like eating, your appetite was poor," "you felt that you were just as good as other people," and "you felt depressed." Positive items were reverse coded, so a higher score on every question indicates higher emotional distress. Items were then summed for adolescents who provided a valid answer to every question in the scale.

Finally, all models control for several demographic and personal characteristics, including educational attainment measures, family structure, age, race/ethnicity, and parents' education levels. Overall *grade point average* (GPA) is a self-reported measure and has the standard range of 0 to 4 (indicating the highest possible grade). An indicator for whether the adolescent successfully graduated from high school and if they attended some college is included in the models predicting suicidal behaviors at Wave III. Because of the age range of the sample, some students had not had time to complete a college degree; however, all had an opportunity to begin their college coursework and graduate from high school.

Family structure captures whether respondents lived in a two-biological-parent family, a single-parent family, a family that includes step-parents, or another family type at Wave I. *Race/ethnicity* was coded as five dichotomous variables: Latino/a, Black, Asian American, and other race or ethnicity, with White as the reference category. We took *parents' education* from the parent questionnaire and used the maximum value in the case of two parents. If this information was missing from the parent questionnaire, we used students' reports of their parents' education level. We coded parents' education as (0) never went to school; (1) less than high school graduation; (2) high school diploma or equivalent; (3) some college, but did not graduate; (4) graduated from a college or university; and (5) professional training beyond a four-year college or university.

Analytic Plan

Our goal with these analyses is to investigate whether a role model's suicide attempt is associated with the development of suicidal behaviors at Times II and III in a sample of adolescents with no suicidal behaviors at Time I. We also examine how long the increase in vulnerability lasts after exposure to a role model's suicide attempt, whether the type of role model makes a difference, and if there is variation in these processes by gender. To investigate these questions we estimate a series of nested logistic regression models with a sample of adolescents with no history of suicidal thoughts at Wave I. Because we are interested in (and anticipate based on prior literature) gender differences in what leads adolescents to contemplate suicide, we estimate all models separately by gender. As a first step, we estimate the bivariate relationships between a role model's suicide attempt (at Wave I or II) and an adolescent's likelihood of suicide ideation and attempt (at Waves II and III) to determine whether suicide suggestion is part of the process of developing suicidal behaviors over time. Next, we add a set of demographic, personal, and social characteristics to the model to determine how robust the impact of suicide suggestion is to potentially confounding risk and protective factors.[2]

Because Add Health data were collected using a complex survey design (described earlier), we estimate all models using the SAS SurveyLogistic Procedure (An 2002) to obtain appropriate estimates and standard errors (Bell et al. 2012). The survey logistic procedure is similar to traditional logistic regression, except for the handling of the variance. We estimated variance using a Taylor expansion approximation that computes variances within each stratum and pools estimates together (An 2002). This method accounts for dependencies within the data due to the complex survey design. Our models also include normalized sample weights to compensate for the substantial oversampling of certain populations. These weights render our analyses more representative of the U.S. population than would unweighted

analyses that fail to correct for Add Health's oversampled populations.

RESULTS

To begin our investigation of suicide suggestion, we first examine the roles of family members' and friends' suicide attempts in adolescent girls' and boys' suicidal behaviors at Wave II, before turning to boys' and girls' behaviors at Wave III. Among boys, reports of a new suicidal attempt were extremely rare; only 1 percent of boys reported a suicide attempt at Wave II after reporting no suicidal thoughts at Wave 1. For this reason, we focus most heavily on suicidal thoughts and examine suicide attempts only among adolescent girls. The models for boys' suicidal attempts are available from the authors by request.

Suicidal Behaviors at Wave II

Table 2 presents odds ratios from logistic regressions predicting suicide ideation and suicide attempts for girls and boys. As a first step, we estimate the bivariate relationship between family members' suicide attempts (Wave I) and adolescents' suicidal thoughts and attempts a year later (Wave II) (see Models 1, 4, and 7 in Table 2). A family member's attempted suicide (Model 1) significantly increases the likelihood that adolescent girls report suicidal thoughts at Wave II; however, it is not associated with suicide attempts at Wave II (Model 4). On average, girls who reported that a family member attempted suicide at Wave I are 2.994 times more likely to report suicidal thoughts at Wave II than are girls who did not experience a family member's suicide attempt. This pattern is not found among boys. For boys, we find no significant relationship between a family member's suicide attempt and boys' likelihood of reporting suicidal thoughts. This is our first piece of evidence for gender differences in suicide suggestion.

Next we turn to friends as role models for suicide suggestion. For girls, a friend's suicide attempt significantly increases their likelihood of reporting suicidal thoughts (Model 2) and attempts (Model 5). For boys, experiencing a friend's suicide attempt has a significant and positive relationship to boys' likelihood of reporting suicidal thoughts (Model 8). These significant bivariate relationships indicate that *who* the role model is may condition the likelihood that suicides spread through social relationships in gendered ways. Our next step is to evaluate whether these relationships maintain their significance once potential risk and protective factors are held constant in our models.

Substantively, our findings do not change after the addition of important controls.[3] On average, adolescent girls are 2.129 times more likely to report suicidal *thoughts* after experiencing a family member's attempted suicide, and 1.561 times more likely after experiencing a friend's suicide attempt, net of all other variables (Model 3). Girls' reports of suicide *attempts,* on average, are significantly related to friends' suicide attempts, but not family members' attempts, net of all other variables, confirming in Model 6 the bivariate relationships observed in Models 4 and 5. For girls, the relationship between suicide suggestion, via family or friend role models, is robust to many vital risk and protective factors for suicide.

For boys, the story is similar. The bivariate relationships observed in Models 7 and 8 are robust to the addition of control variables. Boys remain affected by a friend's suicide attempt at Wave I. Specifically, a friend's suicide attempt renders boys 1.649 times more likely to report suicidal thoughts at Wave II. The suicide attempt of a family member remains insignificant (confirming associations found in Model 7).

Overall, these findings suggest that suicide suggestion is associated with the development of suicidal behaviors within a year or so of a role model's suicide attempt, particularly when the role model is a friend. Significant gender differences do emerge: girls appear more sensitive than boys to familial role models.

Suicidal Behaviors at Wave III

In the analyses presented in Table 3, we investigate the impact a role model's suicide attempt at Wave II has on respondents' suicidal thoughts and attempts at Wave III, as

Table 2. Odds Ratios from Models Predicting Suicidal Thoughts and Attempts among Adolescents at Wave II

	Girls						Boys		
	Suicide Ideation			Suicide Attempt			Suicide Ideation		
	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7	Model 8	Model 9
Suicide Suggestion									
Family Suicide Attempt	2.994***		2.129**	1.069		.535	1.263		.947
Friend Suicide Attempt		2.054***	1.561**		3.214***	2.577***		1.935**	1.649*
Background									
Age			.733***			.679***			.979
African American			.625*			1.041			.809
Asian American			.966			1.580			.741
Latino\a			.811			1.082			.863
Other Race or Ethnicity			.692			1.332			1.019
Parents' Education Level			.967			.865			1.060
Same-Sex Attraction			1.660			1.281			1.499
GPA			.870			.967			.796
Social Integration									
Religious Attendance			.996			.900			.969
Single-Parent Family			1.499*			1.145			.943
Step-Parent Family			1.295			1.868			.866
Other Family Structure			1.050			1.578			1.817
Family Integration Scale			.877			.681			.770
Friends Care			1.204			1.216			1.404**
Psychological Factors									
Emotional Distress			1.067***			1.067***			1.038**
–2 Log Likelihood	2708.714	2698.139	2499.105	1073.977	1039.891	947.583	1729.374	1717.750	1672.626
Response Profile (n=1/n=0)	351/4172	351/4172	351/4172	100/4423	100/4423	100/4423	222/4079	222/4079	222/4079
N	4,523	4,523	4,523	4,523	4,523	4,523	4,301	4,301	4,301

Note: All independent variables measured at Wave I.
Source: The National Longitudinal Study of Adolescent Health.
*$p < .05$; **$p < .01$; ***$p < .001$ (two-tailed tests).

Table 3. Odds Ratios from Models Predicting Suicidal Thoughts and Attempts among Adolescents at Wave III

	Girls						Boys		
	Suicide Ideation			Suicide Attempt			Suicide Ideation		
	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7	Model 8	Model 9
Suicide Suggestion									
Family Suicide Attempt	.725		.466	1.298		.779	1.782		1.572
Friend Suicide Attempt		1.978***	1.546		1.794	1.254		1.665	1.168
Background									
Age			.811***			.824			.861*
African American			.535*			.693			.477*
Asian American			1.286			4.808***			.551
Latino\a			.804			.698			.900
Other Race or Ethnicity			.678			<.001***			.683
Parents' Education Level			1.220*			1.173			1.248*
Gay, Lesbian, Bisexual Identity (W3)			2.879**			2.917			3.042**
GPA			.840			.645			.823
High School Dropout (W3)			1.557			2.688*			1.555
Some College (W3)			1.063			1.264			.881
Social Integration									
Religious Attendance			.845			.883			.964
Single-Parent Family			1.200			2.796*			1.184
Step-Parent Family			.995			2.560*			1.049
Other Family Structure			1.447			1.939			1.894
Not Currently Married or Cohabiting (W3)			1.309			1.173			2.751***
Family Integration Scale			.871			1.015			1.083
Friends Care			1.014			1.481			.799
Psychological Factors									
Emotional Distress			1.041**			1.026			1.055***
–2 Log Likelihood	1841.515	1821.903	1709.455	794.630	789.706	709.774	1660.011	1656.320	1547.991
Response Profile (n=1/n=0)	202/3873	202/3873	202/3873	59/4016	59/4016	59/4016	197/3658	197/3658	197/3658
N	4,075	4,075	4,075	4,075	4,075	4,075	3,855	3,855	3,855

Note: All independent variables measured at Wave II unless otherwise noted.
Source: The National Longitudinal Study of Adolescent Health.
*$p < .05$; **$p < .01$; ***$p < .001$ (two-tailed tests).

respondents are entering early adulthood. These models help us understand the temporality of suicide suggestion, while also allowing us to establish a clear time order between an adolescent's history of suicidal thoughts (Wave I), the experience of a friend's or family member's suicide attempt (Wave II), and subsequent suicidal behaviors (Wave III).

Overall, models presented in Table 3 demonstrate a significantly different pattern from those presented in Table 2. For boys and girls, the impact of a role model's suicide attempt, whether a family member or a friend, appears to fade with time. By Wave III, we find only one significant relationship between a measure of suicide suggestion and suicidal thoughts. Model 2 in Table 3 indicates a significant bivariate relationship between the experience of a friend's suicide attempt at Wave II and girls' reports of suicidal thoughts at Wave III. This finding, however, does not hold in full models, although the odds ratio is in the expected direction (OR = 1.546) and the *p*-value is very close to the threshold for statistical significance ($p > .055$) (Model 3 in Table 3). We further investigated the change in statistical significance between the bivariate and saturated models in analyses not presented here (but available from the authors by request). We found that adolescent girls' emotional distress at Wave II explains the impact of a friend's suicide attempt on girls' likelihood of reporting suicidal thoughts at Wave III, net of other key controls. The significant effect of a friend's suicide attempt on girls' likelihood of suicidal thoughts remains until emotional distress is included in the model. This suggests that emotional distress may serve as an important mechanism through which suicide suggestion operates, particularly for girls.

Our models from Wave III suggest that the increased risk of suicide suggestion found over the short run (in Table 2) fades with time. Six years later, we find little evidence that experiencing a role model's suicide attempt, whether friend or family member, has a long-term effect, except perhaps for girls for whom it is mediated by emotional distress.

DISCUSSION

Within the sociology of suicide, social integration and regulation are often emphasized as the primary social forces that protect or put individuals at risk of suicide. These Durkheimian mechanisms are undoubtedly important (Bearman 1991; Pescosolido 1990; Pescosolido and Georgianna 1989; Wray et al. 2011), but much research on the spread of health behaviors implicates social ties as not just mechanisms for social support, but also potential conduits for the spread of suicidal behaviors via suicide suggestion, illuminating another side to social integration. We find that suicide attempts of role models—primarily friends—are in fact associated with adolescents' development of suicidal thoughts and, in some cases, attempts. Effects of suicide suggestion appear to fade with time, girls are more vulnerable to suicide suggestion than boys, and the type of role model—for teenagers at least—matters. Our findings suggest that social relationships, contra Durkheim, are not always protective against suicide, at least not when significant others exhibit suicidal tendencies. This reinforces the idea that the structure—and content—of social networks conditions their role in preventing suicidality. Specifically, social ties can be conduits of not just social support but also antisocial behaviors, like suicidality.

Our study has four primary implications for advancing the sociological understanding of suicide. Our most essential contribution to the literature on suicide suggestion via personal role models is the evidence we provide indicating that being aware of a role model's suicide attempt is associated with the development of suicidal thoughts and sometimes attempts. This relationship is robust to many measures of risk and protective factors. Experiencing the suicide attempt of a significant other may serve as a vehicle for learning a way to deal with distressing life events—by becoming suicidal (Jamison 1999). Future research should continue to probe the question of how suicide suggestion contributes to the development of suicidality. Many potential mechanisms—social learning, imitation,

and emotional contagion—may underlay the observed association between role models and those exposed to their suicidality. Qualitative research, in particular, may provide valuable insights into which potential mechanisms promote the spread of suicidality via social ties. Understanding how and when suicide suggestion becomes salient to youths' suicidality would greatly help practitioners prevent suicides. Our study provides a first step toward this larger goal.

In addition to providing insights into suicide suggestion as an important mechanism in the adolescent suicide process, our study has implications for understanding the temporality of suicide suggestion via individuals' role models. Previous research on suicide rates and media exposure found effects of suicide suggestion tend to last two to four weeks (Phillips 1974; Stack 1987). Considering the potential differences in connectedness derived from face-to-face relationships and direct contact versus mediated sources, we hypothesized that personal role models would have a stronger, or longer lasting, effect on adolescents exposed to their behavior. In fact, our findings suggest that having a friend attempt suicide has a longer lasting effect than reading about a suicide in the paper or seeing a fictive suicide on television. We find that effects of a friend's or family member's suicide attempt last at least one year, if not more—considerably longer than the effect of exposure via the media documented in prior research. By six years, however, the effect of a friend's or family member's suicide attempt appears to fade in significance. Among adolescent girls, however, a friend's suicide attempt may continue to shape suicidal thoughts even six years later; notably, this effect is explained by girls' emotional distress levels. Future research should examine this pattern in more detail, as this finding suggests an indirect, but potentially important, long-term impact of suicide suggestion via girls' emotional distress.

Perhaps it is not shocking that we do not find strong evidence that effects of role models' suicide attempts last over the long run. Teens who survive the first year (or so) following a friend's suicide attempt may be, or become, emotionally resilient. By early adulthood, a role model's suicide attempt in adolescence may no longer be central to one's daily life, a life no longer constrained within the bounds of high school. Research on contagion generally focuses on relatively bounded social spaces—like Native American reservations, mental wards, or high schools—and finds these spaces are at higher risk of geographic-temporal suicide clustering (e.g., Gould et al. 1990). Outside of relatively bounded social environments, do effects of role models' suicides spread via social ties? Investigating the role of exposure to suicides inside and out of bounded social contexts would add more depth to our understanding of how suicides—and potentially other behaviors—become socially contagious.

Our third major contribution to the literature comes from our emphasis on the role of gender in the suicide suggestion process. Given that boys and girls experience peer relationships differently (Crosnoe 2000), understanding how a social mechanism, such as suicide suggestion, differs for boys and girls is crucial to arriving at a full understanding of the development of adolescent suicidality. In fact, we find significant gender differences in the role of suicide suggestion: suggestion appears more salient to girls. Among boys, friends are the only relevant personal role models for triggering the development of suicidal thoughts; girls' suicidal behaviors, on the other hand, are influenced by both family and friends. Moreover, among girls, suicidal thoughts *and attempts* are associated with suicide suggestion. Finally, effects of a friend's or family member's suicide attempt may last longer for girls.

Although we found girls were more vulnerable, absent an observed history of suicidal thoughts, boys were not immune to suicide suggestion. Note that Thompson and Light (2011), who analyzed suicide attempts net of prior suicidal thoughts, found that boys and girls responded similarly to a role model's suicide attempt. This suggests the role of gender may change at different points in the suicidal process and that a predisposition toward suicidality may be particularly important for understanding those differences.

Why would girls be more vulnerable than boys to suicide suggestion? A definitive answer to this question is beyond the scope of this article, but we can suggest some theoretical considerations that may help explain this variation and offer paths for future research. Because girls develop and maintain more intense intimate relationships (Crosnoe 2000), they may be more primed to "take the role of the other" and hence may be more vulnerable to suggestive mechanisms, including developing emotional distress that sustains the original suggestive triggers. For boys, having relationships that are far less emotionally anchored may reduce or mitigate the effects of suggestion, which raises vital questions about which mechanisms are more salient in the development of boys' suicidal thoughts. Future research should continue to examine the complex role gender plays in the adolescent suicide process, as this may help determine different strategies for preventing suicides.

Our fourth and final major contribution to the sociology of suicide stems from our examination of how different role models—friends and family members—vary in terms of their importance in the suicide suggestion process. Our findings indicate that peers may be more meaningful than family to adolescents, for both boys and girls. Social psychology has long shown that behavior is more strongly shaped by members of reference groups central to the formation and maintenance of one's identity (Stryker 1980). To be sure, a teen's family consists of similar individuals whom the teen may identify with, but research on adolescents clearly demonstrates that purposive efforts to differentiate oneself from one's family are accompanied by concomitant identification with peers. This is not to say that a family member's suicidal tendencies are not distressing in adolescence. For example, we find that for adolescent girls, over the short run, a family member's suicide attempt increases their likelihood of reporting suicidal thoughts (but not attempts) one year later. Yet taken as a whole, our findings indicate that friends' suicide attempts are more influential than family members' suicide attempts in adolescents' lives, at least once adolescents' Wave I suicidality is controlled.

Limitations

Although our findings provide new and important insights into the sociology of suicide, this study is not without its limitations. First, and perhaps most obvious, we are limited to analyzing respondents' suicidal behaviors because we have no information on Add Health respondents who commit suicide. Individuals who report suicidal thoughts or have a history of nonfatal suicide attempts are significantly more likely to commit suicide, but fatal suicide attempts are most common among individuals with no history of nonfatal suicide attempts. Generalizing these findings to the spread of suicide deaths should thus be done with caution. Furthermore, there is attrition in the Add Health sample between waves, and given the higher completion rate among male suicide attempters, more boys than girls may be missing from our analyses due to a completed suicide. Additionally, respondents who actually commit suicide may have been the most likely to be affected by suicide suggestion. Unfortunately, we could find no information from Add Health on whether suicide, or even death, played a significant role in sample attrition. Fortunately, the rarity of suicide among adolescents reduces the risk of this substantially biasing our findings. However, this discussion highlights the significance of finding a way to compare the "lethality" of all types of role models, from the personal to the media-based. Future data collection efforts should note this key gap in the literature.

Our second limitation is related. We chose to focus on friends' and family members' suicide attempts, rather than actual suicides, for practical reasons. Very few respondents reported having a friend or family member complete suicide. This fact may affect our findings on the importance of suicide suggestion. The power of suicide suggestion in the case of a suicide may be greater than the power of suggestion based on a nonfatal suicide attempt. If anything, our findings may thus underrepresent the

potential salience of suicide suggestion as a social mechanism in suicidal behaviors.

Finally, although we did our best to account for adolescents' vulnerability to suicide, we are limited by available data. Specifically, we analyzed a sample of adolescents who reported no suicidal thoughts at Wave I in an attempt to parse out effects of selection into friendships from the influence those friendships may have on an individual. Some adolescents with a history of suicidality, perhaps prior to Wave I, may have been included in our sample. Our study provides one of the best efforts to date to isolate selection from the effect of suicide suggestion, but further investigation of these issues is needed before we can be confident that suggestion affects the development of suicidality.

CONCLUSIONS

Sociologists commonly turn to Durkheimian measures of social integration and regulation when searching for sociological explanations for suicide, but our findings indicate that suicides, like other behaviors, can spread through social relationships via suicide suggestion. Friends' and family members' suicide attempts may trigger the development of suicidal behaviors, suggesting that exposure to role models is a powerful way that drastic and deviant behaviors, like suicide, become normalized. Notably, the relationship to the role model conditions the experience of suicide suggestion. Furthermore, adolescent girls appear more susceptible than boys to adopting the suicidal behaviors they observe through social relationships. This study provides important information for the evolution of the sociology of suicide, but our findings also have vital policy implications for public health officials attempting to prevent adolescent suicide. Namely, policies and practitioners need to be sensitive to the importance of suicide attempts (and not simply suicides), particularly among peers and for girls. Additionally, the increased risk of suicidality associated with friends' suicide attempts may last a year or more, which is longer than previously thought.

For adolescents, ties do bind, but whether these ties integrate adolescents into society, with positive repercussions for their emotional well-being, or whether they promote feelings of alienation, depends in part on the qualities embedded in those ties. On the surface, these findings may appear to contradict Durkheim's sociology, given his focus on solidarity through collective effervescence. Yet, Durkheim argued that solidarity was a product of a shared, collective conscience that spreads through ritualized, emotion-laden interaction. Why should we expect deviant behavior like suicide to be precluded from the types of norms that can spread across actors? Instead, we posit that for a full understanding of how social integration works in individuals' lives to shape their life chances, we must consider not only the social support social ties provide, but also the emotions, behaviors, and values that inhere in those social relations.

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Notes

1. We are particularly grateful to an anonymous reviewer for suggesting this formulation.
2. The SAS programs used to recode and analyze all data are available from the authors by request.
3. Tables presenting odds ratios and confidence intervals are available from the authors by request.

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Media Contagion and Suicide Among the Young

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Research continues to demonstrate that vulnerable youth are susceptible to the influence of reports and portrayals of suicide in the mass media. The evidence is stronger for the influence of reports in the news media than in fictional formats. However, several studies have found dramatic effects of televised portrayals that have led to increased rates of suicide and suicide attempts using the same methods displayed in the shows. Recent content analyses of newspapers and films in the United States reveal substantial opportunity for exposure to suicide, especially among young victims. One approach to reducing the harmful effects of media portrayals is to educate journalists and media programmers about ways to present suicide so that imitation will be minimized and help-seeking encouraged. Recently released recommendations for journalists are attached as an appendix. Similar initiatives with the entertainment industry would be highly desirable.

Keywords: *suicide; contagion; media; youth*

There is ample evidence from the literature on suicide clusters and the impact of the media to support the contention that suicide is "contagious." Suicide contagion can be viewed within the larger context of behavioral contagion, which has been described as a situation in which the same behavior spreads quickly and spontaneously through a group (Gould, 1990). Social learning theory is another paradigm through which suicide contagion may be understood. According to this theory, most human behavior is learned observationally through modeling (Bandura, 1977).

Suicide clusters have been recognized since history has been recorded (e.g., Bakwin, 1957; Popow, 1911). Early research provided only descriptive accounts of suicide "epidemics" (see Gould & Davidson, 1988), but the past decade has witnessed a methodological and qualitative shift from descriptive to inferential studies (Velting & Gould, 1997). Several of these have reported significant clustering of suicides, defined by temporal-spatial factors, among teenagers and

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young adults (Brent et al., 1989; Gould, Petrie, Kleinman, & Wallenstein, 1994; Gould, Wallenstein, & Kleinman, 1990; Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990), with only minimal effects beyond 24 years of age (Gould, Wallenstein, & Kleinman, 1990; Gould, Wallenstein, Kleinman, O'Carroll, et al., 1990). Gould, Wallenstein, Kleinman, O'Carroll, et al. (1990) found that the relative risk of suicide following exposure to another individual's suicide was 2 to 4 times higher among 15- to 19-year-olds than among other age groups.

Similar age-specific patterns have been reported for clusters of attempted suicides (Gould et al., 1994). Estimates of the percentage of teenage suicides that occur in clusters average between 1% and 2%, with considerable variation by state and year, yielding estimates from less than 1% to 13% (Gould, Wallenstein, & Kleinman, 1990). These estimates reflect only mortality data and, thus, do not include clusters of attempted suicides (Gould et al., 1994). Although most of the research on clustering of youth suicide has reported significant clustering (Brent et al., 1989; Gould et al., 1994; Gould, Wallenstein, & Kleinman, 1990; Gould, Wallenstein, Kleinman, O'Carroll, et al., 1990), one study found no clustering of adolescent suicides within a particular locale for a specified time frame (Gibbons, Clark, & Fawcett, 1990). Given the relative rarity of suicide clusters, the examination of one location does not yield enough statistical power to clearly detect clustering. Case-control psychological autopsies of suicide clusters are attempting to identify the mechanisms underlying youth suicide clusters (Davidson, Rosenberg, Mercy, Franklin, & Simmons, 1989; Gould, Forman, Kleinman, & Wallenstein, 1995).

Evidence of the significant impact of media coverage on suicide continues to mount (see Gould, 2001; Pirkis & Blood, 2001a, 2001b; Schmidtke & Schaller, 2000; Stack, 2000). The occurrence of imitative suicides following media stories is largely known as the "Werther effect," derived from the impression that Goethe's novel *The Sorrows of Young Werther* in 1774 triggered an increase in suicides, leading to its ban in many European states. Research on the "Werther effect" was advanced by the systematic work of Phillips (Bollen & Phillips, 1981, 1982; Phillips, 1974, 1979; Phillips & Carstensen, 1986, 1988), whose research consistently found a strong relationship between reports of suicide in newspapers or on television and subsequent increases in the suicide rate.

CONTAGION FROM NEWS

Since 1990, the effect of media coverage on suicide rates has been documented in many other countries besides the United States, ranging from Western countries including Austria (e.g., Etzersdorfer, Sonneck, & Nagel-Kuess, 1992), Germany (e.g., Jonas, 1992), and Hungary (e.g., Fekete, & Mascai, 1990) to Australia (e.g., Hassan, 1995) and to East Asian countries, such as Japan (Ishii, 1991; Stack, 1996). This has added to the extensive work prior to 1990 in

the United States, which found considerable evidence that suicide stories in the mass media, including newspaper articles (e.g., Barraclough, Shepherd, & Jennings, 1977; Blumenthal & Bergner, 1973; Etzersdorfer et al., 1992; Ganzeboom & de Haan, 1982; Ishii, 1991; Jonas, 1992; Motto, 1970; Phillips, 1974, 1979, 1980; Stack, 1989, 1990a, 1990c, 1992, 1996; Wasserman, 1984) and television news reports (e.g., Bollen & Phillips, 1982; Phillips & Carstensen, 1986; Stack, 1990b, 1991, 1993) are followed by a significant increase in the number of suicides.

The magnitude of the increase in suicides following a suicide story is proportional to the amount, duration, and prominence of media coverage (see Gould, 2001, for review). A "dose-response" relationship has recently been reported by Etzersdorfer, Voracek, and Sonneck (2001) in an examination of the relationship between the regional distribution of a tabloid newspaper's coverage of a celebrity suicide by firearms in Austria and an increase in firearm suicides. Nearly 40% of the variance in changes in suicide by firearm was attributable to the differential distribution of the tabloid. This is consistent with the dose-response effect first reported by Phillips (1974). In a quantitative analysis of 293 findings from 42 studies, Stack (2000) found that studies assessing the effect of the suicide of an entertainer or political celebrity were 14.3 times more likely to find a "copycat" effect than studies that did not. Furthermore, studies based on real suicides in contrast to fictional stories were 4.03 times more likely to find an imitation effect. Although Stack (2000) did not identify any age-specific effects, the impact of suicide stories on subsequent completed suicides has been reported to be greatest for teenagers (Phillips & Carstensen, 1986).

CONTAGION FROM FICTION

Fictional dramatizations (e.g., Fowler, 1986; Gould & Shaffer, 1986; Gould, Shaffer, & Kleinman, 1988; Hawton et al., 1999; Holding, 1974, 1975; Schmidtke & Hafner, 1988) also have been associated with an increase in suicide. Those who have tracked hospitalizations after a dramatic fictional portrayal have found effects. So, for example, after the airing of a TV movie that included an act of suicide, Ostroff, Behrends, Lee, and Oliphant (l985) and Ostroff and Boyd (l987) found an increase in hospitalization of adolescents who had attempted suicide. All of those interviewed reported having seen the program. A similar study of the six-part TV series "Death of a Student" in West Germany by Schmidtke and Hafner (l981) found an increase in suicides by adolescents and young adults in the 70 days following the airing of a TV movie showing a suicide by leaping into the path of a train. The number of suicides by that method increased as well. In England, a number of teams studied the effect of the portrayal of an attempted overdose in a popular British soap opera. Williams, Lawton, Ellis, Walsh, and Reed (l987) found an increase in attempts and Sandler, Connell, and Welsh (l986) found an increased use of the same method.

More recent research finds similar effects. Hawton and his colleagues (1999) found that a depicted overdose was followed by an increase in that type of self-poisoning in 49 English emergency rooms in the following weeks. Self-poisonings went up 17% in the week that followed the episode's airing and 9% in the second week. Of importance, "20% said that it had influenced their decision to take an overdose" and "17% said it had influenced their choice of drug" (Hawton et al., 1999, p. 972).

DISSENTING VOICES

In contrast to this ample body of literature supportive of the hypothesis that suicides dramatized in the media encourage imitation, a few studies have not reported an association between media reporting and subsequent suicides (Berman, 1988; Phillips & Paight, 1987) or found an association only among adolescent, not adult, suicides (Kessler, Downey, Stipp, & Milavsky, 1989). A highly publicized recent study by Mercy et al. (2001) found that exposure to media accounts of suicidal behavior and exposure to the suicidal behavior in friends or acquaintances were associated with a lower risk of youth suicide attempts compared to persons who had not recently attempted suicide. However, the interpretability of the findings is limited because (a) the media exposure measure was an aggregate of different types of media stories; (b) attempters may have had less exposure to media generally (e.g., read fewer books, fewer newspapers, etc.); (c) attempters had significantly more proximal stressors, possibly overshadowing their recollection of media exposure; (d) the timing of exposure was a 30-day interval, in contrast to most other studies, which examined a shorter interval following the exposure; and (e) nearly half of the sample was between 25 to 34 years of age, a group not particularly sensitive to imitation.

Another finding by Mercy et al. (2001)—no effect of parental suicide—also was inconsistent with the prevailing research literature. In contrast with this finding, a recent study (Cutler, Glaeser, & Norberg, 2001) using data from ADD Health, a nationally representative stratified random sample of U.S. high school students, found that teenagers who knew friends or family members who had attempted suicide were about 3 times more likely to attempt suicide than teens who did not know someone who had attempted suicide. There was support for the causality of the association because in an examination of two waves of data, teenagers who had not already made a suicide attempt in the first wave were more likely to attempt suicide by the second wave if they had a friend or relative attempt suicide. Stack's (2000) review of the literature indicates that methodological differences among studies examining the impact of the media are strong predictors of differences in the findings. A summary of interactive factors that may moderate the impact of media stories, including characteristics of the stories, individual reader/viewer attributes, and social context of the stories, is presented by Gould (2001).

ALTERNATIVE RESEARCH STRATEGIES

Recently, alternative research strategies have been introduced to study media influences. In contrast to the ecological designs that utilize death certificate data to study differential community suicide rates, the newer paradigms include experimental designs that examine youths' reactions to media dramatizations or written vignettes about suicide (e.g., Biblarz, Brown, Biblarz, Pilgrim, & Baldree, 1991; Gibson & Range, 1991), content-analytic studies that assess the specific display and content characteristics of media stories (e.g., Fekete et al., 2001; Fekete & Schmidtke, 1995; Michel, Frey, Schlaepfer, & Valach, 1995; Pirkis et al., 2002; Weimann & Fishman, 1995), and studies that directly assess suicide attempters following media displays (Hawton et al., 1999).

The existence of suicide contagion should no longer be questioned. The Surgeon General's report on Mental Health concluded that "evidence has accumulated that supports the observation that suicide can be facilitated in vulnerable teens by exposure to real or fictional accounts of suicide" (Surgeon General of the United States, 1999).

Because media influences may be more easily modifiable than some of the other factors that contribute to suicide, such as genetic vulnerability (Hawton & Williams, 2001), greater efforts need to be focused on the media's potential for preventive programming or reporting.

THE ROLE OF MEDIA GUIDELINES

Guidelines for the news. In view of the important role that media depictions may play in influencing vulnerable persons to attempt suicide, considerable attention has been devoted to the possible preventive effects of appropriate reporting of suicide in the news media. Indeed, studies have identified a decrease in suicides following the implementation of media guidelines (Etzersdorfer et al., 1992; Etzersdorfer & Sonneck, 1998; Sonneck, Etzersdorfer, & Nagel-Kuess, 1994) or during the cessation of news stories that occurred during newspaper strikes (Blumental & Bergner, 1973; Motto, 1970). As a result, several countries (e.g., Australia Department of Health and Aged Care, 1999) as well as the World Health Organization (2000) have developed guidelines for the reporting of suicide in the news media.

To ascertain the need for similar guidelines in the United States, the Annenberg Public Policy Center (APPC) conducted interviews with 59 journalists who had written stories about individual acts of suicide in major U.S. newspapers. The interviews revealed that disseminating the recommendations to reporters is an important activity. Many reporters did not appreciate the potential for suicidal contagion as a result of newspaper stories. Those who had heard of the phenomenon expressed doubts about its validity. As a result, the recommendations were written with the specific aim of dispelling doubts about the

TABLE 1: Suicide Stories in Nine Most Circulated Newspapers in 1998

Newspaper	*Number of Stories*	*% in First Nine Pages*	*% Referring to Suicide in Headline*
Chicago Tribune	159	78.0	63.5
New York Daily News	58	41.4	50.0
Dallas Morning News	181	44.8	45.9
Houston Chronicle	107	39.3	56.1
Los Angeles Times	176	71.0	71.0
The New York Times	90	67.8	54.4
Newsday	83	32.5	51.8
USA Today	35	91.4	25.7
Washington Post	83	84.3	71.1
Total	972	60.3	57.4

phenomenon of suicide contagion and providing suggestions for responsible coverage that reporters could implement.

APPC also examined recent reporting practices in the top-10 major newspapers in the United States.[1] This content analysis revealed that the opportunity for suicide contagion from stories in major newspapers is quite high. As seen in Table 1, although the number of stories covering a recent act of suicide in the United States varied greatly across the newspapers, five of the newspapers placed more than half of their stories on the first nine pages of the paper. In addition, seven out of nine newspapers featured suicide in at least half of their stories' headlines. An in-depth examination of *The New York Times* from 1990, 1995, and 1999 revealed that reports of suicide victims younger than age 25 were common. In both 1995 and 1999, more than 20% of the victims featured in suicide stories were younger than age 25, whereas the proportion of all national suicides that were younger than age 25 was only about 14%. In addition, whereas about 60% of the stories mentioned a cause or motive for the suicide, only about 8% mentioned depression as a possible precursor. These findings reinforced the need for guidelines for news reporting in the United States.

The appendix to this article contains the most recently released recommendations for journalists in the United States. These recommendations represent the consensus of suicide experts at several federal agencies as well as private foundations based on the research literature and theories of behavioral contagion. The statement suggests that reporters not give suicide stories undue prominence in newspapers or television news broadcasts. This includes avoiding sensational headlines that focus on the suicide, avoiding prominent placement in the newspaper or news broadcast, and avoiding detailed descriptions of the method. In addition, the recommendations call for a balanced description of suicide victims so that the victim is not presented as a model for those considering the same act. Finally, the recommendations suggest that whenever possible stories include the important role of mental disorders such as depression and substance abuse as

precursors to the act. This information about the victim's background not only provides context for the act but also opens the possibility for information about treatment. Nearly all of the mental disorders that precede suicide are treatable, and if vulnerable individuals sought care rather than focusing on suicide as a solution to their problems, many suicides might be prevented.

The need for guidelines for fictional programming. Guidelines for the treatment of fictional portrayals of suicide in film and television have not been developed. One lack of support for such guidelines has been the absence of evidence for the prevalence of suicide portrayal in such popular culture channels as television and film. Young people (age 12-24) represent 40% of moviegoers, a 9% increase in frequent movie-going in half a decade (see the Motion Picture Association of America Web site at mpaa.org/useconicreview/2001AttendanceStudy/sld001.htm). Because young people are disproportionately represented in movie theater audiences, it is important to understand the effects on them of fiction portrayals of suicide in film.

On the assumption that the effects of filmic portrayal are consistent with depictions in other popular media, Jamieson (2002) tracked portrayal of suicide in U.S. films from 1917 to 1997. To identify films that depicted suicide, he constructed a list from the Internet Movie Database (IMD) (www.imdb.com). This site is a professionally maintained database of movie plot summaries collected by interested contributors. To establish a rate, Jamieson divided the number of films that contained suicide in the plot for each year by the number of films released in that year (see Figure 1).

One limitation of the IMD database is that it only contains information for films that were summarized by contributors. The American Film Institute's database (www.afi.com) contains summaries of all films released in the U.S. for the years 1917 to 1950. A comparison of these two sources indicates high agreement for the years of overlap ($r = .62$), suggesting that the IMD provides a valid picture of trends in movies containing suicide in the plot summary. Furthermore, the rates shown in Figure 1 provide support for the concern that filmic portrayal of suicide has increased in recent decades to the point where nearly 1 in 10 films now depicts a suicide or suicide attempt.

To establish a rate for films by year, Jamieson divided the number of films that portrayed suicide in a year by the number of films released that year. These rates shown in Figure 1 provide support for the concern that filmic portrayal of suicide has increased in recent decades to the point where nearly 1 in 10 films now depicts a suicide or suicide attempt.[2]

A separate content analysis of depictions of suicide in the top-30 box office films distributed from 1950-2000 in the United States identified 96 films with at least one suicide portrayal (Jamieson, 2002). Furthermore, the proportion of filmic suicides showing characters younger than age 25 has been higher than the proportion of actual suicides attributable to this age group, a phenomenon that appears to have characterized top-selling films since at least the 1960s (see Figure 2).

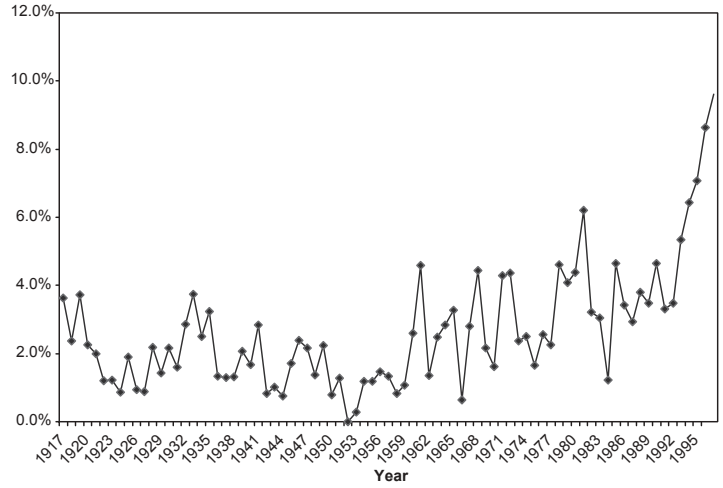

Figure 1: Suicide Movies as a Percentage of Total Movies Produced, 1917-1997
SOURCE: The rise in films with suicidal portrayal is based on a compilation of plot summaries contained in the Internet Movie Database (www.imdb.com).

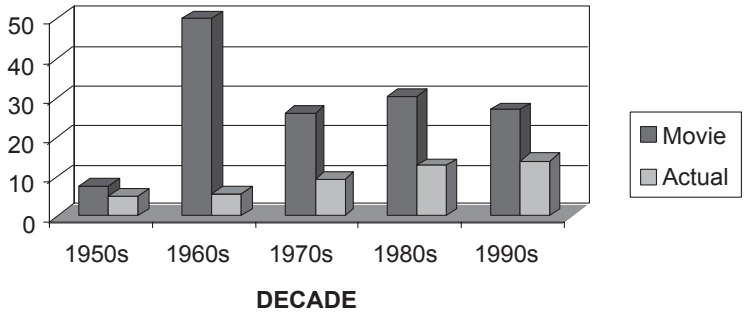

Figure 2: Younger Than Age 25 Suicide Rates Versus Younger Than Age 25 Movie Suicide Rates
NOTE: This figure depicts the percentage of top-30 box office films by decade with characters younger than age 25 who either committed or attempted to commit suicide compared to the actual percentage of deaths due to suicide in the same decade in the United States.

If, as the suicide contagion literature suggests, the young are particularly susceptible to model acts committed by those of the same age group, the increase in the depiction of suicide in film is cause for concern. Developing guidelines for fictional portrayal similar to those created for news coverage would be desirable.

In summary, the substantial evidence that vulnerable youth are susceptible to the influence of reports and portrayals of suicide in the mass media underscores

the importance of educating media professionals about the potential for suicide imitation and ways to avert it.

APPENDIX
Reporting on Suicide: Recommendations for the Media

American Foundation for Suicide Prevention
American Association of Suicidology
Annenberg Public Policy Center
Developed in collaboration with
Office of the Surgeon General •
Centers for Disease Control and Prevention •
National Institute of Mental Health • Substance Abuse and Mental Health Services Administration

The media can play a powerful role in educating the public about suicide prevention. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They also can highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy and need to be covered but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates (Etzersdorfer & Sonneck, 1998; Sonneck, Etzersdorfer, & Nagel-Kuess, 1994).

Certain ways of describing suicide in the news contribute to what behavioral scientists call "suicide contagion" or "copycat" suicides (Gould, 2001; Schmidtke & Hafner, 1988).

Research suggests that inadvertently romanticizing suicide or idealizing those who take their own lives by portraying suicide as a heroic or romantic act may encourage others to identify with the victim (Fekete & Schmidtke, 1995).

Exposure to suicide method through media reports can encourage vulnerable individuals to imitate it (Fekete & Macsai, 1990). Clinicians believe the danger is even greater if there is a detailed description of the method. Research indicates that detailed descriptions or pictures of the location or site of a suicide encourage imitation (Sonneck et al., 1994).

Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim (Fekete & Schmidtke, 1995).

SUICIDE AND MENTAL ILLNESS

DID YOU KNOW?

- More than 90% of suicide victims have a significant psychiatric illness at the time of their death. These are often undiagnosed, untreated, or both. Mood disorders and substance abuse are the two most common (Barraclogh & Hughes, 1987; Brent et al., 1993; Conwell et al., 1996; Robins, 1981; Shaffer et al., 1996).

- When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults (Brent et al., 1993; Shaffer et al., 1996).
- Research has shown that when open aggression, anxiety, or agitation is present in individuals who are depressed, the risk for suicide increases significantly (Fawcett, 1990; Mann, Waternaux, Haas, & Malone, 1999; Soloff, Lynch, Kelly, Malone, & Mann, 2000).

The cause of an individual suicide is invariably more complicated than a recent painful event such as the breakup of a relationship or the loss of a job. An individual suicide cannot be adequately explained as the understandable response to an individual's stressful occupation or an individual's membership in a group encountering discrimination. Social conditions alone do not explain a suicide (Gould, Fisher, Parides, Flory, & Shaffer, 1996; Moscicki, 1999). People who appear to become suicidal in response to such events, or in response to a physical illness, generally have significant underlying mental problems, although they may be well hidden (Barraclough & Hughes, 1987).

QUESTIONS TO ASK

- Had the victim ever received treatment for depression or any other mental disorder?
- Did the victim have a problem with substance abuse?

ANGLES TO PURSUE

- Conveying that effective treatments for most of these conditions are available (but underutilized) may encourage those with such problems to seek help.
- Acknowledging the deceased person's problems and struggles as well as the positive aspects of his or her life or character contributes to a more balanced picture.

INTERVIEWING SURVIVING RELATIVES AND FRIENDS

Research shows that during the period immediately after a death by suicide, grieving family members or friends have difficulty understanding what happened. Responses may be extreme, problems may be minimized, and motives may be complicated (Ness & Pfeffer, 1990).

Studies of suicide based on in-depth interviews with those close to the victim indicate that in their first, shocked reaction, friends and family members may find a loved one's death by suicide inexplicable or they may deny that there were warning signs (Barraclough, Bunch, Nelson, & Sainsbury, 1974; Brent, Perper, Kolko, & Zelenak, 1988). Accounts based on these initial reactions are often unreliable.

ANGLES TO PURSUE

- Thorough investigation generally reveals underlying problems unrecognized even by close friends and family members. Most victims do, however, give warning signs of their risk for suicide (see the Web site for the American Foundation for Suicide Prevention for further information: www.afsp.org).
- Some informants are inclined to suggest that a particular individual, for instance, a family member, a school, or a health service provider, in some way played a role in

the victim's death by suicide. Thorough investigation almost always finds multiple causes for suicide and fails to corroborate a simple attribution of responsibility.

CONCERNS

- Dramatizing the impact of suicide through descriptions and pictures of grieving relatives, teachers or classmates, or community expressions of grief may encourage potential victims to see suicide as a way of getting attention or as a form of retaliation against others.
- Using adolescents on TV or in print media to tell the stories of their suicide attempts may be harmful to the adolescents themselves or may encourage other vulnerable young people to seek attention in this way.

LANGUAGE

Referring to a "rise" in suicide rates is usually more accurate than calling such a rise an "epidemic," which implies a more dramatic and sudden increase than what we generally find in suicide rates. Research has shown that the use in headlines of the word *suicide* or referring to the cause of death as self-inflicted increases the likelihood of contagion (Phillips, Lesyna, & Paight, 1992).

RECOMMENDATIONS FOR LANGUAGE

- Whenever possible, it is preferable to avoid referring to suicide in the headline. Unless the suicide death took place in public, the cause of death should be reported in the body of the story and not in the headline.
- In deaths that will be covered nationally, such as of celebrities, or those apt to be covered locally, such as persons living in small towns, consider phrasing for headlines such as "Marilyn Monroe dead at 36" or "John Smith dead at 48." Consideration of how they died could be reported in the body of the article.
- In the body of the story, it is preferable to describe the deceased as "having died by suicide" rather than as "a suicide" or having "committed suicide." The latter two expressions reduce the person to the mode of death or connote criminal or sinful behavior.
- Contrasting "suicide deaths" with "non-fatal attempts" is preferable to using terms such as "successful," "unsuccessful," or "failed."

SPECIAL SITUATIONS

CELEBRITY DEATHS

Celebrity deaths by suicide are more likely than noncelebrity deaths to produce imitation (Wasserman, 1984). Although suicides by celebrities will receive prominent coverage, it is important not to let the glamour of the individual obscure any mental health problems or use of drugs.

HOMICIDE-SUICIDES

In covering murder-suicides, be aware that the tragedy of the homicide can mask the suicidal aspect of the act. Feelings of depression and hopelessness present before the ho-

micide and suicide are often the impetus for both (Nock & Marzuk, 1999; Rosenbaum, 1990).

SUICIDE PACTS

Suicide pacts are mutual arrangements between two people who kill themselves at the same time, and are rare. They are not simply the act of loving individuals who do not wish to be separated. Research shows that most pacts involve an individual who is coercive and another who is extremely dependent (Fishbain, D'Achille, Barsky, & Aldrich, 1984).

NOTE: These new, unified recommendations were released at a press conference on August 9, 2001, at the National Press Club in Washington, DC. They were developed at a consensus workshop cosponsored by Annenberg Public Policy Center and the American Foundation for Suicide Prevention. Workshop participants also included the American Association of Suicidology, Office of the Surgeon General, Centers for Disease Control and Prevention, National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, World Health Organization, National Swedish Centre for Suicide Research, and New Zealand Youth Suicide Prevention Strategy.

NOTES

1. Although the top-10 newspapers include the *Wall Street Journal*, virtually no suicide reporting was found in this year.

2. This analysis is limited by its reliance on an index of suicides created by others. Moreover, the simple existence of suicide in a plot may not be sufficient to produce contagion.

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MADELYN GOULD *is a professor of psychiatry and public health (epidemiology) at Columbia University, College of Physicians and Surgeons, and a research scientist at the New York State Psychiatric Institute. Her grants include projects to examine risk factors for teenage suicide, cluster suicides, the impact of the media on suicide, the effect of suicide on fellow students, and the utility of telephone crisis services for teenagers. She participated in the 1978 President's Commission on Mental Health and the Secretary of Health and Human Services' Task Force on Youth Suicide (1989). She was an expert reviewer in 1998 for the National Suicide Prevention Conference on Advancing the National Strategy for Suicide Prevention, authored the chapter on youth suicide prevention, as part of the Surgeon General's 1999 National Suicide Prevention Strategy, and has served as a leadership consultant for the Surgeon General's Leadership Working Group for a National Suicide Prevention Strategy. She received the Shneidman Award for Research from the American Association of Suicidology (AAS) in 1991.*

PATRICK JAMIESON *is the associate research director at the Adolescent Risk Communication Institute of the Annenberg Public Policy Center at the University of Pennsylvania and is a doctoral candidate in the Education, Culture, and Society program of Penn's Graduate School of Education.*

DANIEL ROMER *is the research director of the Adolescent Risk Communication Institute at the Annenberg Public Policy Center, University of Pennsylvania. He directs research on adolescent risk perception and behavior with particular emphasis on the effects of the media and other social influences.*

Queensland
Government

Metro North
Hospital and Health Service

22 September 2015

To the Commission of Inquiry – Barrett Adolescent Centre

I have been asked to provide an opinion concerning potential risks associated with disclosure and publication of information concerning patients transitioned from the Barrett Adolescent Centre (Barrett Centre) into alternative care arrangements.

With respect to this, I offer the following comments:

1. As a result of any inquiry, it is impossible to predict the responses of patients who received care whilst in the Barrett Centre and their families. It is likely that whilst the inquiry may bring relief to some individuals, it will engender distress in others.
2. Following the closure of the Barrett Centre, information of the suicides and attempts of suicide was widely disseminated through social media as well as mainstream media.
3. [redacted]
4. On the balance of probabilities, the planned inquiry and dissemination of information arising from a hearing will likely cause distress in some patients and their families which may result in serious psychological harm.
5. In view of this risk, any inquiry into the closure of the Barrett Centre should handle information with the utmost sensitivity.
6. Information about any individual patients should be kept confidential.
7. It is unclear how other aspects of the inquiry best be managed. Clearly it is paramount that support is available for the patients who received treatment at the Barrett Centre and their families whilst this inquiry is undertaken so as to minimise the risk of psychological harm and suicide.

I would be pleased to provide further comment on the above matters should it assist the Commission.

Yours sincerely

[redacted]

A/Professor James Scott
Child and Adolescent Psychiatrist
Royal Brisbane and Women's Hospital

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Dr A Aboud
Telephone: [redacted]
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Our Ref: AB LETTER – BAC Commission of Inquiry 240915

Julie Cameron
Partner
111 Eagle Street
BRISBANE QLD 4000

Dear Ms Cameron

Barrett Adolescent Centre Commission of Inquiry

I am a doctor and Specialist Psychiatrist employed as a Clinical Director by West Moreton Hospital and Health Service. I write, in response to your letter dated 18 September 2015 to provide an expert medical opinion in respect of matters raised.

I recognise the potential concern that has been highlighted by West Moreton Hospital and Health Board about the potential effect, which disclosure and publicity of certain matters through the inquiry process may have on former Barrett Adolescent Centre (BAC) patients, their families and others. These effects may occur in the context of: patient confidentially not being maintained; public hearings (including web streaming); media publication of matters relating to the patients who are the subject of the terms of reference.

It is my opinion that there are potentially serious risks associated with the above. The former BAC patients, their families and others (such as friends and associates, and also former staff) may be made vulnerable to developing or exacerbation of mental difficulties. For some of these individuals, in particular former BAC patients, the inquiry process may be quite stressful and even lead to an increase in self-harm behaviour and suicidal urge. Compromised confidentiality may potentially make this process more traumatic and increase the risks. Those with pre-existing mental health problems will be most vulnerable, yet so might those without pre-existing mental health problems, but harbouring risk factors for such.

It is important to be aware that de-identification may not achieve true anonymity for individuals and sensitive material. Individuals and families and associates may well be able to identify such persons, based on material presented.

.../2

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The issue of copycat suicides has an evidence base in the scientific literature and must surely be an important consideration in a process such as this inquiry.

It is my opinion that mechanisms should be put in place to: protect patient confidentiality; minimise potential risk to current patients, and other persons who were contemporary patients of those the subject of the terms of reference; minimise the potential for "copycat" self-harm/suicide by others at risk within our community. In my view such mechanisms would include holding closed, as opposed to open, court hearings and also consideration of placing appropriate boundaries on media reporting.

Additionally, those involved in the hearings as witnesses should be provided with support, broad and focused, according to their known vulnerabilities.

Yours sincerely

Dr Andrew Aboud MB BCh BAO MRCPsych BSc FRANZCP
Clinical Director, Prison Mental Health Services
The Park – Centre for Mental Health
West Moreton Hospital and Health Service

24 September 2015

Queensland
Government

Department of Health

Enquiries to: Dr W J Kingswell
Executive Director
Mental Health Alcohol and Other Drugs Branch
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File Ref: CE000111

Wensley Bitton, Senior Principal Lawyer
Barrett Adolescent Centre Commission of Inquiry Co-ordination Team
Legal Services Unit, Legal Branch
Department of Health, Queensland Government
Level 12, 147-163 Charlotte Street
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Email: [redacted]

Dear Wensley

Expert Opinion - BAC COI (15_758)

Thank you for alerting me to the Department of Health's intention to make a request of the Commissioner to consider blanket orders to amongst other matters "wholly preserve the confidentiality" of documents relevant to the care of former patients of the Barrett Adolescent Centre (BAC). One of the proposed methods for ensuring this occurs is to close sessions touching on these matters.

In my view this is critically important. As you know there is a literature that supports an association between media reporting of suicide and self-harm and a copycat or contagion effect. While I believe that is a risk, the more important risk is that sensitive personal and clinical information will be exposed in the public space. The BAC catered to a very small cohort and individuals will be readily identifiable amongst former patients, families and staff but also more broadly within the community. Some of these clinical records will note very sensitive information such as a history of physical or sexual abuse.

The population accessing the BAC was particularly vulnerable to stress as evidenced by the three suicides that precipitated this inquiry. Public exposure of a young person's medical and personal record and information provided by family carers and staff of a clinical or personal nature will be potentially highly embarrassing and stressful and worsen their already poor mental health and place the young person at risk of deliberate self-harm or suicide.

Yours sincerely

[redacted]

Dr William John Kingswell
Executive Director
Mental Health Alcohol and Other Drugs Branch
Department of Health, Queensland
24//09/2015

Queensland
Government

Department of Health

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Mental Health Alcohol and Other Drugs Branch
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HC-00 4884

Ms Louise Syme
Crown Law
State Law Building
50 Ann Street
BRISBANE QLD 4000

Dear Ms Syme

I have been asked to provide an expert opinion in relation to risks for patients and other people arising from the Barrett Adolescent Commission of Inquiry if:

a. Patient confidentiality is not being maintained;

b. Public hearings (including web streaming); and

c. Media publication of matters relating to the patients who are the subject of the terms of reference.

In particular you have asked about adverse consequences that can arise from holding public hearing or reporting of the hearings in the media such as the potential for "copycat suicide" (also called imitative suicide) or the worsening of mental state for individuals whose psychiatric records will be considered by the Inquiry or any other individuals.

Concerns about copycat suicide stimulated by media coverage have been present for many years and there is now considerable evidence relating to this. Mindframe, an Australian national media initiative which has been operating within the Hunter Institute of Mental Health for greater than 10 years, was set up particularly to address these issues. It is considered within local mental health circles to be the authority. It monitors reporting of suicide in the media and produces guidelines around sensible media reporting of suicide using evidence from academic studies .They suggest "There is strong support for the relationship between media reporting of suicide deaths and increases in completed and attempted suicide rates". They note that more 100 international studies have looked at the link between media reporting of suicide and suicidal behaviour.

Although not every study has confirmed an increase in suicide rates following media coverage (e.g. where suicide is sensitively portrayed as a waste of life and concentrates on the devastating

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effects of suicide on others this may not be the case) but where there appears to be sensational reporting or a glorification of the suicide there is risk of a rise in the suicide rate.

There is also evidence that certain groups may be more vulnerable e.g. when the person identifies with the person who suicided, in young people, or when the person is already experiencing mental health issues.

An important review, *Suicide and the news and information media* by Australians Jane Pirkis and Warwick Blood (2010) concluded that presentations of suicide in news and information media can influence copycat acts in circumstances such as "irresponsible" presentations in news and information media. They also note that suicide is a behaviour which is susceptible imitation which leads to suicide "clusters". "Clusters" may be another way of describing "copycat" events but usually refers to a group of suicide events that are in a limited geographical area or cultural subgroup. In Australia concerns have been raised about cluster suicides in groups of young people and particularly young indigenous people.

There is also evidence that explicit descriptions of methods and places of suicide have led to increased suicide rates. Another report suggested that media depicting real suicide events rather than fictionalised ones can lead to a higher increase in rate. These are things that are likely to arise in the Commission's deliberations.

Studies on copycat suicide look particularly at press and media reporting rather than directly at court or inquiry appearances. I have been unable to find any studies that have linked presentation of psychiatric material in open court or inquiry hearings directly with potential for copycat suicide but there is of course the obvious link through press reporting.

Even with de-identification of witnesses and material there remain risks of potential self-identification with the suicide described, particularly by young people who have an existing mental health condition or who have previously been patients of that particular or any other mental health service. My conclusion is therefore that the evidence suggests there is an increased risk of copycat behaviour amongst vulnerable young people from the press coverage and particularly if the reporting is insensitive or sensationalised.

For persons with a mental health history who are appearing in the Inquiry, the stress could lead to deterioration in their mental state. I assume that any current or former patients and their family giving evidence will have access to dedicated concurrent and ongoing psychiatric support to deal with this. I want to point out however that publication of their stories can increase this stress even if de-identified. [redacted]

Similarly the community of patients and families whose stories may be aired in this Inquiry is small and many know each other. Working out who is who may be much easier for those with some knowledge than the general public. It is likely that not everyone whose case will be examined in the Inquiry will welcome public scrutiny. The chances of further traumatisation by publicity similarly remain high.

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It is also possible that former patients who hear reports of other's experiences may both identify with those stories and increase their risk or may misidentify the stories as their own and then feel aggrieved that their story is in the press.

My opinion is that the best way to protect this group of people would be for closed court hearing and limitations on media publications.

The Mainframe guidelines encourage responsible and sensitive reporting of issues and emphasising what can be done to help. My observations over recent years have been that in general the mainstream media have begun to heed those recommendations (the two Mindframe reports The Media Monitoring Project: Changes in media reporting of suicide and mental health and illness in Australia: 2000/01–2006/07also suggest this). There does however remain an element of sensational reporting of suicides in the mainstream media. There are other less controllable methods of reporting through social media and, although not directly related, the power of on line bullying and its link to suicide is a reminder of the devastating effects of social media. Given the sensitivities for individuals and the potential risk, limitations around reporting on individuals and guidelines around sensible reporting of the general issues would be essential. Closed sessions where appropriate would decrease the risk of poor social media coverage.

Closed hearings for those affected would be very important in protecting the mental health of participants. Serious consideration needs to be given to the potential harmful effects on vulnerable people of uncontrolled or sensational reporting.

Yours sincerely

[redacted]

[redacted] Associate Professor John Allan MBBS FRANZCP PhD
Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch.
23 09/2015

Useful references

http://www.mindframe-media.info/for-media/reporting-suicide/evidence-and-research/evidence-about-suicide-in-the-media

- See more at: http://www.mindframe-media.info/for-media/reporting-suicide/evidence-and-research/evidence-about-suicide-in-the-media#sthash.Xfa6FC6k.dpuf .

http://eprints.lse.ac.uk/41020/1/blogs.lse.ac.uk-The_Leveson_inquiry_should_encourage_more_sensitive_media_coverage_of_suicides_to_help_prevent_copyca.pdf

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