"I don't have to be alone anymore"

The new face of youth mental health intervention: an analysis of a proactive online intervention and risk assessment practices on Instagram.

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Abstract

Background: Mental health intervention, both online and in-person, operates within a traditional model whereby support is provided if a young person (or their family) actively seeks support. Proactive outreach is an innovative approach to intervention and has been shown to be effective in other areas of healthcare. Live for Tomorrow chat (LFT) was delivered on Instagram and comprised of counsellors who reached out to provide brief person-centred intervention to young people who posted content indicating distress or suicidality.

Aim: This thesis focused on two aims presented across two articles. The first aim was to explore young people's experiences of distress and LFT's proactive online intervention. The second aim was to explore how counsellors engaged young people and how risk assessment was conducted in this proactive online intervention.

Methods: Thirty-five transcripts of conversations with young people aged thirteen to twenty-five were analysed using the six-step approach of Braun and Clarke's reflexive thematic analysis. These transcripts included a counselling intervention and a follow-up chat that collected feedback about the counselling intervention.

Results: A total of thirteen themes across two articles were identified. These findings highlighted that in moments of psychological distress and suicidality, young people who engaged in this intervention experienced a multitude of difficulties and felt alone in this distress. Suicidality was experienced in this context. Young people expressed and managed their distress

through using social media and created an identity around these experiences. Social media also allowed them to support each other. Young people experienced the proactive approach of LFT as someone showing they cared and would listen, which are key therapeutic elements. Counsellors were able to use counselling micro-skills to facilitate conversations. Counsellors would approach conversations about suicidality by seeking permission from the young person to talk about suicidality, assuring confidentiality, validating the young person's experience of suicidality, and focused on identifying interventions.

Conclusion: Proactive online chat-based interventions represent a novel approach to engaging with young people experiencing psychological distress and suicidality. The findings have demonstrated the feasibility and benefits of moving mental health intervention to a medium where young people are currently disclosing distress and intervening proactively.

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Contents

Glossary and Nomenclature

"So we need to watch carefully with words we use"

(Young Person 26)

A common definition of terms allows a shared understanding in research and clinical practice (Silverman et al., 2007). However, the language used across suicide research is inconsistent, which can result in confusion in the use of the terminology and make comparing literature difficult.

Therefore, the following definitions are used in this thesis:

Psychological distress is an umbrella term often defined as a state of emotional suffering with non-specific symptoms of stress, anxiety and depression (L'Abate, 2012; Viertiö et al., 2021). Psychological distress can be, but is not always, in the context of a mental health disorder (Viertiö et al., 2021).

Self-harm refers to intentional self-injury or self-poisoning, regardless of suicidal intent (De Leo et al., 2021; Hawton, Hall et al., 2003). This definition encompasses the broad range of behaviours and motivations behind self-harm (Silverman, 2006).

Non-Suicidal Self Injury (NSSI) is a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic term which refers to intentionally injuring oneself without any suicidal intent (American Psychiatric Association, 2013).

Suicidal ideation is defined as a thought focused on causing one's own death (De Leo et al., 2021; Nock et al., 2008). It is further defined as the consideration of, or desire to, end one's own life. Suicidal ideation typically ranges from passive ideation, such as wanting to be dead, to active ideation, such as wanting to kill oneself or thinking of a specific method (Cha et al., 2018).

Suicidal behaviours are those behaviours where someone is intending to take one's life (O'Connor & Nock, 2014). The DSM-5 defines this behaviour as Suicide-Related Behaviour Disorder, which is applied to someone who has attempted suicide in the past two years (American Psychiatric Association, 2013).

A suicide attempt is a non-fatal self-inflicted behaviour with some inferred or explicit attempt to end one's life (Silverman et al., 2007),

Suicide is defined as intentionally causing one's own death (De Leo et al., 2021). Suicide is usually classified through the coronial process; however, this can vary by jurisdiction.

Suicidality includes suicidal ideation, suicidal behaviours and suicide (American Psychological Association, 2022).

For the purposes of the research undertaken for this thesis, the focus has been on young people experiencing suicidality and psychological distress; self-harm was not excluded and young people may have been engaging in self-harm but this was not explicitly assessed nor were

transcripts included or excluded on the basis of self-harm. This may include instances of self-harm with suicidal intent under the spectrum of suicidality. Furthermore, as the term adolescence includes multiple age ranges across the literature, this thesis will use the terms adolescence and young people interchangeably, encompassing those individuals aged 13 to 25 years.

Chapter One: Introduction and Literature Review

"I also use it as a way to express my sadness"

(Young Person 58)

All around the world, there are examples of news items showing the real-life impact of Instagram use on the expression of psychological distress and suicidality. A 16-year-old Malaysian girl died from suicide after posting a story where her followers voted on whether she should live or die, 69% voted death (NBC News, 16 May 2019). An American 24-year-old woman scheduled a post with a suicide note that went live the day following her death (New York Post, 26 December 2020). In the United Kingdom (UK), the coroner directly attributed exposure to social media content to the suicide death of a 14-year-old girl. An investigation of the UK girl's Instagram use found that she had saved, liked or shared an average of 12 pieces per day of content related to suicide, self-harm and depression (Business & Human Rights Resource Centre, 6 October 2022). These events have led to a global discussion regarding the prevalence of this type of content on social media platforms and young people's exposure to and creation of this content. Beyond discussions of the impact of the content and a push for tighter regulations on social media companies to eliminate it (BBC, 11 November 2020), there has been little discussion regarding the young people behind these posts and the support they need.

This thesis explores a real-time perspective of young people's experience of psychological distress and suicidality and their experience of a proactive online intervention that operates on Instagram. Furthermore, it seeks to capture the counsellor's techniques and how intervention translates into this online space. This proactive online intervention service was

conducted as part of the services offered by Live for Tomorrow (LFT). Thirty-five transcripts of the conversations between counsellors and young people were analysed, which included the initial counselling intervention and a subsequent follow-up conversation where the young person was asked about their experience of the counselling intervention and for their feedback on it. These transcripts were analysed using the six-step process of reflexive thematic analysis (Braun & Clarke, 2021)

Structure of the thesis: Along with a Literature Review (Chapter One) and Methodology section (Chapter Two), this thesis contains two articles (Chapters Three and Four), which have been submitted and reviewed for publication in academic journals. These articles each contain their own literature review and discussion. Therefore, there is some inevitable repetition in sections of this thesis. Chapter Five comprises the Discussion and combines the findings from both articles and considers the wider clinical and research implications of this thesis.

At times, I use the third person pronoun “we” to reference the perspectives of myself and the researcher team, as the process of qualitative analysis is collaborative. This occurs particularly in Chapters Two and Three, which present the two co-authored journal articles.

Literature Review

In this chapter, I will present the existing body of literature that is relevant to and contextualises the current research. I start this literature review by focusing on the psychological understandings of psychological distress and suicidality, introducing models of suicidality and discussing help-seeking and current interventions for young people. I will then explore how the digital world has transformed how young people interact, disclose their psychological distress and suicidality, and create communities. These discussions situate the research project, which has developed from a place of recognising the extent of disclosure and existence of these communities in these online platforms and seeks to explore the provision of a proactive intervention in this space.

Psychological distress and suicidality in young people

Given that my research focuses on youth psychological distress and suicidality, it is important to understand the developmental processes that provide a context for these experiences. Adolescence is a period characterised by physical, social, psychological and emotional changes that occur in the transition from childhood to adulthood (Kapur, 2015). Identity development is a key task for young people during adolescence (Erikson, 1994), often associated with an increase in seeking independence from family and aligning more primarily with peers (World Health Organization, 2001). Adolescence is also considered the peak stage for emerging mental health difficulties (McGorry & Mei, 2018).

Psychological distress is theorised to be developed from excessive amounts of stress caused when the demands on an individual exceed their internal or external resources (Kofoworola & Alayode, 2012). Psychological distress can result from economic and lifestyle

factors, school, family and friend relationship difficulties (Sweeting et al., 2010), as well as adverse life experiences like abuse (Jackson & Finney, 2002). Psychological distress can impact approximately 25% of young people (Brennan et al., 2021); however, this can reach much higher levels in populations who experience stressful external experiences and circumstances (L'Abate, 2012). Psychological distress is often contributed to by negative emotion states and adolescence is a key period where young people experience increased emotional intensity and reactivity (Silvers et al., 2012). Emotional regulation is also being developed in this period and its role is to manage heighted psychological distress.

Chronic experiences of life stressors and psychological distress have been found to predict suicidality and in particular, psychological distress is strongly related to suicidal ideation (Menon et al., 2018; O'Connor et al., 2012; Rainbow et al., 2021). This relationship between psychological distress and suicidality is theorised to be due to the experience of psychological distress as unbearable or the perception that the young person is unable to effectively regulate their emotion (Kiekens et al., 2017; Robinson et al., 2018). Although there can be a transitional relationship of severity between psychological distress, suicidal ideation and suicide attempt, this progression is rarely linear (Khasakhala et al., 2011).

Understanding psychological distress and suicidal ideation in young people is important because intervening in psychological distress, suicidal ideation and suicide attempts plays a role in suicide prevention and represents indicated interventions in the World Health Organisation's "Preventing Suicide" report (World Health Organization, 2014). Suicidal ideation and suicidal attempts are thought to be extreme expressions of psychological distress (Kessler, Berglund, Borges, Nock & Wang, 2005). Internationally, lifetime rates of suicidal ideation in young people

aged up to 25 years are 24% (Mortier et al., 2018; Nock et al., 2008), and a recent international survey of 275,057 young people aged 12-17 demonstrated a 12-month prevalence rate of 14% (Biswas et al., 2020). Rates of suicidal ideation in young people are increasing, with Fleming et al. (2022) demonstrating that in New Zealand, suicidal ideation increased to 20.8% in 2019, up from previous rates of 15.3% reported in 2012. The experience of suicidal ideation can present as chronic and pervasive (Czyz & King, 2015) but can also fluctuate in severity and intent (Anvar et al., 2022).

Suicidal ideation is associated with double the risk of death by suicide (Ribeiro et al., 2016), and 60% of those who transition from ideation to planning and attempting suicide do so within the first year of ideation onset (Nock et al., 2008). A suicide attempt is reported to have a 12-month prevalence in young people of 11.5% across seven European countries (Muehlenkamp et al., 2012), with an increase of emergency department presentations in Canada by 135% between 2009 and 2017 (Gardner et al., 2019). A study conducted by Hawton et al. (2020) demonstrated that young people who present to the hospital for self-harm are 30 times more likely to die by suicide in the 12 months following compared to the general population.

Suicide was the second leading cause of death among those aged 15 to 29 in 2016 (World Health Organization, 2019). Between the ages of 10 and 29 years old, approximately 222,093 people died by suicide in 2019, and for each of these suicide deaths, there are estimates that 20 others may have attempted suicide (World Health Organization, 2019). Adolescents and young adults have the highest rates of deaths by suicide in Aotearoa New Zealand compared to other age populations and must be a key focus of innovation and research. For example, in in

2018, young people aged 15 to 19 years died by suicide at a rate of 23.14 deaths per 100,000, and those aged 20 to 24 at a rate of 26.87 deaths per 100,000 (Coronial Services of New Zealand, 2019). These rates were much higher than the national rate of 13.93 deaths per 100,000 in 2018 (Coronial Services of New Zealand, 2019).

The impact of the worldwide pandemic on psychological distress and suicidality is particularly important in current times. People were isolated and support and connection with community, friends and family were reduced alongside prolonged stress exposure (Saladino et al., 2020). Inequality, poverty and illness of individuals and families increased (Kiran, 2020). Mental health services moved online, and other avenues of mental health support ceased altogether (Saladino et al., 2020).

International studies across several countries demonstrated increased psychological distress in young people during the pandemic and associated lockdowns (Glowacz & Schmits, 2020; Varma et al., 2021). There have been conflicting studies regarding the effect of the pandemic on attempted and completed suicides, with some studies showing an increased rate of attempted suicide and death by suicide among children and adolescents in the first year of the pandemic (Wasserman et al., 2021) compared to other studies showing no increase in suicide deaths (Pirkis et al., 2021; Sinyor et al., 2022). The long-term effects of the pandemic on mental health remains uncertain; however, it is evident that education, family systems, and friendships have been disrupted.

Psychological distress and suicidality throughout childhood and adolescence can have long-term impacts on the individual, their family and community. Surviving a suicide attempt

does not necessarily alleviate distress and suicidality, with most survivors reporting feeling sad, disappointed, embarrassed or ashamed (Chesley & Loring-McNulty, 2003). Some individuals reported that these feelings did change, but 30% continued to report negative feelings regarding their survival (Chesley & Loring-McNulty, 2003). Furthermore, not receiving adequate support following a suicide attempt can increase psychological distress, suicidal ideation and future suicide attempts (McKay & Shand, 2016). Narratives from survivors of suicide attempts indicate that an attempt continues to impact their life (Maple et al., 2019). Webb (2010) described the act of attempting suicide as killing a part of the self. Other studies have shown that incidences of self-harm and suicide attempts can lead to post-traumatic stress symptoms (O'Connor et al., 2021). Suicide attempts and self-harm can also cause physical damage through injury, infection, organ damage or premature death (Robinson, 2017; Rocos & Chesser, 2016). Alongside the psychological and physical impacts, psychological distress and suicidality in youth can impair education opportunities, vocational trajectories and social interactions, and remain a feature of someone's life into adulthood (Robinson, 2017; Wittchen et al., 1998). Findings by Esch et al. (2014) reported that internalising and externalising disorders, substance abuse and suicidal ideation were significantly related to subsequent school dropout, which led to limited, unstable vocational opportunities, precarious living conditions and the onset of anxiety and mood disorders. Within the workforce, self-harm and suicide attempts can impact future work attendance and progression. Research by Nguyen et al. (2017) found that following a self-harm injury, almost half of the patients did not return to work for 24 months. In another study, youth who attempted suicide were more likely to have lower annual earnings, lower retirement savings and higher reliance on welfare support than youth who did not attempt suicide, with an estimated wage loss of $98,384 across a 40-year working career (Orri et al., 2022). Furthermore, the

presence of psychological distress, in particular depression symptomology, has been found to predict absence from work, with higher levels of distress positively correlated with the number of days missed (Hardy et al., 2003).

The chronicity of psychological distress and suicidality can also have long-term impacts on the family and social systems. Suicide is a confusing death, and often social networks are disrupted through the need to affix blame or keep the suicide a secret (Cerel et al., 2008). Families who are carers of young people who are experiencing suicidality are less likely to seek help due to feelings of shame or guilt, further increasing their isolation (Townsend et al., 2021). Psychological distress and suicidality also affect the individual's ability to develop their own family system. Orri et al. (2022) reported that those who attempted suicide were almost two times less likely to have partners in their 20s and 30s compared to those who had not attempted suicide.

Psychological distress and suicidality also have broader economic impacts that effect a country’s productivity and the economic loss of productivity (Kinchin & Doran, 2017). A retrospective panel by Smith and Smith (2010) found that childhood psychological problems impact adult socio-economic status, with a total lifetime economic cost of $2.1 trillion. Suicide also has economic costs to society, with the loss of potential contributions to society (Kinchin & Doran, 2017). A report on the cost of suicide in New Zealand detailed that the cost per suicide is estimated at $493,871, and the cost per suicide attempt is $7,796 (Ministry of Health, 2017).

In summary, youth suicide occurs at worrying rates and significantly impacts the young person and their community. Early intervention for psychological distress and suicidality represents an important opportunity for suicide prevention (Rainbow et al., 2021). Early intervention can work on identifying modifiable risk factors contributing to psychological distress and suicidality.

Risk factors of suicidality for young people

Youth suicide is a complex result of psychosocial factors combined with developmental and environmental stresses (Van Heeringen, 2001). These interactions can start from birth and can accumulate to make an individual more vulnerable to experiencing psychological distress and suicidality. Research into risk factors is well-established and has identified a range of non-modifiable risk factors, signifying that these are not feasibly changeable, and modifiable factors, which can be targeted for intervention (Gordon & Melvin, 2014; Stone & Crosby, 2014).

Non-modifiable risk factors

Genetic factors appear to play a role in suicidal behaviour within families, with 30-50% heritability of suicidal behaviour (Wasserman et al., 2021). Low levels of 5-HIAA (a metabolite of serotonin) and brain-derived neurotropic factor (BDNF) have been found in adolescents with suicidal behaviour (Tyano et al., 2006; Salas-Magaña et al., 2017). Gender differences in suicide rates are also apparent. Males die by suicide at a higher rate than females (OR 1.96, 95% CI 1.54-2.50), whereas females have higher rates of attempted suicide (HR 2.50, 95% CI 1.8–3.6) (Miranda-Mendizabal et al., 2019).The discrepancy between suicide and suicide attempts is believed to be due to males choosing more lethal methods (Cibis et al., 2012) and the traditional

masculine gender role reducing help-seeking behaviour prior to and following a suicide attempt (Möller-Leimkühler, 2003).

A young person's upbringing may also result in the development of psychological distress and suicidality. Young people reporting suicidal behaviour are more likely to have insecure attachment styles, both dismissive and preoccupied types (Wright et al., 2005). Those who have previously attempted suicide have been shown to have higher scores on attachment avoidance, indicating insecure attachment (Sheftall et al., 2014). This insecure attachment style appears to result in hopelessness, problems communicating with others regarding the intensity of their suicidality, and destructive solutions to separation anxieties (Wright et al., 2005).

Genetic and environmental influences can interact to contribute to a predisposition to suicidal behaviours (Brezo et al., 2006). Impulsivity is particularly prevalent throughout adolescent years as a part of normal development; however, higher levels of impulsivity increase the risk of suicide attempts (McGirr et al., 2008). Research in young people who had attempted suicide found that 79% of young people had made no plan for their attempt more than 24 hours in advance (Hedeland et al., 2016). Higher levels of impulsive behaviours decline as a factor with age (McGirr et al., 2008). Antisocial traits and behaviour in young people were found to be associated with a ten-fold increase in suicide attempts (Thompson & Swartout, 2018). Furthermore, traits of young people who were less extraverted and more socially disconnected were found to predict future suicide attempts (Mars et al., 2019). Neuroticism is also a well-researched trait that contributes to suicidal ideation, attempts and suicide (Brezo et al., 2006).

Minority groups have higher rates of suicide across factors such as race, ethnicity, immigration status, and sexuality (Cash & Bridge, 2009; Lipsicas & Mäkinen, 2010). The development of suicidality in minority populations is complex. Factors such as racism, discrimination, and social exclusion can impact the sense of self and broader systemic difficulties such as policy and service provision and utilisation (Williams, 1999). In one study, young people who reported family rejection or negative family reactions following "coming out" had an eight-fold greater likelihood of attempting suicide (Ryan et al., 2009). Migrant populations also report higher rates of suicidal ideation and self-harm than non-migrant populations, possibly due to complex factors of acculturation stress, socioeconomic status and stigma (Basu et al., 2022). However, these results are not uniform, indicating that classifying the diverse range of cultures and needs under the one term "migrant" may be inappropriate to address the nuance of their experiences (Basu et al., 2022).

Modifiable risk factors

Modifiable risk factors for suicidality in young people are vital to identify as this is where interventions can take place (Gordon & Melvin, 2014).

Adverse childhood experiences (ACEs) and negative life events have been associated with the development of psychological distress, mental disorders as well as an increased risk of suicidal ideation and attempts (Brodsky & Stanley, 2008; Jackson & Finney, 2002). Younger individuals appear to be more vulnerable to negative life events (Jackson & Finney, 2002). Childhood adversities have been shown to have the strongest associations with a suicide attempt during childhood, with experiences of sexual abuse the strongest predictor of attempts in young

people (Bruffaerts et al., 2010). Exposure to multiple advertises in childhood increases the risk of suicidal behaviours in a graded relationship (Bruffaerts et al., 2010). It has also been shown that young people who have experienced a higher number of negative life events or stressors made medically serious suicide attempts compared to controls (Beautrais, 2003b). Recurrent stressful events (such as physical injury, relocation, and school conflict) appear to have the same cumulative effect as ACEs at increasing serious suicide attempt risk (Gvion & Levi-Belz, 2018).

ACE's can also include experiences that may have been traumatic for a child, such as school difficulties, familial discord, relocation, and physical injury (Karatekin & Hill, 2019). School problems and academic difficulties have been found to be a factor in 14% of deaths by suicide (Bilsen, 2018). These difficulties can be related to low levels of achievement, truancy, suspension and limited to no enjoyment of school, all of which were related to suicidal ideation and risk of suicide attempt (Fergusson et al., 2003). Bullying occurs in many schools to varying degrees and the effects of bullying on mental wellbeing are well-documented. Bullying can often result in increased anxiety and depression, poor educational outcomes and more aggressive or antisocial behaviours (Gardella et al., 2017). Bullying can also contribute to suicide risk among victims and perpetrators (Cash & Bridge, 2009). With the development of technology, cyber-bullying has become prevalent and is associated with similar negative outcomes, including an increase in suicidal behaviour (Foody et al., 2015).

Family and friends play a particularly prevalent modifiable risk factor and potential protective factor when considering a young person's suicidality. In approximately 50% of those who die by suicide, family factors, including family mental health, substance abuse, conflict, poor communication and violence are involved (Gould et al., 1996; Portzky et al., 2005). In

particular, conflict with parents has been shown to proceed 40% of suicide deaths in young people (Soole et al., 2015). Suicide risk in young people is also increased if there are other family members who have died by suicide, possibly due to modelling behaviours, coping strategies, and genetics (Agerbo et al., 2002).

Within friendships, interpersonal loss in this area has a significant impact and has been identified as a factor in 20% of youth who die by suicide (Spirito & Esposito-Smythers, 2006). The absence of relationships, feeling disconnected, and lack of belonging also contribute to suicidality (Arango et al., 2019). Given the increased importance of social connection during this stage of development, young people become particularly affected by the adverse impacts of isolation (Heinrich & Gullone, 2006). Loneliness, in particular, has been demonstrated to predict suicidal ideation and attempts among young people (Gallagher et al., 2014; Schinka et al., 2012). However, the relationship between loneliness and increased suicidality is unclear and may be mediated by psychopathology (Cha et al., 2018).

Imitation can contribute to suicide risk (previously described as contagion; however, this language has become outdated due to its implication of infection) which refers to learning through modelling the behaviour of others (Bilsen, 2018). A study conducted with 398,081 children found that those exposed to parental suicide were 3.91 times more likely to die by suicide (Lee et al., 2017) while a systematic review showed that exposure to any suicidal behaviours significantly increased the risk of the person developing suicidal behaviours compared to those who were not exposed (Maple et al., 2017). Imitation can also result in increased rates of suicide in young people following the death by suicide of someone they admire, for example, a celebrity, or through reporting in media reporting such as news or

television shows (Beautrais, 2000; Bridge et al., 2020; Gould et al., 2003). This increase in suicide and suicide imitative behaviours occurs particularly within populations already vulnerable to suicidal thoughts, such as those with depression (Pirkis et al., 2016). Imitation can be reinforced through suicide being portrayed as admirable or brave or through similarities between the young person and the person who died (Bilsen, 2018). Concerns about imitation due to media reporting have also been further exacerbated by the use of the internet and the proliferation of pro-suicide websites, which can influence those who are already considering suicide to attempt (Robert et al., 2015).

Although suicidality can be experienced outside of the context of a mental disorder, approximately 90% of people who attempt or die by suicide had a known mental illness, of which peak onset occurs in adolescence (Bachmann, 2018; Bertolote & Fleischmann, 2002; Solmi et al., 2022). Of those who attempt suicide, 50 to 65% of those young people had been diagnosed with depression (Bilsen, 2018). Anxiety and depressive disorders have also been found to be strongly associated with suicide across both males and females (Page et al., 2014; Twenge, Cooper, Joiner, Duffy & Binau, 2019). Other disorders, such as anorexia nervosa, schizophrenia, and borderline and antisocial personality disorder all have high rates of suicide (Bilsen, 2018; Palmer et al., 2005). The comorbidity of mental disorders significantly increases suicide risk, particularly the comorbidity of affective disorders and substance abuse disorders (Bilsen, 2018).

Alcohol use is a normal risk-taking behaviour in adolescence; however, alcohol misuse is often associated with triggering conflict, such as in peer and intimate relationships (Bilsen,

2018). Alcohol misuse is most likely underestimated and under-reported in relation to suicide. Alcohol can result in a reduction of impulse control and often exacerbates depressive symptoms and despair (Thase, Ihsan & Cornelius, 2001). Subsequently, alcohol intoxication or a history of alcohol abuse is often associated with youth suicide (Norström & Rossow, 2016). In New Zealand, 28.7% of youth suicide deaths involved acute alcohol use (Crossin, Cleland, Beautrais, Witt & Boden, 2022). Policies that have been implemented in Western countries that limit harmful alcohol consumption showed a reduction in suicidal behaviour (Kõlves et al., 2020). Not only does the consumption of alcohol increase the risk of suicide, but so does the exposure to heavy parental drinking. Rossow and Moan (2012) found that increased exposure to parental intoxication increased suicidal ideation and attempts, even after controlling for the adolescent's frequency of drinking. Cannabis and other illicit drug use are found to be predictors in the transition from suicidal thoughts to a suicide attempt, increasing suicide capability possibly through inhibition reduction and decision-making impairment (Mars et al., 2019).

Alongside external experiences that can impact a young person's suicidality, internal experiences also contribute to the development of suicidality and are modifiable to reduce the experience of suicidality. Cognitive styles can impact how a person understands life experiences and have been linked to suicide attempts in young people (Beautrais et al., 1999). The feeling of hopelessness has been linked to an increased risk of suicidal behaviours and is a critical factor in mediating the relationship between depression and suicidal ideation (Weishaar & Beck, 1992). Hopelessness has been shown to increase the risk of suicide in those already experiencing suicidal ideation (Beautrais et al., 1999). High external locus of control also contributes to the risk of suicidal behaviour via a lack of a sense of control over the young person's immediate

environment (Beautrais et al., 1999; Evans et al., 2005). Other cognitive styles that research has indicated may be involved in suicidal behaviour include perfectionistic tendencies, memory bias to negative attributions of events and impaired problem-solving (Sheehy & O'Connor, 2002). In particular, young people who attempt suicide have been found to have poor problem orientation and problem-solving skills compared to non-psychiatric controls and non-suicidal psychiatric patients (Grover et al., 2009; Sadowski & Kelley, 1993). McLaughlin et al. (1996) conducted a study on self-harm behaviours in 51 adolescents who had taken overdoses. Thirty-eight per cent of the young people reported that they were unsure if taking the overdose would change their problems, but they could not think of anything else to do.

Lack of belonging and burdensomeness are well-recognised as contributing factors for suicidality among young people (Arango et al., 2019; Joiner, 2005). Burdensomeness is defined as a belief that one's existence is a liability and burden on family, friends and/or society (Joiner, 2009). Adolescents have been shown to perceive themselves as an expendable part of the family system (Sabbath, 1969). There are limited studies undertaken in adolescents investigating the impact of burdensomeness; however, Woznica and Shapiro (1990) found that adolescents who felt they were expendable or unwanted in the family system experienced higher levels of suicidal ideation. More recently, Opperman et al. (2015) conducted a study with 129 adolescents aged 12 to 15 years that demonstrated that burdensomeness and low family connection were significantly associated with severe suicidal ideation.

Studies demonstrate that emotional dysregulation is associated with an increased risk of suicidality and self-harm in young people (Cha et al., 2018; Pisani et al., 2013; Titelius et al.,

2018; Wolff et al., 2018). A cross-sectional longitudinal study conducted by Pisani et al. (2013) collected nearly 8000 anonymous online surveys from young people in the community. These surveys found that difficulties identifying emotions and emotional dysregulation were associated with an increased risk of suicide attempts in the previous 12 months. Similar findings have been replicated whereby difficulties regulating and accepting emotions are associated with chronic suicidality in young people (Wolff et al., 2018).

One of the most consistent risk factors for suicide attempts is a history of past suicide attempts, with 25-33% of suicides preceded by an earlier attempt (Cooper et al., 2005). Suicide attempts that led to medical intervention have been shown to result in a five times higher mortality rate within five years (Beautrais, 2003a). As suicide attempts often occur impulsively in reaction to acute psychosocial stressors, the restriction of access to means has been demonstrated to be an important prevention strategy (Yip et al., 2012). Restriction of means is a crucial step as a barrier to transitioning from suicidal ideation to a suicide attempt.

Furthermore, approximately 40-50% of young people who die by suicide have a previous history of self-harm (Hawton, Zahl, et al., 2003). Whether researchers have used the concept of suicide attempt or self-harm, these behaviours which frequently overlap have been shown to be risk factors in future suicidal behaviour. Self-harm frequency is an important predictor of the risk of transitioning between suicidal ideation and attempts (Whitlock et al., 2013). This relationship is posited to exist through shared neurobiological vulnerability or the direct action of self-harm to reduce inhibition to attempt suicide (Mars et al., 2019).

It is essential for clinicians to be aware of these risk factors and to respond to them appropriately. Understanding risk factors allows clinicians to identify areas where individuals may be particularly vulnerable to developing psychological distress or suicidality (Franklin et al., 2017). Modifiable risk factors can offer intervention opportunities (Beautrais, 2000). Regular assessment of these modifiable risk factors as a part of routine clinical practice is vital for ensuring a good treatment plan, as research shows that 66-85% of people who had died by suicide had previous healthcare contact within the 12 months before their deaths highlighting the importance that clinicians use this opportunity to create a treatment plan (Ahmedani et al., 2014; Schaffer et al., 2016).

Limitations of risk factors: The field of research has focused on increasing awareness and understanding regarding the development of psychological distress and suicidality in the name of suicide prevention. Similar to most areas of research, the study of psychological distress and suicidality looks at where things go 'wrong', identifying risk factors that can quantify this experience. Dour et al. (2011) argue that an interaction of factors results in suicidality rather than the presence of an independent risk factor. However, there is a limited understanding of these risk factors' multifaceted relationships and interactions. The presence of a risk factor does not lead to suicidality in the majority of the young people in the community (Bourke, 2003), further highlighting the difficulties in attempting to determine what causes psychological distress or suicidality.

Moreover, risk factor research in suicide often occurs within the context of psychological autopsy studies and retrospective accounts, making it difficult to ascertain the factors that led to the suicide from the person who has died (Berman et al., 2006). It is also true that those

experiencing acute suicidality are often excluded from studies due to ethical risk (Andriessen et al., 2019). Furthermore, most studies investigating risk factors are conducted using quantitative analysis, so there are difficulties in understanding an in-depth and nuanced account of suicidality (Hjelmeland & Knizek, 2010).

Protective factors from psychological distress and suicidality

As well as understanding risk factors and their complex interactions, it is vital to acknowledge the resilience of people and how identifying and increasing protective factors in intervention is also an importance aspect of suicide prevention (Allen et al., 2022; Cramer & Tucker, 2021). Most protective factors are the inverse of the above risk factors and will be covered briefly, highlighting nuances not addressed above.

The presence of positive and future-oriented thinking, particularly a positive attributional style, allows young people to gain perspective, a sense of control and self-efficacy in their lives (Everall et al., 2006; Sapouna & Wolke, 2013). This positive evaluation allows young people to access and utilise their coping abilities and skills, reducing the risk of suicidality (Johnson et al., 2010). Cognitive skills involving emotional regulation, impulse control and cognitive flexibility allow the young person to respond to situations effectively (Sánchez-Teruel & Robles-Bello, 2014). These skills have been shown to increase resilience in young people who experience suicidal ideation and moderate suicidal behaviour even when exposed to past or current adverse events (Han et al., 2022; Sánchez-Teruel & Robles-Bello, 2014).

Family and school connectedness are frequently highlighted as being negatively associated with suicidal ideation and behaviour (Sapouna & Wolke, 2013; Whitlock et al., 2014). Perceived social support, caring and communication are also established as major protective factors (Wasserman et al., 2021), with parental support as the most consistently demonstrated protective factor, and protective even if academic and peer relationships are poor (Kidd et al., 2006). A longitudinal study conducted by Arango et al. (2019) comprising 142 young people found that connectedness with family, school and community was negatively associated with suicidal ideation. Quality peer relationships are also strong protective factors where more robust, satisfying peer and romantic relationships are associated with reduced suicidality in young people (Czyz et al., 2012; Everall et al., 2006). Participation in community, sporting and positive health activities may also mitigate the negative effects of adverse life experiences, reducing suicidal behaviour and distress (Chandy et al., 1996; Tomori & Zalar, 2000).

Young people who have accessed treatment from a health professional have highlighted this as one factor that prevented repeated suicidal behaviour, describing the intervention as helping them to develop adaptive coping strategies (Chesley & Loring-McNulty, 2003; Holman & Williams, 2022).

Models of suicidality

Models and psychological theory move beyond listing individual risk factors towards integrated theories of what puts individuals at risk of suicide (Sánchez, 2001). There are a multitude of theories regarding suicide that are available, mainly focused on adult populations with some adaptation to adolescents (Stewart, Eaddy, Horton, Hughes & Kennard, 2017).

Models allow for more nuance and storytelling to occur with regard to the development of psychological distress and suicidality (Michel, 2021). Psychological models are often used in the development of clinical interventions to create evidence-based practice; therefore, an understanding of models assists in the development and refinement of clinical practice (Eccles et al., 2012; Michel, 2021). The three models below encompass both individual and socio-cultural processes.

The interpersonal theory of suicide (IPTS) was developed by Joiner (2005) to create an explanatory model for suicide. IPTS posits that for an individual to engage in suicidal behaviour, they must possess both a desire for death and the capability to enact that desire. This theory conceptualises that three constructs are necessary for suicidal behaviour. The first two constructs are interpersonal and related to the desire for death: perceived burdensomeness and thwarted belongingness (Joiner, 2005; Van Orden et al., 2010). Perceived burdensomeness is characterised by self-hatred and the belief that one is a liability to others. Recently, perceived burdensomeness has been shown to be more strongly associated with suicidal ideation, independently of thwarted belongingness and hopelessness (Chu et al., 2017; Ma et al., 2016). Thwarted belongingness arises due to social isolation and feelings of loneliness (Joiner, 2005; Van Orden et al., 2010). Thwarted belongingness combines social isolation, one of the most reliable predictors of suicidal ideation and behaviour (Van Orden et al., 2010), and the theory suggests that when this need for connection is unmet (Baumeister & Leary, 1995), the desire for death occurs. The need to belong is a basic human motivation, and inadequate levels of belonging increase the experience of rejection and negative emotions (Baumeister & Leary, 1995). Both thwarted belongingness and perceived burdensomeness contribute to the desire to die but do not result in a suicide attempt.

The capability to enact suicidal behaviour is referred to as acquired capability (Van Orden et al., 2010). Acquired capability can be developed through habituation and repeated engagement in behaviours or exposure to situations that desensitise an individual to fear and pain (Joiner, 2005). This may include self-injury, potentially serving as a source of emotional relief, which over time may increase pain tolerance and decrease fear of death (Joiner, 2005; Willoughby et al., 2015). Those who have previously attempted suicide appear to experience higher levels of future suicidality and pain tolerance (Joiner, 2005).

The three-step theory of suicide was presented by Klonsky and May (2015) to explain suicidality. They posit that the combination of pain and hopelessness causes suicidal desire, which intensifies when the pain exceeds or overwhelms connectedness. Similar to the IPTS model, the three-step theory describes that the transition from suicidal ideation to suicide attempt occurs when there is a capability for suicide (Klonsky, Pachkowski, Shahnaz & May, 2021). However, the three-step model does not require capability to be high rather practicality (such as privacy and access to means) are determined to be sufficient even if acquired contributors to capability are missing. The three-step model has been supported across community and clinical settings, and countries (Pachkowski, Hewitt & Klonsky, 2021; Tsai, Lari, Saffy & Klonsky, 2021). As this is a relatively new theory, studies are still being completed across its validity in different age ranges and there is no current research investigating the three-step model in young people.

The Integrated Motivational-Volitional Model (IMV) of Suicide is separated into three parts, which together explain different biopsychosocial motivations for suicidal behaviour

(O'Connor & Kirtley, 2018; O'Connor, 2011). Part one of the model is called the pre-motivational phase, which identifies the context of biopsychosocial factors in a diathesis-environmental-life events model, primarily identifying the vulnerability factors and negative events that may trigger suicidal ideation and behaviour. This model allows for an understanding of the social and environmental contexts of suicide risk, such as socially prescribed perfectionism (O'Connor, 2007), decreased serotonergic neurotransmission (Turecki, 2014), early life adversity (Turecki & Brent, 2016) or social-economic inequality (Platt, 2016). The second phase is referred to as the motivational phase, the onset of suicidal ideation. The emergence of suicidal thoughts and intent is based on experiences such as defeat, humiliation, social rejection or loss, which lead to a sense of entrapment (O'Connor & Kirtley, 2018; Turecki & Brent, 2016). Entrapment can be experienced internally through one's thoughts or feelings, or externally through situations or environments that result in feeling stuck with no alternative options (Gilbert & Allan, 1998). A sense of entrapment can lead to a transition to suicidal ideation through motivational moderators which can either decrease the likelihood of transition (such as reasons for living, belongingness or future thinking) or increase the likelihood of transition (such as burdensomeness, little social support, or depleted resilience) (O'Connor & Kirtley, 2018). The final phase is the volitional phase, whereby suicidal ideation transitions to a suicide attempt or death. O'Connor and Kirtley (2018) note a similarity between the volitional phase of their IMV model and the acquired capability phase in the IPTS model; however, they suggest that volitional motivators are broader than acquired capability and also include psychological, physiological, social and environmental factors, such as being exposed to suicide or mental imagery of suicide.

These models are both adult-based; however, some research has been done to extend and apply these theories to young people. Barzilay et al. (2015) measured perceived burdensomeness, thwarted belongingness, and the presence of suicidal ideation in 1,196 Israeli high school students. The findings demonstrated that perceived burdensomeness interacted with thwarted belongingness and predicted suicidal ideation, consistent with the IPTS model (Barzilay et al., 2015). There was a notable difference in this population, which showed that acquired capability, mainly through self-harm, predicted suicide attempts independently from suicidal ideation i.e., young people did not necessarily have suicidal ideation but engaged in suicide attempts if they experienced perceived burdensomeness and thwarted belongingness (Barzilay et al., 2015). Stewart et al. (2017) also demonstrated some support for the IPTS model in adolescents; however, highlighted the need for adaptation of the theory to encompass the developmental stage of adolescence and more consideration of impulsivity as an indirect role in suicide attempts. These findings highlight that although the IPTS theory has application in young people, the current model does not fully capture the relationship and progression of suicidality in young people.

Similarly, the IMV model has limited research to support its applicability to young people. Li et al. (2021) tested the model in a population of 1,239 Chinese adolescents and demonstrated that ‘defeat’ resulted in entrapment which subsequently was associated with suicidal ideation and attempts. These results aligned with the model’s theory; however, this study appears to be the only study applying the IMV model to young people. Therefore, more research is needed in this area to understand the applicability and generalisability of this model to young people.

Young people's perspectives on psychological distress and suicidality

The focus of research on youth psychological distress and suicidality has typically been conducted as studies *on* young people rather than *with* them (Balen et al., 2000; Claveirole, 2004). More recently, there has been a transition to research exploring young people's experiences. For example, Heled and Read (2005) gathered responses from 384 undergraduates through open-ended questions investigating opinions on New Zealand's high youth suicide rate. Students highlighted that the pressure to 'conform and perform' contributed to suicidality. This result was replicated by Lake et al. (2013) in the US with a further exploration of the views young people experiencing suicidality had of mental illness. These results showed that young people who were suicidal were less likely to associate suicide with mental illness than non-suicidal young people, attributing suicide to negative life experiences. These findings highlight that young people view suicidality as a social process that is an understandable response to life difficulties rather than being due to psychopathology. Stubbing and Gibson (2019) described the tension between young people recognising suicide as a complex problem that primarily was a normal response to distress; however, at the same time, mental illness may account for and contribute to suicide.

The function of young people's suicidality continues to be complex, with young people highlighting reasons such as wanting to die, escape, and communicate distress (Jacobson et al., 2013; Madge et al., 2008). Motives and intent are unique to every individual. In qualitative studies of young people who have survived a suicide attempt, they have described suicide as a way to end their suffering (Holliday & Vandermause, 2015), a way to communicate their distress, or as a cry of pain (O'Connor et al., 2006; Orri et al., 2014). Interestingly, Orri et al. (2014) also

found a theme of revenge in the retrospective accounts of suicide attempts by young people who described wanting to make others feel guilty for their death. As suicidality and distress are difficult experiences to manage, suicidality may also be used as a form of help-seeking when young people feel unable or may not have the language to express their distress (Holliday & Vandermause, 2015).

Although this research begins to explore young people's perspectives regarding their experiences of psychological distress and suicidality, they rely on retrospective recall, which may influence the findings.

Early intervention for psychological distress and suicidality

Early intervention with young people is undoubtedly the best practice for reducing psychological distress and suicidality, leading to better outcomes for the person, family and community (Colizzi et al., 2020). Traditionally, intervention has been reactive and focused on treatment in the context of mental health disorders rather than on prevention, and it has primarily been adult-focused (MacDonald et al., 2018; McGorry & Mei, 2018). Practitioners often act as gatekeepers to mental health services, with general practice as the initial point of contact when seeking mental health support (Rickwood et al., 2007). Mental health support may provide different levels of support, including social work, medical reviews for medication, skills groups, and therapy ranging from brief to long-term therapy. However, many of these supports face delays with long waitlists and multiple help-seeking attempts needed before support is received (Farmer et al., 2003). Young people have described a need for intervention when experiencing

psychological distress and functional impairment prior to and regardless of reaching the threshold for psychiatric diagnosis (Rickwood et al., 2014; Sharma et al., 2021).

According to World Health Organisation, early intervention for young people with psychological distress and suicidal ideation is an important indicated intervention to prevent suicide (World Health Organization, 2014). The updated framework for the implementation of suicide prevention (the LIVE LIFE approach) similarly highlights the importance of early identification (World Health Organization, 2022). LIVE LIFE recommends four key interventions for effective intervention: limiting access to means of suicide; interacting with the media on the reporting of suicide; fostering socio-economic skills in adolescence; and the early identification, assessment, management and follow-up of individuals affected by suicidal behaviours.

In accordance with best practice, many OECD countries have adopted a national suicide prevention strategy that aligns with the previous World Health Organisation guidance (World Health Organization, 2014) and spans universal approaches to the population, selective approaches to communities with a higher risk of suicide and indicated approaches to individuals with suicidal behaviours (Robinson, Bailey, et al., 2018). These key universal, indicated, and selective approaches are outlined below.

Universal approaches: A universal approach adopts intervention across an entire population to enhance awareness and knowledge (World Health Organization, 2014). There are limited studies on the effectiveness of universal approaches and the effect on youth suicide; however, Klimes-Dougan et al. (2013) conducted a systemic review that suggested although

universal suicide prevention programmes had a positive impact on help-seeking attitudes, they have a limited impact on help-seeking behaviour. An example of a universal approach is means restriction to prevent the availability of means to attempt suicide or self-harm, such as policies restricting firearm sales or restricting the amount of paracetamol that can be purchased (Yip et al., 2012). Environmental modification has been found to reduce suicide lethality or defer an individual from attempting if their preferred method is unavailable (Clarke, 2017). However, means restriction does not reduce the attempt itself, with individuals often choosing less lethal methods (Yip et al., 2012). The less lethal method is preferred from a public health approach, but this does not address the effects of distress and suicidality on the young person and their community.

Universal approaches can help address several social risk factors that can lead to the development of psychological distress and suicidality, such as poverty, housing instability, and educational/occupational opportunities (Robinson, Bailey et al., 2016). It is important to note that evaluating the efficacy of universal approaches is difficult as they are often multi-component initiatives, and ascertaining the practical component of suicide prevention programmes can be difficult.

Selective and Indicated approaches: Selective approaches are targeted explicitly towards populations with an elevated risk, for example, those who are part of a minority and discriminated against groups, while indicated approaches aim to intervene with those known to have experienced distress, suicidality or self-harm (World Health Organization, 2014).

There is evidence that clinical interventions, as they key examples of selective and indicated approaches, are effective for young people experiencing distress, mental disorders and

suicidality (Robinson, Bailey et al., 2016). Cognitive Behavioural Therapy (CBT) in adolescents focuses on changing thoughts, feelings and behaviour (Kendall, 1993). A meta-analysis that combined over 50 years of research demonstrated that CBT for youth had robust effect sizes across internalising and externalising symptoms across youth, parent and teacher reports (Weisz et al., 2017). Furthermore, CBT can also impact the experience of suicidality in young people. A Cochrane review of randomised controlled studies have shown that CBT significantly reduces suicidal ideation and the number of incidents of deliberate self-harm in young people (Robinson et al., 2011). These results have been replicated across many studies (Alavi, Sharifi, Ghanizadeh & Dehbozorgi, 2013; Donaldson, Spirito & Esposito-Smythers, 2005; Robinson, Bailey, Witt et al., 2018; Slee et al., 2008).

Family and systemic therapies are efficacious in various disorders such as eating disorders, depression, substance abuse, and bipolar and anxiety disorders (Carr, 2016; Cottrell & Boston, 2002; Riedinger et al., 2017). Family and systemic therapies allow for the cohesion of the family system through psychoeducation, externalising the problem through reframing, and family-based therapeutic intervention (Carr, 2016). In a systematic review of 38 randomised control studies, systemic therapy proved an efficacious treatment of internalising disorders in young people (Retzlaff et al., 2013). Dialectical Behaviour Therapy (DBT) works on distress tolerance, mindfulness, interpersonal skills and emotional regulation skills and is an approach that involves both group and individual work (Linehan, 2014). In adolescents, an adaption includes family skills training (Mehlum et al., 2019). DBT has a research evidence base in reducing impulsive behaviour, including acting on suicidal thoughts and self-harm (Fortune & Hawton, 2005; Hawton et al., 2016; Mehlum et al., 2019; Witt et al., 2021).

In a study investigating the beliefs of young people and their parents on a range of interventions, many young people and parents agreed on the provision and perceived efficacy of mental health interventions (Jorm & Wright, 2007). However, young people reported more hesitancy to use medications as a helpful form of treatment. Many rated some medications as harmful, citing adverse side effects or lack of symptom improvement (Gupta & Ariefdjohan, 2021; Jorm & Wright, 2007; Moses, 2011). Indeed, there is no evidence for medications for self-harm, and limited efficacy of antidepressants in young people, especially for depression (Locher et al., 2017; Merry, Hetrick & Stasiak, 2017). Most research focuses on the use of interventions originally designed for adults and contain little to no adaption for use with young people. Interventions with young people often contain high levels of attrition, potentially highlighting an issue with the acceptability of the intervention (Robinson, Bailey et al., 2018).

Given the limited evidence that currently exists for specific interventions, particularly those for suicidality, consensus based clinical recommendations have been developed and focus on managing risk and addressing the underlying causes of that risk. Interpersonal effectiveness training and family therapy can be used to increase motivation to live, autonomy and skills in emotional management (Rice et al., 2018). As young people do not exist in silos, focusing on the caregiver's active role in treatment can help with psychoeducation, relationship conflict and crisis management (Rice et al., 2018). Importantly, Rice et al., (2014) identified that engendering hopefulness regarding recovery and developing adaptive coping as critical components of any treatment plan.

Beyond structured therapy models, peer support is emerging in many environments, including formal community service providers and in informal environments such as help groups

(Beales & Wilson, 2015). Many studies have found extraordinary value in peer support relationships (Trachtenberg et al., 2013). Peer support by individuals with their own lived experience of mental illness was initially developed to oppose the over-medicalisation of mental disorders (Beales & Wilson, 2015).

There has been relatively scarce evidence on the effectiveness of peer support, which is difficult to compare due to the diverse definitions and roles that peer support individuals occupy. A Cochrane review identified 11 randomised controlled trials that found adult service users had no better or worse outcomes with peer support workers than mental health service staff (Pitt et al., 2013). Notably, peer support increased the patients' feelings of empowerment, self-confidence and self-esteem (Davidson & Guy, 2012; Resnick & Rosenheck, 2008). In turn, there is also evidence that peer support work benefits the peer support worker themselves. Peer support workers report feeling more confident, valued, less stigmatised and having a positive sense of identity (Poremski et al., 2022; Repper & Carter, 2011; Salzer & Shear, 2002). There can also be disadvantages of peer support, for example, not having access to adequate training, the emotional toll of working in “triggering” environments, and concerns around personal boundaries between service users and peer support workers (Poremski et al., 2022). However, these results are all from studies conducted in adult populations, with methodological problems indicating that more research is needed in this area to better the health and social benefits of these populations (Beales & Wilson, 2015; Trachtenberg et al., 2013).

Limited studies have investigated the efficacy of peer support workers in child and adolescent mental health services. A systematic review by De Beer et al. (2022) on youth peer support workers found similar results to the adult studies where youth peer support workers could foster relationships based on authentic empathy and non-judgemental attitudes and

advocate for the young person. However, concerns were raised regarding the relationships between non-peer support staff and youth peer support workers regarding lack of control and power imbalances. Overall, the study reinforced the importance and value of peer support roles. Peer support values align with what young people want from services (Gibson et al., 2016). Young people report significant benefits from social connectedness, validation of their experience and informational support, such as sharing coping strategies and resources (Prescott et al., 2017). Adolescents have also identified that they would be more open to support from someone who went through similar experiences and could offer practical support on how they solved their difficulty (Salzer & Shear, 2002).

As identified earlier, there are often significant barriers to accessing interventions for young people, so early intervention is not occurring (Robinson, Bailey et al., 2016). To address this, headspace was developed in Australia to bridge the gap between primary and secondary mental health services (White et al., 2022). This service was shown to result in improved overall functioning, self-harm and distress scores in the young people who used it (White et al., 2022). Notably, it was positively experienced by the young people and provided various social, occupational, educational and healthcare interventions, addressing the complexities of mental health and other psychosocial presentations. Studies have also demonstrated that youth-friendly services, developed alongside youth, increase willingness to access help, enabling earlier intervention (Byrne & Rosen, 2014). The effectiveness of headspace has led to other countries adopting youth-focused early intervention models, such as Jigsaw in Ireland and Youthspace in the UK (McGorry & Mei, 2018).

Other components of intervention

Risk Assessment

Clinical intervention usually begins with and includes a risk assessment, which can occur across various settings, using various methods (Turecki et al, 2019). The concept of risk assessment is used across professions and is defined as "the evaluation of the possible risks in a product, situation, activity or course of action" (Collins Dictionary, 2020). This concept has been adopted for the evaluation of suicide risk, which is the evaluation of the risk of a person going on to attempt or die by suicide (Masango et al., 2008). Risk assessment involves collecting information about a range of socio-demographic and clinical factors, for example, history of mental illness, social support, and substance abuse. These factors can usually be collected through quantitative methods such as risk assessment screening tools and qualitatively through assessment interviews (McGlothlin, 2008).

Various screening tools and models have been developed to assist clinicians in identifying suicide risk (James & Gilliland, 2012). Because of the multitude of risk assessment tools, there are significant difficulties in developing standardised risk assessment practices across services (Graney et al., 2020). Graney et al. (2020) identified that the majority of tools were checklist tick boxes with minimal clinical judgement needed. Only 59% of the tools required active engagement from the patient, only 40% of the tools assessed suicidal intent, and staff used these tools to make predictions of future behaviour. Popular risk assessment tools involve self-report, with varying levels of sensitivity and specificity; however, there is a paucity of research exploring the cut-offs, reliability and sensitivity for adolescents. An example of risk assessment can include tools such as The Beck Hopelessness Scale (Beck & Steer, 1988), The Beck

Depression Inventory (Beck et al., 1996), and The Beck Scale for Suicide Ideation (BSS) (Beck et al., 1988). An alternative to assessing the number of risk factors and symptoms is to address the strengths and reasons that the young person is still alive. The Reasons for Living Inventory for Adolescents (RFL-A) (Osman et al., 1998) was developed to examine the factors that allow the young person to continue to survive. Additionally, the RFL-A also possesses more predictive power in adolescent populations compared to the BHS (Gutierrez et al., 2000). The RFL-A scale has also been shown to distinguish between non-suicidal, first attempter and attempter groups and offer more specific guidance on target interventions for clinicians (Gutierrez et al., 2000).

Clinical interviewing skills are also used to assess suicidal ideation and risk. Clinical judgement is frequently used among those trained in mental health professions (social workers, psychologists, counsellors) and is a combination of their clinical experience, knowledge and training (Granello & Granello, 2007).

Structured clinical interviewing is determined by asking direct questions such as “are you thinking about killing yourself” (McGlothlin, 2008) and subsequently asking if the person has a plan to act on their thoughts. Scale questions can assist in determining the likelihood of immediate suicidal risk, “on a scale from 1 to 10 (1 being not likely at all and 10 being definite), how likely are you to attempt suicide within the next 72 hours?”. Additional questions can be asked to assess the thought's frequency, intensity and duration to determine the severity of suicidal ideation and the chronology of the person’s experience (McGlothlin, 2008). Questions also involve assessing the plan's specific details, the method's lethality, and the means' availability. Additional questions regarding previous suicide attempts, substance use and identifying triggering factors for suicidal thoughts can be asked (Horwitz et al., 2015; James &

Gilliland, 2012; McGlothlin, 2008). Finally, questions that identify protective factors and reasons for living can offer a strengths-based approach to risk assessment (Gutierrez et al., 2000).

The above interviewing structure has been utilised as an assessment strategy to assess suicidal ideation and suicidal behaviour and its collection of information regarding other risk and protective factors that may increase or decrease the individual's likelihood to attempt suicide. Many ministries and health institutions worldwide appear to utilise similar interviewing techniques and the integration of risk assessment tools (Ministry of Education, 2019; Ontario Hospital Association, 2011; Oranga Tamariki, 2019). Clinicians have highlighted the value of risk assessment tools for communicating with other healthcare teams and promoting conversations around risk factors (Graney et al., 2020). Formal risk assessment structures can allow for mental health training and accountability among healthcare providers from diverse disciplines (Patterson et al., 1983) while accredited training programmes can provide evidence-based assessments to enhance better practice and increase the accountability of any professional who has contact with individuals to initiate a discussion about mental health and suicide (Large et al., 2011).

However, studies that have investigated the predictive value of risk assessment, including via tools and clinical assessments have found that all scales had low predictive value where often risk factors are so generic that they are not able to assist in the clinical practice of risk assessment (Chan et al., 2016). There is also an over-reliance on the communication of suicidal ideation for risk assessment to be accurate (Silverman & Berman, 2014).

Risk assessment is particularly problematic in psychiatric use, where there is an increased risk of suicide after being discharged from a psychiatric hospital. Approximately 3% of those

who were classified as “high risk” died by suicide in the year post-discharge (Large et al., 2011). However, 60% of died by suicide in the same period were classified as low risk (Large et al., 2011). With these results, one could argue that there is no utility in using screening tools for risk assessment with low sensitivity and outcome predictability (Franklin et al., 2017; Large et al., 2011; O'Connor et al., 2013). The checklist-type nature of these tools may also hinder open conversation and the therapeutic relationship (Graney et al., 2020). One-third of clinicians have reported poor levels of training and described the time-consuming nature of these tools, which can create an aversion to using them effectively (Graney et al., 2020). Risk assessment tools also encourage a stratification of risk, where the aim of the assessment is to identify individual risk factors and protective factors to stratify the severity of risk (Masango et al., 2008). The stratification of risk can then allow clinicians to determine risk level and allocate treatments accordingly (Center for Mental Health Services, 2012; Graney et al., 2020). Although this practice occurs in clinical settings, reviews have found insufficient evidence to support the use of risk screening tools due to their low specificity and predictive validity (Bolton et al., 2015) and has frequently been advised against in recent research (Fortune & Hetrick, 2022).

Patients who have completed risk assessment tools also note the inconsistency of approaches and the impersonal nature of the assessment (Graney et al., 2020). Many patients have reported not being aware that a tool was being used during care meetings or offered the opportunity to have any support person. Information for crisis contacts were not provided to 33% of patients surveyed, and only 52% felt understood and listened to. Furthermore, the discussion of suicide itself “is passed over quickly in assessment” (Graney et al., 2020), which patients attributed to the staff not feeling open and confident when discussing suicide. Young people viewed the labels, such as “risk”, themselves as problematic and reductionist and preferred

conversations that were holistic, focusing on genuine connection and practical support (Bellairs-Walsh et al., 2020).

Although there has been a global shift to recognising the limitations of risk assessment and stratification towards a psychosocial conversation, many clinicians continue to engage in practices that are no longer recommended as best practice. This lack of awareness or change may be due to inadequate training in conducting risk-based conversations or time-restricted appointments in cases like GP practices (Bellairs-Walsh et al., 2020).

Assessment of suicidality should be a dynamic and continuous assessment as it is recognised that many suicide attempts often occur due to immediate, environmental triggers that build upon existing static and dynamic risk factors (Rice et al., 2018). Risk frequently changes, making assessing suicide risk difficult and predicting suicidal behaviour impossible. A meta-analysis of 50 years of research found that no categorisation of suicidal thoughts or behaviours can accurately predict suicide above chance (Franklin et al., 2017). The focus of risk assessment needs to change beyond using screening tools or clinical judgement in an attempt to predict suicidal behaviour and allocate resources accordingly. Instead, the focus should be placed on the individual, seeking to reduce distress and modifiable risk factors while providing treatment for anyone who seeks it (Fortune & Hetrick, 2022)

Safety planning typically takes place following the assessment of suicidal or self-harm disclosures to reduce the incidence of these occurring in the future (Nuij et al., 2021). Safety planning has been shown to be effective at reducing suicidal behaviour and can work as a stand-

alone or comprehensive intervention component (Knapp, 2023; Nuij et al., 2021). Safety planning should be regular and collaborative, with active input and engagement from the individual, where collaborative safety plans have been shown to reduce suicide attempts by 43% (Nuij et al., 2021). These plans may include identifying triggers or warning signs, outlining coping strategies (internal and external), listing people who can be contacted for support, and methods to make the environment safer (Stanley & Brown, 2012). Safety planning is different to no-suicide contracts which have been examined to have no clinical utility or empirical evidence to support their effectiveness. No-suicide contracts go against core safety planning protocols of collaboration and may coerce the individual to hide their suicide risk (Kroll, 2000; Rudd, 2006; Stanley & Brown, 2012). Individual autonomy, consent and involvement in safety planning and the individual's decision regarding whether they take their life is an effective intervention that paradoxically can directly address some of the drivers of suicide, such as helplessness and defensiveness (Knapp, 2022).

Counselling techniques

Engaging young people in an intervention requires counselling skills. Several studies have investigated the type of approaches and behaviours that may influence the effectiveness of an intervention (Mathieu et al., 2021). Most research on counsellors' responses focuses on qualitative studies investigating the types of questions that counsellors use to create a therapeutic alliance and construct shared meaning (Butler et al., 2010; Cook & Monk, 2020). Therapeutic alliance has been consistently demonstrated in the literature to have a significant effect on therapeutic outcome (Karver, Handelsman, Fields & Bickman, 2006; Krupnick et al., 2006). Cook and Monk (2020) reported that a necessary component of working with adolescents was

the counsellor's proactive invitations to the young person to express themselves, allowing the adolescent to gain power in the therapeutic relationship.

Primarily, both youth and clinicians have highlighted that client-centred care focused on the young person being heard and understood was vital for successful interactions (Gibson et al., 2016). Counselling techniques such as non-judgemental reflection, unconditional positive regard and therapist self-disclosure have been shown to allow adolescents to express themselves more freely (Sagen et al., 2013). Being listened to, respected and understood were the primary things young people identified as being needed from counsellors (Gondek et al., 2017; Grealish et al., 2013; Idenfors et al., 2015). In a study conducted by Cook and Monk (2020), young people reported the tension between the young person exercising their power, such as deciding the agenda and setting goals, and the desire for the counsellor's advice and strategies. However, all participants highlighted the importance that counselling allowed them to express themselves, which brought relief.

Young people's disclosure of suicide

Current conventional mental health systems are not youth-friendly or accessible, which introduces barriers to young people disclosing suicidality (MacDonald et al., 2018).

Findings from McGillivray et al. (2022) indicated although 81.9% of young people reported disclosing suicidal thoughts to another person, 39% of these did not disclose to their mental health professional, and 16.1% reported never disclosed suicidal thoughts to anyone. Of those that did not disclose suicidality, barriers included confidentiality, prioritising other mental health difficulties, the belief that suicidal thoughts will go away, fear of judgement,

normalisation of suicidal thoughts, not being asked about the thoughts or a belief that a professional cannot help. Non-disclosure of risk is common in young people due to perceived consequences and past unhelpful reactions. Allowing for nondisclosure can build trust and autonomy and ultimately facilitate help-seeking and risk disclosure (Podlogar & Joiner, 2020).

Help-seeking and connecting young people with support

Help-seeking behaviour can be defined as an individual's demand for help or social support (Barker, 2007). Help-seeking is not a linear behaviour and is influenced by knowledge of skills and positive relationships (Rickwood et al., 2005). Accessing and utilising social support is associated with lower rates of suicide, increased social competency and decreased rates of depression compared to those who do not utilise social support (World Health Organization, 2000). The process of seeking help, either formal or informal, is beneficial for adolescent development, health and overall life satisfaction (Baumeister & Leary, 1995; Costello et al., 2001). Willingness to seek help is nuanced and based on multiple factors and processes within an individual, their family and mental health service need and utilisation (Zwaanswijk, Van Der Ende, et al., 2003). Shapiro (1984) delineated help-seeking into four decision-making stages: deciding they need help, deciding to seek help, deciding from whom to seek help, and deciding how to seek help. This decision-making process is affected by numerous individual and exogenous factors that impact the young person taking the next step. Saunders et al. (1994) proposed an additional initial step requiring the individual to recognise the problem before the decision of needing help.

When young people do seek support, they appear to prefer support from friends or family compared to health professionals (Evans et al., 2005; Fortune et al., 2008; Rickwood et al., 2007). In particular, 90% of adolescents will disclose their distress to their peers rather than a professional (Kalafat & Elias, 1995). A young person's decision to reach out to someone they know rather than a professional is determined by trust and familiarity (Frydenberg, 2018). Once disclosed to peers, future help-seeking, especially regarding seeking help from professional services, depends on the opinions and attitudes held by peers (Rothi & Leavey, 2006). A peer that has had a successful experience with prior help-seeking or has experienced similar problems can facilitate the formal help-seeking process due to the trust and familiarity of the friendship bond (Wilson & Deane, 2001). Females are more likely to seek help and use their social support systems compared to males, most likely due to internalised gender norms. (Barker & Mikulencak, 2000). In contrast, males have been shown to be more likely to negate or avoid recognising any problem in the first place and rely on themselves (Offer et al., 1991).

Barriers to help-seeking

Despite the evidence supporting early intervention and mental health service availability in most OECD countries, an extensive amount of research demonstrates that young people do not seek help for mental health problems, especially suicidality (Carlton & Deane, 2000; Pisani et al., 2013; Rickwood et al., 2005; Zwaanswijk, Van Der Ende, et al., 2003).

Young people are reluctant to get professional help and are often the lowest help-seeking age group (Carlton & Deane, 2000) with many studies conducted into proposed reasons that young people do not seek professional support (Gibson, 2021; Gulliver et al., 2010; Rickwood et al., 2007). An Australian study of 3092 young people aged 15-24 found that 22% of females and

39% of males would not seek help from formal services (Donald et al., 2000). Similarly, a survey of 11,154 Norwegian youth aged 15-16 found that only one-third of young people had sought professional help for mental health symptoms (Zachrisson et al., 2006).

As adolescence is a stage of life where autonomy and independence are developing, many young people believe they should be able to handle problems themselves. Gould et al. (2004) reported that one-third of adolescents experiencing depression, suicidal ideation or substance use disorders used help-avoidant strategies such as the belief that one should rely on themselves. These young people were less likely to use help-seeking strategies such as reaching out to a peer, with some feeling that no one could help or that the problem would resolve (Nada-Raja et al., 2003). Concerning professional support, young people have identified losing control and a sense of self-efficacy as barriers to seeking support (Fuller et al., 2000).

Poor mental health literacy, where the young person is unable to recognise, describe and regulate their emotions, is a significant barrier to help-seeking (Ciarrochi et al., 2003; Zachrisson et al., 2006). On average, mental health literacy appears less developed in young males (Rickwood et al., 2004). Young people often have difficulty recognising and communicating their problems and needs (World Health Organization, 2000). Findings from a school-based study reported that adolescents experiencing self-harm thoughts were less likely to seek professional help than those who were asked if they would seek help *if* they had self-harm thoughts (Carlton & Deane, 2000). The responsibility placed on the young person to identify their difficulties affects their ability and the effectiveness of their help-seeking behaviours and subsequent access to mental health services (Rothi & Leavey, 2006).

Within populations who are highly psychologically distressed or experiencing suicidality, help-negation is common, described as a lower intention to seek help from both formal and informal sources (Carlton & Deane, 2000; Wilson & Deane, 2001). Help negation may be partly due to the desire to control one aspect of their lives, hopelessness at their worth, or the value of help (Deane et al., 2001). Males, minority and indigenous populations, and LGBTQIA+ communities are more likely to negate help (Rickwood et al., 2005; Rickwood et al., 2007; D'augelli, 2022). A study conducted across Australia using data from 2721 young people aged 14-24 found that help negation was present across all forms of support in suicidal clients apart from anonymous helplines (Rickwood et al., 2005).

Mental illness stigma, negative attitudes and fears of mental health services are also cited as barriers to help-seeking. This relationship is multi-faceted, where young people are afraid of being seen as "crazy" by peers or others, fears that the support may not help or fear that they will not be listened to or taken seriously (Rickwood et al., 2007; Wisdom et al., 2006). Alongside fear, there are often feelings of shame and embarrassment (Rothi & Leavey, 2006). In countries where distressed or suicidal behaviour can be seen as "deviant" or those with mental health are culturally or religiously ostracised, these factors can impede a young person's ability to seek help (Barker, 2007).

A major concern across all research with young people about help-seeking regards confidentiality: in particular, young people want their information to remain confidential from their parents (Gibson et al., 2016; Gilbert, Rickert & Aalsma, 2014). Young people described the rationale behind this desire for confidentiality due to parents not knowing about the young

person accessing services, that their problems were related to their parents or not wanting to worry about their parents (Gibson et al., 2016). Young people express considerable fear that confidentiality might be broken or that they will be forced to have family involved in treatment (Gibson et al., 2016). Therefore, young people prefer to seek help from sources they trust, such as their friends (Gulliver et al., 2010).

In Western societies, parents often retain dominant power regarding health and can be considered primary gatekeepers to healthcare (Rothi & Leavey, 2006). Poor parental understandings of mental health, services and support, parental psychopathology, education level, belief systems, parental abuse and neglect, and the burden the parent experiences from the young person's distress all influence help-seeking and become barriers to a young person receiving support (Rothi & Leavey, 2006; Zwaanswijk, Verhaak, et al., 2003). As young people are mostly still dependent on their parents, financial difficulties and mental health intervention and transport costs can affect help-seeking (Bruffaerts et al., 2011). Furthermore, young people have identified that their suicidality is not understood, listened to or validated by their parents, preventing them from disclosing their difficulties (Gilchrist & Sullivan, 2006; Lachal et al., 2015). Past adverse help-seeking attempts with young people's families hinder young people from disclosing, even when they want to, and they are often fearful of parents' reactions to their difficult emotions (Everall et al., 2006). Young people report seeing adults as unwilling to have conversations about suicide (Gibson et al., 2019). There is also a mismatch between young people and their parent's perceptions of their accessibility. Young people describe their parents as unapproachable and untrustworthy, while parents believe they are accessible (Gilchrist & Sullivan, 2006). There is frequently a mismatch between adolescent perceptions of their needs

and potential difficulties versus adult perceptions of adolescents' needs (World Health Organization, 2000).

When young people do reach out for help, difficulty obtaining a mental health referral can be a difficult process to overcome. Young people who reported high levels of internalising problems were less likely to be referred to mental health services (Zwaanswijk, Van Der Ende, et al., 2003). Older adolescents were more likely to perceive themselves as having more serious mental health concerns compared to younger adolescents, but this need for support did not translate to mental health referrals (Zwaanswijk, Van Der Ende et al., 2003). Zwaanswijk, Van Der Ende, et al. (2003) found that in a sample of 1,120 Dutch adolescents aged 11 to 18, only 6.4% of adolescents who noted emotional or behaviour problems were referred to mental health services. When parents perceive significant emotional or behavioural difficulties with their child, 28% of adolescents had contact with mental health services (Sourander et al., 2001). These results may insinuate that adolescents are less likely than their parents to seek support when concerned about their mental health.

Furthermore, entering the service for support in the first place can be difficult due to the criteria required for referral acceptance. Suicidality itself is not a diagnosable or psychiatric disorder, and contrary to popular belief, many young people who experience suicidal ideation or engage in self-harm are not always experiencing severe mental illness (Hawton et al., 2006). Therefore, services may not identify suicidal individuals, resulting in limited access to services and availability of evidence-based care (Lawrence et al., 2021; Robinson, 2008).

Mental health services are often understaffed and under-resourced, resulting in lengthy waitlists and large caseloads for clinicians (Barker, 2007). Due to the nature of these services, they are more likely to be negatively experienced by the young person, negatively impacting their utilisation of mental health services altogether and hindering recovery (Aisbett et al., 2007). Formal services can also result in what are perceived as negative consequences, such as hospitalisation, which the affects help-seeking intentions and disclosure of suicidal ideation (Gulliver et al., 2010; Hom et al., 2017). This theme is connected to mental health literacy as young people often have misconceptions that milder forms of distress and suicidal ideation may result in institutionalisation (Blanchard & Farber, 2020).

Further mismatch occurs between what young people want from services and what services provide (Gibson et al., 2016), with young people highlighting that services do not match their needs and are often inflexible (Gibson et al., 2016).

Many services with the OECD are also based upon dominant socio-cultural narratives of mental wellbeing and do not align with the individual's or family's needs. People who do not identify with this way of being experience discrimination across the health system (Sorkin et al., 2010). In particular, barriers to care differ due to race and ethnicity. Black and Hispanic adolescents have been shown to be significantly more like to report not knowing who to see, having no transport to attend appointments or fear of what the professional may say, resulting in both groups being significantly less likely compared to white adolescents to receive counselling (Kodjo & Auinger, 2004). It is important to highlight that these lower rates are due to the hostile and inappropriate environments of the health system and subsequent interventions. Migrant and refugee populations have also been shown to be less likely to seek support potentially due to

cultural differences with the host culture, language barriers, limited knowledge on how to access services, fear and uncertainty regarding the impact on visa status, and often needing to prioritise other pressing issues such as housing and health problems (Fegert et al., 2018; Rothi & Leavey, 2006). This pattern of increased barriers and reduced service utilisation is seen in minority and indigenous groups internationally (Johnson & Cameron, 2001; Lee et al., 2009; Lu et al., 2021; Theodore et al., 2022).

Although the help-seeking literature is well-researched and published, research has tended to be in Western countries with fully funded mental health services. However, many developing countries may not provide these mental health services or may be overwhelmed (World Health Organization, 2000). Furthermore, World Health Organization (2000) highlight the difficulty and achievability of research being able to accurately measure and assess the use of informal supports and their combination or influence on other formal levels of support. Therefore, there is a limited understanding of the influence and relationship of different factors that may facilitate or impede help-seeking.

Online access transforms help-seeking and intervention

With the introduction of the internet, more avenues for help-seeking have developed. Young people search for mental health information online or through mobile applications (apps) and sometimes seek this type of information online more than face-to-face support (Gray et al., 2005; Pretorius et al., 2019; Rickwood et al., 2007; Robinson et al., 2015). Young people may seek information through formal online resources published by healthcare providers or professional websites (Rickwood et al., 2005). Online informal resources, such as social media

or discussion boards, are also used where a particular topic is highlighted as a ‘post’, and others can comment on this post (Collin et al., 2011). Many young adults aged 18-29 look up mental health information online, with 33% searching online for information about mental health issues, 38% about prescription drugs and 34% about alternative medicines (Jones & Fox, 2009). Young people described being able to use online information to prepare for their in-person visits or challenge what they hear from a healthcare provider. Young people reported that online information-seeking was beneficial as it offered community, anonymity and somewhere to turn when they felt there was nowhere else (Gowen, 2013).

Online information seeking can have a role in early intervention as a young person can gain an understanding of their symptoms and others’ experiences, increasing the willingness to seek professional help (Birnbaum et al., 2017). Information seeking online can facilitate the help-seeking process and offers a safer medium for this exploration process, such as control and anonymity, the lack of which has been highlighted above as barriers to face-to-face information and help-seeking (Burns et al., 2016; Gowen, 2013). Frost et al. (2015) found that over half of the young people in the study used the internet as a first step to help-seeking, later gaining support offline. Another study showed that 21% of 12–17 year-olds and 34% of 18-25 year-olds reported searching for information online, of which 94% felt somewhat or very satisfied with the information they received (Burns et al., 2010). In contrast, findings from a study with 176 university students aged 18-25 reported that 59% of the online resources made no impact, with 40% reporting that they helped a little (Feng & Campbell, 2011). The difference in perceived helpfulness of online information resources may be due to the awareness that online information

may not always be trustworthy or accurate but this does not appear to be a barrier to using online methods to obtain information (Gowen, 2013).

Once an individual has sought information online, there are avenues for actively seeking help and support online. Various technology and therapy models have been translated into a digital space, from online CBT interventions or video-based psychotherapy to virtual reality or artificial intelligence programs (Aboujaoude et al., 2020). A number of services for general mental health and wellbeing have emerged over the recent years, including teleweb services (such as online chat counselling), digital self-help programmes (for example Reachout, justathought), and mobile apps (such as TalkLife) (Brody et al., 2020; Fernandez et al., 2021). Over 10,000 mental health apps are now available, and nearly 100 new online mental health start-ups are created each year (Roland et al., 2020). Informal levels of support include mental health pages and communities based on social media, which offer peer support or apps that can be downloaded and focus on coping skills (Punukollu & Marques, 2019). These types of support rely on the young person to have knowledge about these options, and either add themselves into the community or download the app needed for support.

There is growing evidence of the value of online intervention in the youth mental health space (Marchant et al., 2017; Rickwood et al., 2005; Rickwood et al., 2016). Online interventions can address some of the previously identified barriers by providing a service that is more accessible and less stigmatising than face-to-face interventions across a variety of settings (Calear & Christensen, 2010; Robinson et al., 2016; Wagner et al., 2014). Young people often prefer help-seeking in a digital space as it offers anonymity and access to peers who understand

their experiences (Greidanus & Everall, 2010; Pretorius et al., 2019; Wilks et al., 2018). Recent studies have demonstrated that those with higher levels of psychological distress and suicidal ideation prefer online help-seeking (Mars et al., 2019; Mok et al., 2021; Wilks et al., 2018). Young people who use online help-seeking have higher suicidal risks and social anxiety compared to suicidal youth who do not use online help-seeking (Bell et al., 2018).

Online interventions also align with the international benchmarks for mental health innovation set by the World Health Organisation (World Health Organization, 2014). A comprehensive review and meta-analysis pooling 92 studies with 9,764 clients across all age groups found that online and face-to-face therapies are similarly effective (Barak et al., 2008). An interesting finding in this study was that young adults (19-24 years) appeared to be more effectively treated by internet-based therapy (Barak et al., 2008). Young people have also highlighted the desire to have services available when and where they need them, not necessarily the traditional structure of weekly sessions (Gibson et al., 2016). Online mental health interventions have been demonstrated as more effective in retaining young people in interventions than face-to-face outpatient care (Liverpool et al., 2020). Online interventions may offer access to young people who otherwise may not seek help, such as those who do not have financial, geographical or familial support to access in-person services (Rickwood et al., 2016). Online therapies have been deemed acceptable by young people, with 72% stating they would access online therapy if needed and 31.9% choosing online therapy compared to face-to-face support (Sweeney et al., 2019). An example of online mental health services for general mental wellbeing is the development of an integrated service of web-chat counselling, user-directed online therapy and peer social networking called MOST+ (Alvarez-Jimenez et al., 2020).

MOST+ increased social connection and resulted in young people reporting feeling better and safe. There were significant improvements across psychological distress, depression, loneliness, autonomy and self-competence.

In terms of suicidality, online interventions using a CBT model have been shown to reduce depressive symptoms and suicidal ideation in young people (Bergin et al., 2020; Rice et al., 2016; Witt et al., 2017). A systematic analysis and meta-analysis of randomised controlled trials using self-guided digital interventions (including CBT, DBT, Acceptance and Commitment Therapy and blended approaches) for suicidality has demonstrated a small but significant reduction in suicidal ideation (Torok et al., 2020). An example of a self-guided intervention is Reframe IT, an eight-week online CBT intervention (Robinson et al., 2015). A pilot study demonstrated a reduction in suicidal ideation, depressive symptoms and hopelessness, with young people reporting that they enjoyed the programme, which included activities such as video diaries, factsheets, and activities (Robinson et al., 2015). Another online intervention called Open Up is a 24/7 online counselling service that can be accessed through various social media channels and its official web portal and allows young people to chat with social workers or trained volunteers (Yip et al., 2021). Open Up reported high user satisfaction and effectiveness in reducing suicide risk levels (Yip et al., 2021). However, they also reported challenges working in a digital environment, where users often only accessed the service once, and difficulty in paid and volunteer staff capacity (Yip et al., 2021).

Digital tools have also been developed to address particular aspects of intervention for suicidality. Online modules targeting perceived burdensomeness and suicide safety planning

have been found to reduce these symptoms and strengthen suicide-related coping skills (Rainbow et al., 2021).

Despite the evidence supporting online intervention methods and young people's acceptability of this modality of intervention, clinicians are often reluctant to utilise this technology (Breedvelt et al., 2019). A convenience sample of 29 volunteer therapists who conducted therapy in online and offline spaces described perceiving their clinical skills, empathy and therapy momentum as lower in online settings than in face-to-face therapy (Messina & Löffler-Stastka, 2021). As the pandemic forced clinicians into online spaces, therapists noted a gap in training and education regarding web-based intervention (Sampaio et al., 2021). Young people who sought help online perceived their help sources as less helpful than those who received offline help (Wong et al., 2021). Studies have demonstrated that online interventions should complement and exist alongside in-person interventions, especially with individuals experiencing suicidality due to the need for more specialised services (Santarossa, Kane, Senn & Woodruff, 2018; Wong et al., 2021).

Informal online support that can be included in the broad scope of digital intervention has also appeared over the recent years. Informal online support networks are run as a purposeful intervention and often comprise of peers who support young people to discuss their difficulties and provide information and support (Kummervold et al., 2002). These support networks typically operate within social media platforms. Social media platforms where such networks have appeared include Reddit, Tumblr, Instagram, YouTube, and TikTok (Andalibi et al., 2017; De Choudhury & De, 2014; Griffith & Stein, 2021; McCashin & Murphy, 2023). Individuals

with a serious mental illness have described the benefits of having these spaces to challenge stigma, increase personal empowerment and provide hope (Naslund et al., 2016).

There is limited research on the effectiveness of these online support groups. Ali et al. (2015) conducted a systematic review to investigate the effectiveness of online support networks, intentionally set up to provide this type of support, on a range of mental health presentations. Overall, two randomised controlled trials demonstrated significant positive outcomes in anxiety and depressive symptoms compared to control groups and the other four remaining studies demonstrated no effect. Importantly, it is good to bear in mind that these types of online support networks do not always primarily or explicitly aim to reduce distress; rather, they grow out of a desire to provide emotional relief and enhance a sense of control (Andersson, 2014). This is demonstrated through a peer support intervention named the Buddy Project which matched individuals who then developed supportive friendships that focused on working through their mental health journeys (Andalibi & Flood, 2021).

Online support networks also develop in a natural, unstructured way where young people seek out others with similar experiences (Naslund et al., 2014). These are not set up intentionally but emerge naturally. Support is often sought through posting on social media or message boards, and communities form around peers who have had or are having similar experiences (Fergie et al., 2016; Webb et al., 2008). Online help-seeking is particularly prevalent in online mutual-help groups, which address issues such as sexual abuse, alcohol addiction, suicidal ideation, depression and many more (Greidanus & Everall, 2010). These groups can take place on apps or websites, which are set up for this purpose and contain a theme such as ‘suicide’, where users can describe their experiences (Greidanus & Everall, 2010). However, help-seeking behaviour

also occurs on sites whose primary role is not to offer mental health support. Sites like Instagram, Tumblr and TikTok have large communities who post content indicating distress (Nesi, 2020; Zhang et al., 2021). These groups provide a space to share personal experiences and provide information and emotional support. Young people use self-disclosure to promote community and develop a shared reciprocal social relationship that allows others to feel safe seeking help from people who have had similar experiences and may feel less threatening (Cline & Haynes, 2001; Tichon & Shapiro, 2004). Young people reported valuing social connectedness, validation of their experience and information provision, such as coping strategies from this online support (Prescott et al., 2017). In an online survey of 1038 young people aged 16-24, approximately 81% found online talking helpful (Ellis et al., 2012). Young people have also identified that a particular 'online disinhibition' allowed them to disclose more than they would have in an in-person context and that this ability to have genuine discourse can be an effective healing process (Pavalanathan & De Choudhury, 2015).

Help-seeking behaviour on these sites often comes in short videos, memes or gifs with text or hashtags accompanying the post. Cavazos-Rehg et al. (2017) found that 82% of posts within these online groups were related to depression, self-harm or suicide, with additional themes of self-loathing and loneliness. Community members will respond to this content through comments on the help-seeker's post disclosing similar experiences, validating the help-seeker's experience or offering specific advice. Research has shown that responses often contained themes of empathy and empowerment, such as responses like 'don't kill yourself, I'm here for you' or 'I don't know you, but I care about you' (Andalibi et al., 2017; Fu et al., 2013; Greidanus & Everall, 2010). Often help-seekers grow into help providers on these platforms and continue participating in these communities.

However, unstructured and unmoderated support networks can also facilitate unhelpful discourse and behaviour. One study showed that social media was used to validate suicidality compared to being used to genuinely help-seek (Horne & Wiggins, 2009). Lewis et al. (2012) also identified that some YouTube viewers expressed admiration or encouragement of those posting content with self-harm. In the comments section of these videos, many described continual self-harm behaviours, with rare comments directed towards recovery. Social media networks potentially normalise self-harm and suicide behaviours (Whitlock et al., 2006; Ybarra et al., 2005).

Combining peer support and evidence-based intervention may be a way to integrate the benefits from both areas. An example of this combination is mental health helplines. Helplines have existed for many decades and traditionally operate through a mixture of paid, clinically trained staff and volunteer peers who receive some form of training (Sundram, Corattur, Dong & Zhong, 2018). Helplines have primarily been telephone based; however, many have evolved to providing support through digital means such as text and online chat counselling (Hanley & Wyatt, 2021; Van Wyk & Gibson, 2022).

Social media is the next generation of helplines. Many young people who use social media for distress or suicidality-based purposes reported joining suicide forums for support and experiencing reduced suicidal ideation, with very few users seeking information on suicide methods (Eichenberg, 2008). Social media has had largely positive effects on the visibility of suicide prevention and provides an opportunity for intervention and to prevent suicide, especially in young people who are hard to engage with traditional services (Robinson et al., 2016). This

modality of intervention has also been identified as useful, engaging and supportive by young people (Kruzan et al., 2022). Young people are responsive to informal support groups and chat forums set up on social media (Lerman et al., 2017), and studies have revealed successful engagement in web-based psychotherapy programmes that have been set up through social media (Naslund et al., 2015; Rice et al., 2016). In a systematic review of social media-based interventions, rating scale measurements demonstrated significant improvements in depressive symptoms and mental health knowledge but no improvement in anxiety symptoms or psychosis (Ridout & Campbell, 2018). A scoping review, which reviewed 15 studies of social media intervention (Kruzan et al., 2022), also found significant reductions in mental health symptoms across most studies, consistent with previous meta-analyses of digital interventions (Goldberg et al., 2022; Linardon et al., 2019).

Research in online and social media-based interventions is limited, potentially because controlled studies using real-time relationships on social media can be challenging to implement. Rice et al. (2016) described the use of moderators and risk management protocols for online and social media-based interventions, both of which develop a connection with the young person, which may also facilitate other areas of help-seeking with otherwise unreachable populations. Moderation by clinical experts has previously been identified as a key factor in successful online interventions (Ridout & Campbell, 2018). As social media is an uncontrolled medium, there are also unforeseen risks that may occur. These risks may include misleading information, hostile comments or uncertainty regarding mental health symptoms or treatment (Naslund et al., 2016).

Counselling techniques online

Core elements of counselling, such as therapeutic alliance and counselling micro-skills (Hanley, 2012), are key elements to building rapport and trust with a young person, both of which have been established as essential in engaging young people in intervention on digital platforms (Gibson & Trnka, 2020). One of the criticisms of online therapy is whether therapeutic rapport can be built. On the contrary, a decade of research into online and teletherapy demonstrates that this criticism is not justified, and a positive working alliance can be built (Cook & Doyle, 2002; Hanley, 2012; Reynolds Jr et al., 2006; Simpson & Reid, 2014). The ability to be more novel in the approach to therapy may even facilitate stronger therapeutic rapport than face-to-face therapy (Kocsis & Yellowlees, 2018). Importantly, young people highlight that online therapy gives them more control over the tempo, intervention, duration and regularity of sessions (Hanley, 2012) and enhances their autonomy through seeking and receiving help how they want (Pretorius et al., 2020).

Research has also reported that many counselling micro-skills, such as open-ended questions, positive regard and summarising, are adopted and easily implemented online (Asri et al., 2022; Mallen et al., 2011). Furthermore, online counselling also uses micro-skills to help young people process and learn problem-solving and decision-making skills, which can be generalised over a lifetime (Hawke, 2017).

A unique aspect of online therapy is the use of emojis. Troiano and Nante (2018) discussed that emojis are used to allow for emotional expression online. Nusrat and Huang (2021) implemented two studies using emojis in text-based counselling. The first study with 111 undergraduate students (mean age of 20.8 years) demonstrated that concise texts with emojis lead to a more positive client experience. The concise text compared to longer texts contributed

to the perception that the therapist is willing to listen, and the addition of the emoji compared to texts without emojis resulted in the perception of the therapist being more empathetic (Nusrat & Huang, 2021).

Young people turn to social media for support

The experience of young people today is vastly different from the experience of young people even a decade ago. The evolving technological landscape of internet, mobile phones and other sources of connection enable new forms of communication and interaction, ranging from access to education to cyber-bullying (Kraft, 2006; Thomas, 2011). Many young people grew up with technology as the norm, so digital spaces feel comfortable and familiar (Greidanus & Everall, 2010).

In particular, young people spend more time on social media platforms than ever before, with 97% of young people using social media regularly (Woods & Scott, 2016). According to Anderson and Jiang (2018), 45% of young people state that they are online “almost constantly” with the most popular platforms for 13 to 17 years old’s being YouTube and Instagram with 85% and 72%, respectively. Many adolescents report beginning relationships with peers online, with 57% of US teens noting that they began friendships online (Lenhart, Anderson & Smith, 2015) and 25% of young people aged 10 to 17 had friendships that were solely based online (Wolak, Mitchell & Finkelhor, 2002). The development of online friendships has been demonstrated to be as meaningful as face-to-face friendships (Chan & Cheng, 2004; Yau & Reich, 2018).

With constant access to information and social media, young people inevitably use the internet to disclose distress and seek support (Robinson et al., 2016). The internet ameliorates previously mentioned barriers, such as providing anonymous, easy-to-access, 24/7, non-judgmental support (Daine et al., 2013; Robinson, Bailey, et al., 2016). Social media is used to exchange information and support with people sharing similar experiences of difficulties and distress (Lal, Nguyen & Theriault, 2016; Lerman, et al., 2017). Young people also report going online as a form of distraction or entertainment, a way to escape or feel numb, or use coping strategies such as online journals (Radovic et al., 2017).

Radovic et al. (2017) found that younger adolescents may engage in more risky or negative behaviours online compared to older adolescents, who seem more hesitant regarding the content they share online. Females appear to share more crisis posts on social media compared to males (Moreno et al., 2013). There is a paucity of research about how minority or indigenous youth use social media to disclose distress. Factors such as self-esteem, loneliness and depression have been found to be associated with increased frequency of social media use (Park et al., 2015). Moreover, it has been suggested that those who are most active on social media are those most in need of support, with studies showing adolescents experiencing high levels of psychological distress, unmet mental health needs, and suicidal ideation were more frequent users of social media (Radovic et al., 2017; Sampasa-Kanyinga & Lewis, 2015). However, most of these studies largely explored young people's online behaviour by studying the metric of frequency of use, which lacks depth into the complexity of how social media is used in practice.

Studies focusing on why young people disclose distress and suicidality on social media demonstrate diverse motivations. Young people reported benefits from sharing their emotions

online, such as receiving social support in the form of validation, help from peers, venting, or feeling visible (Moreno et al., 2013; Naslund, Grande, Aschbrenner & Elwyn, 2014; Radovic et al., 2017; Robinson et al., 2016; Singleton et al., 2016). However, young people also report that participating in conversations on social media regarding posts of distress or suicidality can be draining (Singleton et al., 2016). It also appears that young people select the social media platform they will use to disclose information based on what they are wanting to receive from the act of posting. Some young people reported wanting to share information with friends and family (Hausmann et al., 2017), while others wanted the anonymity that comes with some social media's ability to control who can read the post or the 'norm' of being anonymous (Andalibi et al., 2017; Singleton et al., 2016)

Overall, there is a paucity of research exploring young people's experience of using social networking sites when distressed (Singleton et al., 2016). An understanding of the experiences, emotional states and online behaviour of young people in distress is needed, especially when considering the near-universal use of social media by young people disclosing distress, suggesting that social media platforms may provide new opportunities for offering support (Naslund et al, 2017).

Instagram, identity and disclosures of psychological distress and suicidality

Instagram is a visual medium that involves the creation of a profile containing a username, biography, and profile picture (Meta, 2021). Users can decide whether they want their account to be public, where all content is accessible to anyone, or private, where content can only be viewed by those the user has added as followers. The user can then create content; the

main aspect of which a post is the image but can be accompanied by text and hashtags (Meta, 2021). Hashtags organise the content on Instagram and users can search hashtags to view all content that has been publicly posted with that hashtag. Instagram contains a private messaging function where anyone can message anyone, regardless of their privacy settings (Meta, 2021).

There is a good reason to prioritise research on Instagram, with over 100 million new posts per day and a rate of new users joining that outpaces Facebook, YouTube and Twitter (Chaffey, 2016). In New Zealand, Instagram is used by 71% of young people aged 18-24 years old (Smith & Anderson, 2018).

Online social identity becomes an extension of adolescent identity formation. Creating an online social identity can be defined as "online membership and belongingness of an individual to a social group in a particular digital world" (Subrahmanyam et al., 2011), and identity on social media contains both self-presentation and self-image (Frunzaru & Garbasevschi, 2016). On Instagram, this can look like interactions with others based on the number of followers or likes received, which might contribute to a sense of belongingness and support of the constructed social identity (Barker, 2012; Seibel, 2019). The more active a person is on social media, the more aware they are of their online identity and how to construct this identity to their liking (Seibel, 2019). Findings by Hakkenberg (2021) demonstrate that social connectedness is the most positive and significant influence on a young person's online social identity, which aligns with previous research on belongingness (Barker, 2012; McKay et al., 2005; Walz, 2009), and supports the IPTS model of suicide (Joiner, 2005).

Social network use can become problematic, and Dempsey (2022) found that different variables predicted problematic social network use. For example, fear of missing out had significant bivariate correlations with problematic Instagram, Twitter and Snapchat use. The fear of missing out can fully mediate social identity, and these relationships can further be moderated by the need to belong (Beyens et al., 2016; Duman & Ozkara, 2021), conceptualising that anxiety of social exclusion facilitates the urge to engage in online connection (Dempsey, 2022). It appears that the more online support an individual receives, the more severe their fear of missing out, leading to an increase in problematic social media use (Fang et al., 2020).

Disclosures about psychological distress and suicidality are occurring on social media platforms, such as Instagram. On Instagram alone, hashtags with #suicidal contain more than 2 million posts and #depressed contains more than 14 million posts. Findings from Brown et al. (2019) demonstrate the vulnerability of young Instagram users, with half of the 47 participants expressing acute suicidality during the interview, and 25% of these users had expressed this suicidality on Instagram. The majority of the participants (89%) in this study were female, which coincides with research demonstrating that females have a higher lifetime prevalence of mood disorders (Riecher-Rössler, 2017), are more likely to participate in online intervention (Crisp & Griffiths, 2014), and are more likely than males to participate in mental health research (Ellis et al., 2014). There is little information regarding males and Instagram mental health expression.

Images can be used as a part of the disclosure of psychological distress and suicidality (Andalibi et al., 2017). For example, some young people share sensitive and graphic images of NSSI on Instagram (Brown et al., 2018; Moreno et al., 2016). Research has found that

photographs posted to Instagram can have detectable markers of depression even prior to diagnosis (Reece & Danforth, 2017). These photos were more likely to be bluer, greyer, and darker, often having the photograph's light and colour filtered out. Users expressing suicidality can often be identified through their writing style, which illustrates a more depressogenic attribution style (Barak & Miron, 2005; Fekete, 2002; Kupferberg & Gilat, 2012) or heightened self-attention and isolation from the online community (De Choudhury et al., 2016).

A study conducted by Carlyle et al. (2018) found that suicide-focused posts on Instagram had significantly higher likes compared to posts that did not have suicidal intent. They concluded that Instagram is a channel for expressing suicidal ideation with the potential impact of normalisation and reinforcement of suicidal and self-harm intent. In the posts themselves, social support was seen in the form of supportive comments, with very few negative comments (Carlyle et al., 2018). However, no responses were from any mental health practitioners or institutions.

Instagram service users' experiences of psychological distress and suicidality have been subject to research, including investigating a user's posts, profiles and context (Fulcher et al., 2020; McCosker & Ysabel, 2021). A wealth of information regarding users, their online habits and their experience of a mental disorder can appear outside of the content they post. A user biography may include "Don't report, just block" which was often on profiles where the user posted potentially triggering content. Biographies may also contain information regarding the user's age, gender, online community affiliation (for example, 'days clean'), diagnoses or trigger warnings (Fulcher et al., 2020). Usernames also provide words related to mental health, such as "depressed", "bipolar", "and suicidal", which appear to relate to their mental illness as a part of

their identity or online persona (Feuston & Piper, 2018; McCosker & Gerrard, 2021). Hashtags are used to connect to the community they are promoting. For example, #depressed connected with a community that, through an analysis conducted by McCosker and Gerrard (2021), was found to be made up of recovery or 'sad aesthetic' content, memes, and real experiences. This research contributes to understanding how users communicate and share information with each other and their experience of mental health as shared on Instagram (McCosker & Gerrard, 2021).

Instagram as an organisation has responded to these disclosures of suicide and self-harm through their community guidelines, particularly under "maintain our supportive environment by not glorifying self-injury" (Meta, 2023b). Self-injury content can be reported by other users or detected by technology that moderators then see and decide whether the content should be removed, whether to contact the person to provide local support organisations or emergency services (Meta, 2022b). Between October and December 2022, five million posts of suicide and self-injury content were actioned (Meta, 2023a). Instagram includes taking action as removing content, covering content with a warning, disabling accounts or reporting to law enforcement (Meta, 2022a). Instagram also attempts to block hashtags related to content that may breach their community guidelines; however, young people revise the hashtags to continue the same community (Moreno et al., 2016). An example is when Instagram blocked #selfharm, the same community then developed #selfharmm and subsequently #selfharmmm when the earlier hashtags were blocked (Moreno et al., 2016).

Proactive outreach

Traditional mental health service provision and the discussion above regarding online interventions and support networks provide a form of intervention and support because the

young person is actively seeking support. These reactive approaches appear insufficient to support young people in distress fully.

There is currently no research that demonstrates how proactive outreach could intervene with psychological distress and suicidality which highlights an important area for mental health researchers and clinicians to begin to research so that any future practice can be evidence based and ensure efficacy.

However, proactive outreach has proven effective in other areas of healthcare, such as hard-to-reach populations in face-to-face interventions. Proactive outreach programmes are believed to be effective as they take intervention in communities where a need exists, reducing barriers (Root et al., 2022), inequities (American Diabetes Association, 2017) and overall economic costs of the disease (Yao et al., 2021). For example, HIV risk was reduced in people who inject drugs through street outreach, providing needle disinfection and HIV testing (Needle et al., 2005). Another example is indigenous health services that sent cardiac health practitioners went into communities, built relationships and administered portable interventions at people's homes in rural communities (Tibby et al., 2010). Proactive implementation of services has also been investigated in early childhood intervention with children with Autism Spectrum Disorder (ASD). Root et al. (2022) reported that reactive services were associated with outcomes such as escalated student behaviour, litigation and non-public school places. Proactive intervention with these children allowed for more specific school programmes, grants, behavioural plans and needs assessments. More effective proactive planning resulted in improved positive student outcomes and in long-term cost savings.

Social media offers an opportunity to transform proactive early intervention services. A study with 80 young people aged 12-21 used semi-structured interviewing to investigate social media and pathways to care for youth with various mood disorders in the early illness stage (Birnbaum et al., 2017). This study found the majority (63.6%) of young people found it acceptable for clinicians to proactively approach them via social media during early symptom onset. A total of 74.3% of young people liked the idea that professionals on social media could provide help or advice.

The new face of mental health support – a proactive online intervention

LFT was a non-profit charitable trust based in Aotearoa New Zealand. They were developed in 2016 by Zeal Education Trust and were supported by Vodafone Foundation New Zealand Technology Development Grants. LFT was developed following the identification of the above barriers to traditional mental health intervention and the existence of content indicating distress and suicidality on social media platforms. Specifically, LFT aimed to create an intervention with a mission to "take meaningful mental health help to people experiencing distress" (Live for Tomorrow Charitable Trust, 2022), addressing the difficulties that many young people report in accessing timely, youth appropriate, free interventions (Gibson et al., 2016). To address the many facets of universal, selected and indicated interventions (World Health Organization, 2016), LFT developed online health promotion campaigns, research, peer support school programmes and LFT chat. LFT chat was run by volunteers and paid staff who proactively reached out to those whose posts indicated distress. LFT chat was the "world's first proactive helpline supporting teens in crisis on social media" (Live for Tomorrow Charitable Trust, 2022), distinct from helplines offering reactive support, which wait for service users to

call. LFT offered a person-centred brief intervention through the social media platform Instagram. Counsellors comprised of paid staff and volunteers who underwent an initial 30-hour training course in counselling micro-skills, crisis management skills and brief intervention. Volunteer counsellors were supported on shifts by a supervisor.

Due to the nature of Instagram, LFT chat could be provided to anyone posting content indicating distress or suicidality worldwide. Initially to find users to reach out to, LFT supervisors would manually search through hashtags on Instagram (such as #suicidal, #kms, #depressed), searching for recently posted content that indicated distress or suicidality. LFT then developed a social listening tool with an algorithm that searched through these hashtags. These hashtags were based on internal research conducted by LFT which explored which hashtags were most likely associated with content that indicated distress. The social listening tool would then create a list of posts that shift supervisors would screen before reaching out to the user. A supervisor or volunteer would then review the post and direct message the user who had posted. As Instagram is an international platform, these posts could have been from anywhere in the world; however, LFT would only reach out to posts containing English. This message would typically indicate that the counsellor had seen their post and offered to listen. If the user accepted the counsellor's offer, the counsellor would seek to engage the user in an interactive crisis-counselling conversation drawn from strengths-based, person-centred and peer support approaches (Live for Tomorrow Charitable Trust, 2022). This entire interaction took place through written chat in the private messaging function of Instagram. According to LFT's Annual Report 2019, conversations occurred with service users across 55 countries and ranged from

approximately 15-120 minutes with some conversations carrying on intermittently across several days (Live for Tomorrow, 2019).

LFT chat no longer operates due to funding constraints whereby the decision was made to redirect funding to target New Zealand youth. This highlights a particularly nuanced difficulty with intervention online that is boundaryless and the inability to only intervene in local areas. Therefore, as recommended by the WHO in their LIVE LIFE approach (World Health Organization, 2022), whole government approaches are needed for early intervention and international suicide prevention approaches need to acknowledge the difficulty of procuring and maintaining funding for online interventions.

Current research

The above literature review demonstrates that it is apparent that youth underutilise current formal support services but desire support for their psychological distress and suicidality. There is a trend of young people seeking support online and disclosing their psychological distress and suicidality on social media platforms. Online interventions offer scope to develop appropriate services for young people that address barriers to help-seeking and incorporate the technology that young people are already using (Gibson, 2021; Gibson & Trnka, 2020). However, even online interventions continue to operate from a reactive, traditional approach requiring the young person to reach out for support. There is no research on proactive reach-out-based mental health policies or interventions. This research will be the first of its kind to report on the experience of young people who engaged with a proactive outreach mental health intervention. This research focuses on the young people and the counsellors involved in this

novel, proactive online intervention. Exploring these experiences will be valuable understanding what young people identify as their experience of distress and suicidality; the experience of young people in a proactive online intervention; exploring how counsellors engaged young people in a proactive online intervention; and exploring how risk assessment is conducted in an online intervention.

Chapter Two: Methodology

"how do you stop the brain from going down the rabbit hole of thoughts?"

(Young Person 7)

This thesis aims to explore the experiences of young people, their interaction with counsellors, and how counsellors operate through the proactive online intervention, Live For Tomorrow (LFT). I begin this chapter by outlining the social constructionist epistemology that underpinned this research. I then discuss the methodology used to address the aims of my research, a reflexive thematic analysis. Lastly, I detail important ethical considerations for this research. Due to the inclusion of methods sections in Chapters Three and Four, the articles submitted for publication, there may be some repetition. However, this chapter seeks to discuss the theoretical frameworks and process of conducting the research in more depth than what can be achieved in word-limited publications.

Epistemological framing

Epistemology describes the positioning of research within a specific set of assumptions and ontology grounds the beliefs that the researchers themselves hold about knowledge and reality (Crotty, 1998). Epistemological grounding provides the base for all research and guides methodology and analysis. Discussing my theoretical and epistemological positioning throughout this project aligns with good practice for psychological research (Crotty, 1998). This research aimed to capture young people's engagement with a proactive online intervention and consider their retrospective evaluation of the service. As such, the epistemology is one which centres on people's own experiences and meaning-making. (Edley, 2001). This approach fits with the aims

of the project by prioritising an individual's meaning-making process and acknowledging that there will be a range of perspectives (Patton, 1990). People make meaning through their own subjective experiences and from the social contexts in which they exist (Edley, 2001). A social constructionist approach states that our understanding of the world and perceptions are developed in a social context (Gergen, 1999). This signifies that our history, social norms, culture and politics influence and impact our lives (Berger & Luckman, 1966). As such, social constructionism allows for the existence of multiple truths (Gergen, 1999). Social constructionism also recognises the power of the dominant narrative, where perspectives and decisions often reflect those who hold positions of power, making it challenging to explore alternative constructions of those who hold less power in social contexts (Gergen, 2001). This epistemology aligns with the research and aims I am exploring in this thesis. I recognise that young people most likely have different narratives to myself and to the dominant psychological research base on their experiences of psychological distress and suicidality. As such, it was important for me to develop a methodology that allows for the expression of young people's experiences.

Qualitative research is a good fit with a social constructionist lens as it seeks to understand the human experience and their interpretations (Creswell, 2008). This approach leads to a more in-depth exploration of an experience, generating more nuanced and rich data (Merriam, 2002). Qualitative methods also allow for the prioritisation of young people's perspectives by providing data grounded in their language and opening up new opportunities for understanding (Willig, 2013). In this research, it is important to note that the project is based in a social-cultural context of a digital environment.

Study Aims

Through analysing the transcripts of an intervention and feedback conversation between a young person and a LFT counsellor, I aimed to gain an understanding of the following: what young people identify as their experience of distress and suicidality; the experience of young people in a proactive online intervention; explore how counsellors engaged young people in a proactive online intervention; and to explore how risk assessment is conducted in an online intervention.

Researcher reflexivity

Reflexivity as a researcher is essential when conducting thematic analysis, whereby the analysis of the data is subject to the process and experience of the researcher (Braun & Clarke, 2019; Russell & Kelly, 2002; Watt, 2007). My choice of thesis topic, research practices and writing process are all shaped by my values, beliefs and experiences. By acknowledging and considering these experiences, I can provide context for this study and describe my process as a researcher.

My interest in psychology as a career stems from my own mental health difficulties as a young person and supporting my friends who also had mental health difficulties. I was fortunate to have a supportive family and friends who helped me through these particularly difficult moments of my life. I also utilised local helpline services, particularly The Lowdown, a New Zealand-based helpline that offered both phone and text-based support. In particular, I remember calling the service and talking to a volunteer, and they then text me the next day to check-in. As a young person, I never forgot the kindness and care of a complete stranger who, to my interpretation, went above and beyond after that call to then reach out to me the following day.

My family values and these experiences drew me towards a career that involved helping people. I entered university training in nutrition and psychology before dedicating myself fully to the psychology pathway. Before my clinical training, I worked with children and adolescents in both a developmental capacity as a behavioural therapist and as a crisis counsellor and supervisor at LFT. My passion for the work at LFT and the real-life impact of what I was seeing as a counsellor and supervisor led to my desire to complete this piece of work. My academic experience and training as a Clinical Psychologist then allowed me to continue developing my knowledge, building on my strength as someone with lived experience and supporting young people in my previous roles. I was also aware that the experiences of today's young people differ significantly to my own; even though there is only a decade of an age difference, the landscape of technology has changed the world that young people inhabit. I was no longer employed at LFT when I conducted this research; however, the experience I had in my role there personally and professionally will have influenced the research I have produced.

As someone who had experience as a support person for others, a history of my own mental health difficulties and experience within LFT, it was essential to continuously be reflexive throughout this research. A value of mine and one of the driving values of LFT focuses on honouring the young person's voice and story. Therefore, I seek to hold the tension between psychological theory and knowledge and young people's perspectives in this thesis. In line with this, both the young person and the counsellor's words are used throughout the analysis and at the start of each chapter to position these results and my thesis.

Methods

Data collection

This thesis aimed to explore the young person's experience of distress and a proactive intervention in an online context, how counsellors engaged young people in a proactive online intervention, and how risk assessment was conducted in this context. Therefore, the experiences of distress and suicidality were focused on for this thesis.

The data that were collected consisted of routinely collected transcripts of counselling and feedback conversations where users were asked to provide feedback on their experience. Transcripts were chosen as they offer a real-time account of how young people communicate in times of distress or crisis. LFT collected and retained these transcripts as part of their standard audit practices. The counselling and feedback conversations transcripts occurred 1st of March 2019 to 29th of February 2020. An LFT staff member anonymised and de-identified these transcripts before being provided to the researcher. LFT was compensated for their staff's time to anonymise and de-identify the transcripts. LFT also provided descriptive statistics of service use to describe the engagement of young people with the service, including the number of users responding to a reach-out message and engaging in a conversation, the average duration of a conversation and the average number of responses in each conversation.

The inclusion criteria were (a) counselling and feedback conversations were with a user aged 13 to 25 years old; (b) counselling and feedback conversations contained a form of 'risk assessment'; (c) the transcript comprised both the counselling intervention and a follow-up chat to obtain feedback of the young person's experience of the counselling intervention. These criteria resulted in a total of 35 transcripts, which varied in length. The final data set contained

274 pages and 79,155 words. Due to the nature of Instagram and the fact that I was limited by the data that had been collected by LFT, detailed demographic information about the young people was not obtained. However, LFT had gathered the young person's age in the feedback conversation, which based on the age inclusion criteria, demonstrated a range of 13-25 years with a mean age of 16.8 years (standard deviation of 3.6 years). LFT only conducted reach out messages and counselling English and therefore transcripts could have been from any young person in the world who was posting and could speak in English.

Ethical considerations

This study was approved by the Auckland Health Research Ethics Committee (AHREC) (Ref: AH2840). Informed consent was sought from LFT for access to their routinely collected standard audit data and their consent to be named in this research. Appendix A contains the Participant Information Sheet provided to LFT and Appendix B contains the signed Consent Form from LFT for participation in this research.

This research carried few risks as this research used transcripts that are routinely collected standard audit data and descriptive statistics about the service. However, there are some ethical issues to consider. I was aware of the need to deal with this data sensitively to protect the young people and their disclosures because of the nature of distress and suicidality that was discussed in these transcripts. As I work from a framework that centres young people's voices, I have used direct quotes from transcripts; however, I have ensured that these have not defined or drawn attention to any individual's unique experience.

Furthermore, informed consent for the use of these transcripts was sought from LFT instead of the service users. In the feedback conversation, LFT asked the users if they could use

these conversations for research purposes. All of the transcripts included in this analysis were young people who provided this consent. However, consent was not specifically sought for this research or the publications. After a discussion between myself and LFT management, we collaboratively decided that re-contacting service users about conversations that may have occurred at any time in the last two years could potentially be harmful. LFT have a strict policy of not re-contacting users who have engaged with their service in order to respect their privacy and avoid re-triggering distress. Furthermore, as the transcripts have been anonymised and provided by LFT, they can therefore be considered audit data.

As an ethical consideration, it is important to note that I used to volunteer and was then subsequently employed by LFT as a supervisor for one and a half years before moving on to another project within the parent organisation. At the time of this research, I was no longer employed by LFT. I consider my previous involvement with LFT to allow for a more in-depth understanding of the organisation, its processes, the nuance of implementing a proactive online intervention and of the users themselves. However, I do note that my positive experience as a counsellor and supervisor informs my view of the service. Therefore, throughout the project, I continued to reflect with my supervisory team regarding the analysis to ensure it was congruent with the data, while recognising my own experience will influence the analysis.

Data analysis

As my research aims to better understand young people's experiences of distress and a service, a reflexive thematic analysis was used. This form of analysis was consistent with the social-constructionist epistemological position (Braun & Clarke, 2006). Data analysis was conducted using NVivo 12 Pro.

In my research, I followed the six phases of reflexive thematic analysis as defined by Braun and Clarke (2021). Although I have listed these phases chronologically, I moved back and forth between phases throughout the analysis of the transcripts. I initially approached the transcripts through a data familiarisation phase, which involved reading and re-reading the transcripts and then writing familiarisation notes of initial trends and potentially interesting quotes. During this time, I also diarised my thoughts and feelings regarding the data. This was followed by systematic data coding, where key labels were drawn from the transcripts. During this stage, I used both NVivo to track the codes in relation to which transcript they referred to and an Excel spreadsheet to draw the iterations of codes together. Initially, there were hundreds of codes to ensure all potentially significant information was gathered. I also generated lists of quotes and extracts to the codes to remain true to the young person's experience with minimal changes to any grammar or spelling errors. I then moved on to phase three and generated themes, searching the codes for similarities and differences. I developed many mindmaps using NVivo and hand-drawing to recognise and understand the relationships between these codes. During this time, I noted it was difficult to let some codes go when they felt salient to me but did not fit into the overall analysis. I was also reflecting that throughout this process, it was my first opportunity to conduct a qualitative study and hence when I had a solid enough framework, I consulted with my supervisory team as a part of the collaborative analysis. This consultation process also allowed for me to be reflexive and collaborative in achieving a richer interpretation of the data. Phase four allowed for the reviewing of potential themes. At this stage, I employed a young person who had lived experience of distress and suicidality and was a user of multiple social media platforms, including Instagram. This young person sat alongside me as we reviewed the data, themes and interpretations, providing my own reflexive commentary on the process of

analysis underlying this data. This process was important to ensure that youth's voices were prioritised in the themes and quotes. Phase five focused on defining and naming the themes, where based on conversations with the supervisory team and the young person, it was highlighted that using the young people's quotes was an integral part of honouring their voices and experiences alongside honouring the core premise of qualitative research. I had entered this research with the idea that I wanted to publish the results. As I was analysing both the young people's responses and the counsellor's responses, I realised the complexity of attempting to condense the richness of both of these experiences into one article. I initially wrote up the results as one document before changing to separating out the two experiences and writing up two separate articles to submit for publication: one based on the experiences of the young person and one based on the counsellor practices. I spent a large amount of time on the narration and order of the themes, to tell a story of these experiences in a logical and meaningful manner.

Assuring quality in qualitative research

As qualitative research is inherently influenced by the researcher conducting it, this can often lead to criticism regarding the validity and reliability of the results (Liamputtong & Ezzy, 2005). However, qualitative analysis is about developing an in-depth understanding of a dataset instead of generalisable findings (Merriam, 2002).

As such, in qualitative research, transparency of the analytic process allows for the results to become more trustworthy. In this project, I have reflected on my decision-making, the involvement of others, and my experiences that influence the results. Supervision with my supervisory team was composed of three researchers, two of whom are clinical psychologists, which allowed me to reflect on and challenge my views. This dialogue contributed significantly

to my reflexivity, which I have previously discussed, and it constitutes an important part of the process of assuring quality. Furthermore, I kept an audit trail of the different codes and themes throughout the data gathering, analysis and report writing phase. This included discussions with supervisors and the young person consulting on the project and my own decision-making that led to the end result of these themes. These processes ensure fidelity through ensuring that results of the analysis accurately reflect the data in the transcripts (Hill, 2005).

Preface to findings

Chapters Three and Four in this thesis discuss the findings of the overall research project. Each chapter focuses on a different component of the analysis. Chapter Three details the young people's experience of a proactive online intervention on Instagram, while Chapter Four focuses on counsellor practices and risk assessment in a proactive online intervention on Instagram. Each of these chapters was written for publication as a journal article and has been submitted to different journals. As such, these pieces of research are co-authored by my supervisory team; however, I was the lead researcher and main contributor of the articles.

It is important to note that although these chapters have been separated as findings, they are based on the same dataset. The conversations between the young person and counsellor were interwoven and inherently linked. It is important to look at both sides of the conversation to fully understand human interaction, providing emphasis to the meanings, experiences and views of those involved (Pope & Mays, 1995). This thesis seeks to honour both of those experiences and meanings.

Chapter Three: Young people's experience of a proactive online intervention on Instagram

"I was happy when someone actually reached out to me especailly when I needed it the most. I had felt so lonely but when you messaged me it felt good to have someone to talk to. You helped me feel like people do actually care."

(Young Person 6)

Chapter Preamble

The following chapter describes the data analysed from the perspective of the young people who are in conversation with an LFT counsellor via the Instagram direct message function. This analysis focused on young people's responses in the counselling and feedback interaction. This article sought to contribute to the field by demonstrating similarities in offline and online presentations of distress, suicidality and coping methods among young people. It also sought to understand the experience that young people had of being proactively reached out to on a social media platform and offered help. Overall, the aim is to provide a greater understanding of young people's experiences, their expression online and the experience of being reached out to by LFT.

This article is a co-authored paper which has been submitted for publication to CRISIS: The Journal of Crisis Intervention and Suicide Prevention journal.

Background

Psychological distress is often defined as a state of emotional suffering with non-specific symptoms of stress, anxiety and depression (L'Abate, 2012; Viertiö et al., 2021), impacting roughly 25% of young people (Brennan et al., 2021) but can reach higher levels in populations exposed to more stressful external circumstances (L'Abate, 2012). Psychological distress can result from economic and lifestyle factors, school, family and friend relationship difficulties (Sweeting et al., 2010), as well as adverse life experiences like abuse (Jackson & Finney, 2002). High levels of psychological distress may indicate the presence of mental disorders e.g., depression and anxiety (Viertiö et al., 2021). Both psychological distress and the presence of mental disorders are strongly related to suicidal ideation (Beautrais, 2000; Rainbow et al., 2021). Suicidal ideation affects 14% of young people each year globally (Biswas et al., 2020) and it is estimated to double the risk of suicide attempt (Ribeiro et al., 2016). Higher levels of suicidal ideation result in lower help-seeking intentions (Carlton & Deane, 2000). Intervention for psychological distress is an early intervention opportunity for suicide prevention (Rainbow et al., 2021).

Barriers to effective help-seeking include shame, mental illness stigma, previous negative experiences, beliefs that help is undeserved/ineffective, and financial difficulties (Bruffaerts et al., 2011). Young people experience additional barriers such as confidentiality from parents, lack of control and agency, and inflexibility of services (Gibson et al., 2016). Additionally, many services are not adapting to what young people want from mental health support, resulting in poor use and engagement (Gibson, 2021).

Young people increasingly use social media to seek support when distressed. Support is often sought through posting on social media or message boards, and communities form around peers who have had or are having similar experiences (Fergie et al., 2016; Webb et al., 2008). Young people use self-disclosure to promote a sense of community and relationship among peers, who are described as safer than professionals (Tichon & Shapiro, 2004). Recent studies have demonstrated that those with higher levels of suicidal ideation prefer online help-seeking (Mok et al., 2021; Wilks et al., 2018) and that young people value social connectedness, validation of their experience and information, such as coping strategies and resources from this online support (Prescott et al., 2017). However, there is a lack of high-quality evidence for the efficacy of online peer support (Ridout & Campbell, 2018) or self-disclosure on social media (Luo & Hancock, 2020) for reducing mental distress.

To date, online support, much like helplines, has been conceived in the traditional sense as the provision of support if a young person actively seeks out that support when distressed. However, as described above, young people are seeking informal support that grows organically online. For example, a search of #suicidal shows over two million posts and #depressed more than 14 million posts. Proactively engaging with those who post content that indicates distress or suicidal ideation is an innovative approach to intervention.

Proactive outreach has been used in other areas, for example, for people who inject drugs, where HIV risk was reduced through providing needle disinfection and HIV testing (Needle et al., 2005) and for proactive outreach to indigenous communities for cardiac interventions (Tibby et al., 2010). Proactive outreach delivers intervention where a need exists, reducing barriers

(Root et al., 2022), inequities (American Diabetes Association, 2017) and economic impacts (Yao et al., 2021).

A proactive approach to intervening with those experiencing distress and suicidal ideation online has yet to be examined and this research is the first to explore the experience of young people receiving this approach.

Methodology

Aims

We explored the young person's experience of distress and a proactive intervention in an online context.

Study setting

Live For Tomorrow (LFT) is a non-profit run from Aotearoa New Zealand. LFT chat was a component of their work which was the “world's first proactive helpline supporting teens in crisis on social media” (Live for Tomorrow Charitable Trust, 2022). LFT chat was a proactive, person-centred brief intervention which operated through the social media platform Instagram, using an algorithm to search hashtags that indicated distress (such as #suicidal, #kms, #depressed). The algorithm produced posts and counsellors used direct messaging to contact the user who had posted, offering to listen. Posts were only reached out to if they were in English. Counsellors were both volunteers and paid staff who underwent training in counselling micro-skills, crisis management skills and brief intervention for this role.

Ethical considerations

This study was approved by the Auckland Health Research Ethics Committee (AHREC) (Ref: AH2840). Informed consent was sought from LFT for access to their routinely collected standard audit data and their consent to be named in this research. To protect the identity of the users, conversations were anonymised and de-identified by LFT staff prior to being provided to the researchers. LFT was compensated by the researchers for their staff's time to anonymise and de-identify the transcripts.

Sampling procedure

We used routinely collected transcripts of the online chats between 1 March 2019 to 29 February 2020. These were anonymised by LFT before being provided to the researcher. The inclusion criteria were (a) online chat with user aged 13 to 25 years old; (b) online chat contained a form of 'risk assessment'; (c) the online chat contained comprised both the counselling intervention, and a follow-up chat to obtain feedback of the young person's experience of the counselling intervention. A total of 35 transcripts were obtained, which varied in length, with the final data set containing 274 pages and 79,155 words (Malterud et al., 2016). Detailed demographic information about the young people was not obtained; however, their mean age was 16.8 years (standard deviation of 3.6 years).

Data analysis

A reflective thematic analysis (Braun & Clarke, 2019) was used that took a social constructionist approach, acknowledging the perspectives of the researchers and the young people, and accepting that distress and suicidal ideation may take on different meanings in different population/cultural groups and at different times across a person's lifetime (Marsh,

2015). Data analysis was led by the first author using NVivo 12 Pro, assisted by co-authors and a young person with lived experience, using a process of consensus (Hill, 2015). Recognised strategies for assuring quality, including reflexivity, were used (Morrow, 2005), with discussions between authors about interpretations and acknowledgement of the first author being: 1) of New Zealand European ethnicity; 2) having lived experience of using helplines for mental health difficulties, and 3) previously employed as a counsellor and supervisor for LFT.

Findings

Table 1. *Overview of themes and subthemes*

Themes	Subthemes
Being alone with distress: *"This life is really torturing me"*	• Difficulties in relationships • Experiences of abuse • School difficulties • Invalidation when reaching out for support • Isolated from others • Feelings of hopelessness
Experiencing suicidal distress: *"I really do want to die"*	• Overwhelming emotions and life experiences • Plans of suicide attempts • History of past attempts • Sense of burdensomeness
Managing distress: *"it's the only thing that's keeping me sane inside"*	• Keeping emotions bottled up • Using distraction to cope • Using self-harm to reduce suicidality • Seeking help from others • Hope for the future
The culture of young people's distress online: #mentalhealth on Instagram	• Using Instagram to express distress • Anonymous and multiple accounts • Curated identity around suicide • Hashtags to connect to similar communities • Creating content for disclosures and connection • Instagram algorithm provides increasing suicidal content • Instagram removing content is invalidating

Mutual support for distress: *"helping each other out & being a listening ear for one another"*	• Online friends are helpful • Letting each other know they are not alone • Supporting others provides a sense of purpose • Helping others can be difficult
Finding help with distress: *"Being reached out to meant that I mattered"*	• Reach out is unexpected • Reach out made them feel special • Someone listening reduced isolation • Intervention stopped them from acting on self-harm or suicidal thoughts • Being online ensured confidentiality • Online intervention offered relief

Being alone with distress: *"This life is really torturing me"*

Young people who engaged in this intervention described difficulties in their relationships with parents, friends, partners, and experiences of abuse and/or school difficulties that contributed to their distress, "*most of my problems are caused by people at school, and definitely family*" (YP56). These difficulties were compounded when young people would try to reach out for support, "*they get annoyed and say they're busy*" (YP13), while others felt the need to keep their experiences a secret, "*I feel like I can't tell any of my friends about [this] because I feel like they would think I was insane* " (YP46).

These experiences led to a sense of "*I don't really have anyone tbh*", and isolation that was described as continuous "*my whole life*" (YP32), and inevitable "*I'll be just fine ..I have to ..after all I've nothing else but me*" (YP8). This sense of isolation was evident when young people reported having people in their life but having no-one who cared for them, with their distress met with indifference, abandonment or minimisation, "*She probably thinks I'm just trying to be dramatic or trying to get attention. She always thinks that when "I'm acting sad*"

(YP54). An accumulation of difficult life experiences and isolation led to young people describing that "*everything hurts physically and emotionally*" with overwhelming physical sensations "*like someone is holding and squeezing on my heart too tight*" (YP58) and a "*never-ending*" (YP10) sense of hopelessness and emptiness.

Experiencing suicidal distress: *"I really do want to die"*

Sixteen young people who engaged in this intervention disclosed suicidal ideation, "*Everything's been going wrong now I just feel dead inside*", where life experiences and their emotions were "*unbearable*" and "*just getting worse*". The possibility of their distress increasing in the future made suicidal thoughts stronger, and "*constantly going through my head*" (YP44) with plans to "*cut too deep*" or "*just overdose*" and a history of past attempts, "*I tried a lot of ways to die before*" (YP30). Often a strong sense of *"I don't want to be a burden :("* was described that would stop them from disclosing their suicidality to others. This burdensomeness appeared to come from a place of empathy for others *"I try to stay positive and be her light as much as possible tho so I don't do that to her"* (YP7), or from past experiences where they had been made to feel like a burden, *"I've told some close friends but they just tell me to stop and make me feel bad bc it hurts them too"* (YP9).

Managing distress: *"it's the only thing that's keeping me sane inside"*

Young people who engaged in this intervention identified different methods to cope with their distress, *"I keep it bottled up"* (YP17) or by distracting themselves *"anything to get my mind off it"* (YP10), using music, drawing, drinking or helping others. Others identified managing their distress by using self-harm, *"I release anger by cutting myself"* (YP9). Young

people described the calming effect of self-harm or using self-harm as punishment, as well as using it to stop themselves from attempting suicide, *"I find cutting a way to calm down the voices in my head telling me to die"* (YP40). Young people discussed good experiences of when *"I sought help"* from professionals, friends and family as well as from their Instagram friends where they gained a sense of connection from having *"someone that they can relate to… Cause we actually understand what's going on"* (YP30). Lastly, one user described that *"I have hope I'll get better"* (YP19) concerning themselves and the future and this drove their ability to cope, *"it's hard but I know I'll make it"* (YP19).

The culture of young people's distress online: *#mentalhealth on Instagram*

Results suggested that young people saw Instagram as a key site for expressing their distress but also recognized the challenges of using social media in this way. They described having alternative accounts to avoid *"giving away my identity"* (YP41) or to *"rant and express my emotions and help connect with others."* (YP54). These accounts are curated around a username usually containing words like 'suicidal', 'depression', 'hate', 'nobody' etc and posts that use *"different hashtags to find others and see other posts like mine"* (YP21). Others described having *"content creator"* accounts, posting content containing suicidal or self-harm memes or disclosures. They described creating content to *"help raise awareness for depression"* (SU26) or *"in the hopes that I can help anyone who needs help"* (YP35).

Young people described the community as *"very friendly"* (YP39) but that their distress is reinforced through continued exposure to depressive and suicidal content, *"if you like sad posts ur explore page is gonna pop up more that kinda posts"* (YP19). Within this community, common statements like *"Block don't report"* are written in the user's bio to prevent their content

being reported and subsequently taken down or deleted by Instagram, *"my other account got deleted was because I was talking about cutting"* (YP46). Young people describe this process of reporting and deleting as *"cold"* where *"mental health on Instagram is basically thrown under a rug"* (YP45). YP32 stated, *"I feel it would be more effective if instead of banding [banning] and or deleting, they would just simply get someone with an acc like yours or someone who helps to talk it out with them and see if they can help"*. Others saw banning and removal of content as having *"a negative effect on the person trying to reach out"* where *"hiding it makes it feel like it's a taboo subject"* (YP31) and that *"Insta has to be proud they finally talk!"* (YP20). Others talked about *"kinda understanding that some posts may be triggering"* (YP39) but that there was a double standard where *"Instagram consistently highlights underage girls posting nudes/bikini pics"* while *"mental health is either flagged or taken down consistently"* (YP45).

Mutual support for distress: *"helping each other out & being a listening ear for one another"*

Many young people who engaged in this intervention talked to their *"online friends"* to help themselves process their difficulties and to help others. They stated they would help by *"Creating content"* to *"post whatever I think will get me through the day and what might help others"* (YP46). They described this help as *"letting them know they are not alone"*, and that they did not want others to feel the same way. They described a sense of purpose as *"helping others also helps me"* and giving back to others led to feeling better about themselves and their lives. However, they also described that *"helping others can be hard sometimes"* with frustration when someone did not listen or want to change or take advice. Helping was particularly difficult when others were suicidal or had challenging stories, and this could impact negatively on the young person, *"sometimes I feel really bad bc of their problems"* (YP57). Helping others was

described as painful when *"the exchange of caring isn't mutual. Like I'd walk through hell for someone but they wouldn't even ask if I was alright"* (YP41).

Finding help with distress: *"Being reached out to meant that I mattered"*

When LFT counsellors proactively reached out to young people, they described this as *"unexpected"* but made them feel *"important like I was someone special* 💔*"* (YP45), which had a flow-on effect on their future help-seeking, *"there is help out there"* (YP60).

Young people who engaged in this intervention reported that it was important to have *"Someone who listened to me"* (YP21) because it reduced feelings of isolation and was *"the reason I'm not cutting right now"* (YP9). A conversation where *"I could say whatever without being judged"* (YP40) online was helpful, *"having instagram like this can help me as i can say my thoughts"* (YP39). Being online was perceived as ensuring confidentiality where counsellors *"won't spill anything to anyone"* (YP17), highlighting this as important for young people due to past betrayals of their confidence or fear of others finding out, *"the last time I told someone something everyone found out so ive been hesitant ever since"* (YP44). Users also described interaction with counsellors as *"It showed me the way"* (YP51). Outcomes from the interaction included encouraging reframing, *"I don't really blame myself for everything anymore* 😊💔*"* (YP48), providing support and psychoeducation, *"started to try to control my overthinking, got back on meds..."* (YP8), and encouraging them to reach out in real life, *"I've been more confident about talking to my parents about my problems and what I'm feeling"* (YP54). Overall, *"A big weight was lifted off of my shoulders"*.

Discussion

The current study aimed to explore the experience of young people's distress and a unique proactive online counselling service. This is a novel study because LFT is the first of its kind in the world. These results were based on the young people who engaged in this intervention. The six key themes highlighted the experience of distress and suicidality, managing the distress, the culture of distress online, getting support from peers and finally, someone reaching out in a non-judgmental and confidential space as valued and important in the young person's recovery.

Young people discussed how their distress-related needs were not being met in their offline relationships and infrequent validation from their help-seeking attempts. Having the ability to post, share and form a community around their distress on Instagram was described as a way of meeting these needs. This community enabled young people to connect with others who had similar experiences. It also led to the opportunity to help others, which was perceived as helpful as they were able to process their own emotions. However, it was also evident that developing the identity of the *"helper"* meant that the young person was not able to resolve their difficulties, often contributing to the maintenance of their distress. This pattern of behaviour has been termed 'pathological altruism' by Kaufman and Jauk (2020).

This research explored suicidal expression and communication online. Young people described their experience of suicidal ideation in response to overwhelming distress, with strong feelings of burdensomeness, hopelessness about the future and the desire to disappear or die. Within Instagram; however, suicidal ideation appeared as an identity, where the young person's page, name, biography, tags and posts were oriented around suicide. Their followers and the

pages that they followed were similar, creating what appeared as a curated identity around suicide. At the time of writing, there were over two million posts under #suicidal on Instagram. Other apps and sites like TalkLife, Reddit Suicide Watch, Tumblr and TikTok have their own "communities" of users expressing suicidal ideation. This curated identity introduces elements of suicidal content being positively reinforced. A study by Carlyle et al. (2018) found that suicide-focused posts on Instagram had significantly higher likes compared to posts that did not have suicidal intent. Recovery is not encouraged as this requires the young person to no longer create content for their page and lose their followers and profile (Fulcher et al., 2020). This belonging and sense of community on Instagram may unintentionally increase a sense of being isolated in the offline world when that feeling of your posts being liked, others reaching out to you and having friends with similar difficulties is not replicated. Furthermore, when content or profiles created as an expression of identity are subsequently banned or taken down by Instagram, the young person can perceive this as further rejecting and isolating.

Online interventions are increasingly popular and effective among young people (Das et al., 2016; Ridout & Campbell, 2018). However, the existing reactive help-seeking model is not currently reaching young people who do not use mental health services, with only 15-36% of adolescents with mental health difficulties receiving treatment (Costello et al., 2014; Sadler et al., 2018). Young people repeatedly highlighted the value of being reached out to by someone, which spoke to their sense of being valued and that someone cared, often perceived as missing in their offline lives.

A key limitation of this study was that data were extracted from transcripts and not interviews, limiting the exploration that could be conducted. The transcripts ranged in different lengths. LFT gathered feedback on their service six months post-intervention, which could have affected recall. Furthermore, LFT gathered this feedback, which may have influenced the young person's ability to provide honest feedback. This study's strengths were that the service's nature allowed the transcripts to be from any country where the user could speak English, increasing external validity. The study also utilized a youth adviser to ensure that the voices of young people were maintained throughout the data analysis.

Conclusion

This study provided important insight into an innovative, proactive approach to mental health intervention on Instagram, how young people experienced this intervention and what is contributing to young people's distress and suicidal experiences. This study found that young people are experiencing a large volume of difficulties and use many ways to cope but turn to Instagram due to its ability to meet some of their needs that are unfulfilled in offline life. This includes being able to curate an identity online, being part of a community and being able to express, anonymously, their thoughts and feelings and to help others in that community. Importantly, this research shows the need for proactive online services for young people, which provides the young person a sense of feeling cared for, and which lends itself to a non-judgmental, confidential space to disclose distress. Services like LFT have an important place in the range of services that must be available to young people in distress.

Chapter Four: Counsellor practices and risk assessment in a proactive online intervention on Instagram

"You have been really great to talk too. There sounds like there is so much going on for you but my favourite thing that you said about yourself tonight (might not be night where you are) is that you believe in your ability and strength. I think that is an amazing thing and I really hope things start to get better because you really do deserve for them to 💛💛*"*

LFT Counsellor

Chapter Preamble

The following chapter explores the data analysed, focusing on the counsellor's interaction with the young person. This article sought to contribute to the field by demonstrating how counselling micro-skills can be translated to an online space, with additional nuances that the digital world affords. It also sought to understand how counsellors relate to the young person and how risk assessment is conducted online. Overall, this provides a greater understanding of how LFT was able to implement a proactive online intervention.

This article is a co-authored paper that has been published in JMIR: The Journal of Medical Internet Research. This article received review feedback and suggestions as a part of the publication process. As a part of this feedback, I also went back and reflected on some of the results and subsequent discussion points and noted how my own experience as a counsellor and supervisor had impacted these sections. In particular, in the discussion, I had gone beyond what the results illustrated as I had pulled on my own passion for the work that LFT had done and my experiences in counselling conversations. After some reflection and supervision, I was able to see clearer connections between the results and discussion points. This required rewriting parts

of the discussion to ensure that it adequately reflected the results obtained from the transcripts. These changes have been integrated into the below article and have allowed me to grow in my reflexivity and practice as a researcher.

Introduction

Prevalence of suicidality in young people

Suicide is a global phenomenon and was the second leading cause of death among those aged 15-29 in 2019 (World Health Organization, 2019). Approximately 222,093 young people aged 10-29 died by suicide in 2019. For each of these young people who died by suicide, it is estimated that 20 others may have attempted suicide (World Health Organization, 2019). Suicidal ideation is defined as the consideration of or desire to end one's own life (Cha et al., 2018). Suicidal ideation affects 14% of young people each year globally (Biswas et al., 2020), and it is estimated to double the risk of suicide attempt (Ribeiro et al., 2016). Young people have higher levels of suicidal ideation than adults and at the same time, have lower levels of help-seeking behaviours (Carlton & Deane, 2000). The term suicidality encompasses the risk of suicide, usually indicated by suicidal ideation or intent, and will be used for this paper due to its inclusivity of different experiences of suicide (American Psychological Association, 2022).

Mental health service use in young people

There are many face-to-face services available for young people; however, young people report several barriers to service utilisation, including shame, previous negative experiences,

concerns regarding confidentiality from parents, lack of control and agency, and inflexibility of services (Bruffaerts et al., 2011; Gibson et al., 2016).

In turn, the literature demonstrates that young people feel more comfortable disclosing their distress online (Gibson & Cartwright, 2014), with those experiencing higher levels of suicidal ideation preferring online help-seeking (Wilks et al., 2018). Online health interventions are becoming more common, especially in a post-COVID era, with young people reporting how they value the anonymity and control offered in these interventions (Chester & Glass, 2006; Gibson et al., 2016), in which young people perceive less judgement or authority from professionals and parents alike (Gibson & Cartwright, 2014).

Online interventions and counselling

Online mental health interventions are delivered via a range of digital platforms including apps, websites, virtual reality, and live chat and have been demonstrated as more effective in the retention of young people in mental health interventions than face-to-face outpatient care (Liverpool et al., 2020). Online interventions may also offer access to young people who otherwise may not seek help at in-person services, such as those who do not have financial, geographical or familial support to access in-person services (Rickwood et al., 2016).

Core elements of counselling, such as therapeutic alliance and counselling micro-skills (Hanley, 2012), are key elements to building rapport and trust with a young person, both which have been established as essential in engaging young people in intervention on digital platforms (Gibson & Trnka, 2020). Literature has demonstrated that therapeutic alliance is equal to if not higher for online interventions compared to face-to-face (Cook & Doyle, 2002; Hanley, 2012).

Research has also reported that many counselling micro-skills such as open-ended questions, positive regard and summarising are adopted and easily implemented online (Asri et al., 2020; Mallen et al., 2011). However, despite literature demonstrating otherwise, some clinicians doubt the efficacy of online interventions, and in particular text counselling, compared to face-to-face interactions (Helton, 2003), highlighting a need for more research demonstrating how text counselling can utilise counsellors existing skillset effectively.

Suicide risk assessment and online intervention

Traditionally, risk assessment involves asking a person about suicidal thoughts, their frequency and intensity and the intent, plan and access to means to act on these thoughts (McGlothlin, 2008). Risk assessment to classify levels of suicide risk has been demonstrated to have no discernible ability to predict future risk of suicidal behaviour (Fortune & Hetrick, 2022). However, services continue to use risk assessment to determine treatment access, which is not only invalidating for service users (Perry et al., 2020) but also allows clinicians to fixate on a classification of severity instead of engaging in compassion, person-centred conversation.

A major area of clinician hesitancy to engage in online interventions involves suicide risk and how to manage a crisis in an online context. In particular, clinicians report feeling untrained in online crisis management (Glueckauf et al., 2018) or felt it was inappropriate to engage online with suicidal clients (Chester & Glass, 2006). COVID has resulted in an uptake of clinicians using telepsychology during the pandemic (Pierce et al., 2021), and it is unclear at this time whether this has resulted in a change of opinion about risk assessment and crisis management online.

A proactive online intervention

To date, mental health intervention services, both online and in-person, have been conceived in the traditional model whereby support is provided if a young person (or their family) actively seeks out that support when distressed. Proactive outreach is an innovative approach to intervention which is effective in other areas of healthcare such as hard-to-reach people who inject drugs, where HIV risk was reduced through street outreach programs providing needle disinfection and HIV testing (Needle et al., 2005). Indigenous health services also utilise proactive responses where cardiac health practitioners go into communities, build relationships and administer portable interventions at people's homes in rural communities (Tibby et al., 2010). Proactive approaches are already being utilised with an adolescent population and show high levels of engagement, such as a smoking cessation program through telephone outreach and helpline support reported a 61.5-80.5% engagement rate (Heffner et al., 2016). Proactive outreach provides intervention in communities where a need exists, reducing inequities (American Diabetes Association, 2017), barriers (Root et al., 2022), and the overall economic costs of the disease (Yao et al., 2021).

A proactive intervention approach for those experiencing psychological distress and suicidality online has yet to be examined. This research is the first to explore counsellors' practice and risk assessment in this context.

Methods

Aim/Research questions

The aim of this qualitative study was to explore how counsellors engaged young people in a proactive online intervention and how risk assessment was conducted in this context.

Study setting and data

Live For Tomorrow (LFT) is a non-profit based in Aotearoa New Zealand. LFT chat was a constituent of their work and was the "world's first proactive helpline supporting teens in crisis on social media" (Live for Tomorrow Charitable Trust, 2022). LFT chat was operated through the social media platform Instagram, using an algorithm to search hashtags that indicated distress (such as #depressed, #kms, #suicidal). The algorithm identified posts that counsellors used to contact the user who had posted, offering to listen and provide a proactive, person-centred brief intervention. Posts were only reached out to if they were in English. Counsellors were volunteers and paid staff trained in counselling micro-skills, crisis management skills, and brief intervention.

In this study, we used transcripts from the online chat that formed part of the counselling intervention and a follow-up chat that was aimed at collecting feedback about the counselling intervention. These transcripts were a part of routinely collected data about the service. The transcripts were collected between 1 March 2019 and 29 February 2020 based on inclusion criteria supplied to LFT. LFT then identified transcripts that met these criteria, anonymised them, and provided these to the researcher. The inclusion criteria were (a) the conversation involved a user between the ages of 13 and 25 years old; (b) the counselling transcript contained a form of risk assessment; (c) the young person was part of both a counselling conversation and a feedback conversation.

The transcripts varied in length, with the final data set containing 274 pages and 79,155 words (Malterud et al., 2016). Detailed demographic information about the young persons was not collected; however, their age was collected with a mean age of 16.8 years (standard deviation of 3.6 years).

Ethical considerations

This study was approved by the Auckland Health Research Ethics Committee (AHREC) (Ref: AH2840). Informed consent was sought from LFT for access to their routinely collected standard audit data and their consent to be named in this research. To protect the identity of the users, conversations were anonymised and de-identified by LFT staff prior to being provided to the researchers. LFT was compensated by the researchers for their staff's time to anonymise and de-identify the transcripts.

Data analysis

Reflexive thematic analysis using the six-step approach of Braun and Clarke (Braun & Clarke, 2019) was used to identify and report patterns within data. The thematic analysis took a social constructionist approach, acknowledging the perspectives of the researchers and the young people and accepting that distress and suicidal ideation may take on different meanings in different population/cultural groups and at different times across a person's lifetime. This paper's analysis focused primarily on the counsellor's responses. Data analysis was led by the first author using NVivo 12 Pro and assisted by the team, including a young person with lived experience, through a process of consensus (Hill, 2015). The analysis included recognised strategies for assuring the quality of qualitative research, including reflexivity (Morrow, 2005). This involved discussions between authors around different interpretations and acknowledgement of the first author: 1) being of New Zealand European ethnicity; 2) having had her own mental health journey including the utilisation of helpline services, and 3) having had previously worked as a counsellor and supervisor for LFT.

User Statistics

LFT provided user statistics to understand how the intervention was operating and, therefore, the context in which the live chats that were documented in the transcripts were conducted. These statistics were for the one-year period within which the live chats documented in the transcripts were undertaken.

Table 1. *Service user data from 1 March 2019 to 29 February 2020.*

Number of posts reached out to	4457
Average time between young person's post and reach-out message from counsellors	10 minutes and 48 seconds
Number of young people who responded	2105 (47%)
Number of young people that engaged in a conversation (classified as three or more messages)	1159 (26%)

The lower number of transcripts used for this study compared to the overall number of young people that engaged in a conversation is due to the third inclusion criterion. This criterion required the young person to have engaged in a second follow-up feedback conversation with a counsellor. Feedback was sought from young people who had engaged in a conversation within the previous six months and relied on the young person responding and providing feedback. Therefore, transcripts were limited with young people who engaged in this feedback conversation.

Results

Table 2. *Overview of themes and subthemes*

Themes	Subthemes
Using microskills to facilitate conversation	• Invitation to conversations • Validation • Reflection • Open questions • Summarizing • Unconditional positive regard • Emoji use
Building confidence and capacity to cope with change	• Reinforcing existing strategies • Provide encouragement • Psychoeducation • Provide strategies
Seeking permission when approaching conversations about suicide	• Asking permission to talk about suicidal ideation or self-harm
Conversations about suicidality follow a structured approach	• Ask about suicidal ideation • Use of posts or tags to further conversation • Ask about suicidal intent • Ask about suicide plans • Ask about access to means • Safety planning
Providing assurances of confidentiality	• Anonymity guaranteed due to nature of Instagram • Confidentiality encouraged disclosure • Fear of disclosing in real life
Validation of the experience of suicide	• Counselors provide empathy • Reflection of emotional distress • Radical genuineness
Using conversations about suicidality to identify intervention	• Use of scale rating questions • Identify the young person's strengths • Using conversation to model therapy interactions • Using conversation to encourage further help-seeking

Using micro-skills to facilitate conversation

Counsellors used counselling micro-skills to invite the young person into a conversation as part of their proactive reach out, "*Hey, I was wondering if you wanted to chat? looks like things are tough for you atm..* 😔" (C5) as well as inviting disclosure, "*can I ask a bit more about why your parents don't want you to talk to someone?*" (C6). Counselling micro-skills were used to provide opportunities for the young person to disclose their difficulties and explore their

experience, including validation of the young person's experience, "😔 *there's only so long you can bottle all those emotions up huh*" (C7), which led to subsequent disclosures:

> C7: *that sounds like people really aren't giving you a break though... can't imagine that makes it easier to deal with all the stress of high school as it is*
>
> YP17: *It doesn't, like I really like helping people with their own problems but it gets so stressful with All my high school stuff , I've lost sleep and appetite over it.*

Counsellors often paired validation with reflective statements to extend a young person's understanding of their experience, "😣 *that sounds really really frustrating friend. And a little bit hurtful that they don't take your feelings seriously?*" (C7). Reflection helped the young person explore their experience, rather than the counsellor attempting to problem solve straight away:

> C22: *it can be so hard to talk about something as difficult as suicide with people who don't really understand what you're going through.. sometimes it can make you feel pretty alone, is that how it's been for you?*
>
> YP44: *Definitely, like my friends try to help but it always seems to make it worse*

Counsellors used open questions to create space and remain open to whatever the young person wanted to discuss. This was often seen at the start of the conversation, "*Would you like to talk a bit about what's going on with you at the moment?*" (C19), during risk assessment, "💛 *what do you think it looks like, to not take it anymore?*" (C7) and when exploring interventions, "*What do you think would be the best thing to happen now?*" (C7).

Summarising was used less frequently by the counsellors than the above techniques but was noted after the disclosure of a lot of information, "I*t sounds like moving house has caused a*

lot of distress for you :/ I'm also hearing that you're feeling really unsure what the future looks like for you 💜 *Your Dad sounds incredibly difficult to be around, friend :(*" (C8). Summarizing was also used for clarification, "*I just want to make sure I've got it clear - the two main sources of stress and pressure right now are school stuff and your friends using you as someone to tell their problems to, is that right?*" (C7). The counsellors also used summarizing to create space for acknowledgement of more positive traits or experiences, "*You are very resilient to have handled it on your own all this time, and it is wonderful that you have best friends in your life that are able to help you through some of the toughest moments*" (C32).

Counsellors used unconditional positive regard to create an environment that allowed the young person to feel safe to disclose, especially when discussing suicide and self-harm, "*This is a judgement-free zone friend, that's cool to hear you aren't cutting but if you were there wouldn't be any judgement from me* 💛" (C7). Unconditional positive regard allowed the young person to disclose further:

> YP55: *I love the emotional pain the torture... and i love the physical pain the cutting etc and most importantly the taste of blood... Sometimes I have to put in serious effort to stop myself from doing something Like once I wanted to cut my stomach open and eat my organs*
>
> *Sounds pretty insane am I right?*
>
> C31: *Aw, not insane. I can imagine it would've been really hard to understand those feelings growing up!*

Emojis were used by counsellors throughout conversations to convey meaning and emotion. Counsellors often used emoji faces after hearing difficult stories from the young person,

"*all of those things you're dealing with sound so exhausting* 🥺" (C15) and to convey care, "A*w friend I can see you're in a really tough spot right now* 💛" (C20). Emoji use appeared to replace non-verbal cues for example, facial expressions and verbal cues such as "mmms", in an online space. Emojis were a unique addition to the counselling micro-skills utilized by the counsellors.

Building confidence and capacity to cope with change

Counsellors encouraged self-efficacy by reinforcing the existing strategies that young people had already been using to cope with their distress, "A*ll the great coping strategies you have… some connections and points of strength and support you can turn to when things feel like they're getting too much*" (C5). The counsellors also provided encouragement to boost the young person's confidence in themselves, "*That's so cool, and you want to be a chef one day? You sound like a very creative person :)*" (C28). They also positively reinforced the young person for their gains, "*that's amazing that you have been clean for 4 weeks! I am really proud of you!*" (C6).

Psychoeducation contributed to the development of self-efficacy by providing the young person with the knowledge to understand their experience, "*Well very generally depression keeps a cycle of thinking and behaving. It will be like negative thinking leads to a lack of motivation to act which can mean a lot of people tend to start doing less and less and this once again reinforces negative thinking*" (C7). Psychoeducation was also used to create a sense of empathy for others, "*sometimes people who suffer from a head injury may end up acting in a different way and that can be soo difficult, especially when it is a loved one, like your sister.*." (C8), or to provide strategies that would assist the young person, "W*rite a list and make it realistic i.e for*

someone who cannot get out of bed day after day I would say for the first day maybe just have the task of getting to the letterbox and nothing else" (C8).

Seeking permission when approaching conversations about suicidality or self-harm

The counsellor would engage in conversation around suicidality/self-harm with a young person if their original post or online chat indicated any level of suicidal ideation or engagement in self-harm. Many counsellors started this conversation by asking permission and indicating what they would be asking about, "*If you don't mind me asking, do you ever think of suicide or self-harm?*" (C6). From the feedback the young person gave, the direct approach appeared to be valued: "*at first i was hesitant like talking about my mental state to a stranger.. but then I welcomed it*" (YP21).

These permission-seeking questions were always answered with disclosures by the young person:

> C4: I *know this is a heavy question, but can I ask if suicide is something you've ever thought about?* 💜
>
> YP9: *I've attempted suicide twice My parents have no clue And my scars are visible I just don't think they care bc I'm pretty sure they've seen them*
>
> C4: *Aww friend xx you must have been in such a dark place to have felt like suicide was the only way out :(*

Conversations about suicidality follow a structured approach

Counsellors used a structured approach to conversations about suicidality, following a structure often implemented in in-person services. Counsellors initially asked about suicidal ideation, "*sometimes when people experience these kinds of trauma they can get suicidal thoughts. Have you been experiencing any of these?*" (C20). Counsellors were able to refer to the Instagram post if suicidal ideation or self-harm were not initially disclosed, "*If you don't mind me asking, your post had a suicide tag, is that something you think about a bit?*" (C3). If the young person had suicidal ideation, suicidal intent was explored, "o*n a scale of 1 - 10 where 1 was you had no intention of attempting suicide today and 10 was you have strong intention to attempt suicide tonight, what number would you give yourself?*" (C22). Subsequent exploration of any plans was explored as seen in the interaction below:

> C20: *Do you have any kind of plan for how you may carry out these suicidal thoughts?*
>
> YP40: *Yes*
>
> C20: *Do you mind telling me?*
>
> YP40: *I would just … until I pass out and hope I dont wake up*

Lastly, the counsellor would ask whether they had any access to means to carry out their plan and safety, "*is there anyone at home atm?*" (C9) or "d*o you think you will be safe or will you be able to reach out if you felt you weren't?*" (C8).

Providing assurances of confidentiality

Due to the nature of Instagram, the counsellors were unable to identify who the young person was or where they were located. This allowed for a high level of confidentiality because the counsellor, even in situations that would within an in-person service would trigger a break of confidentiality, could not disclose this information:

> C22: *you mentioned you were suicidal - sounds like you're in such a dark place to be feeling that way :(do you mind telling me if that's something you're planning to carry out in the near future?*
>
> YP44: *U won't tell anyone?*
>
> C22: *there's not really anyone I can tell <3 I'm worried for your safety though*
>
> YP44: *I'm not sure, I've attempted it before but that failed*

This high level of confidentiality increased the young person's amount of disclosure, "*talking to someone online is a bit easier since not to be rude but they don't really know much about you and it's easy to get things off your chest*" (YP17) and reduced the fear that young people had of disclosing content in real life, "*If I told any of the professionals ab the stuff that goes on in my head they would put me in a mental hospital*" (YP55).

Validation of the experience of suicidality

Where suicidal ideation or self-harm was disclosed, counsellors demonstrated empathy and validated the experiences of what had led the young person to feel suicidal (without validating the act of suicide itself), "*I think that wanting to 'disappear' is a really understandable response for wanting to leave behind the pain that you feel every day*" (C32). Counsellors

appeared to use several different levels of validation. Accurate reflections appeared in many risk assessments with counsellors validating the emotional distress that comes with suicidal thoughts, "*That is a heavy conclusion to come to friend and I can imagine that would have taken quite a few strong thoughts to get there...*" (C22). Alongside this validation, counsellors demonstrated radical genuineness in their validation of the young person being able to disclose their suicidality, "*I'm really glad we could chat - I feel honoured that you've felt able to be so open and honest with me* 💜 *you're such a brave human xx*" (C4).

Using conversations about suicidality to identify interventions

In conversations about suicidality, the counsellor used the opportunity to identify appropriate interventions in almost every transcript. Counsellors would use a scale rating question to understand the intent of suicidal behaviour and to talk about protective factors, "*So with a scale of 6.5 I would guess there is something keeping you around?*" (C21) which subsequently enabled encouragement of identifying the young person's strengths to prevent suicide attempts:

> YP19: *I'm not talking to my mom bc I don't want to worry her, but I'll try to tell her*
>
> C8: *Hey that's really cool you're thinking about telling your Mum - from what you said earlier it does sound like she cares.*
>
> YP19: *Yes she cares a lot my siblings and I, she's the best person I've ever met. My dad used to mistreat physically and emotionally my siblings and I but I love him too.*
>
> *(Following day)* YP19: *Hello, I talked with my mom. She helped me a lot. You gave me the strength to tell her even though it was extremely hard for me*

The relationship between the counsellor and the young person was also used to model how therapeutic interactions might happen in other services, overcoming some of the barriers and misconceptions that young people had, "i*t can be so relieving when we are able to safely express how we're feeling and what's happened/happening in our lives, hey? Being listened to and heard can be so powerful xx how would you feel about talking to someone else on an online platform like this?"* (C4). This comparison allowed the young person to understand what a help-seeking experience could be like, increasing the young person's confidence to utilize this in the future:

> C22: *Okay so there are a couple of places you could try….[Local helpline information provided] I really hope you find the right support. You deserve to feel really good <3*
>
> OSU44: *Yeah, but like I said yesterday I'm terrible at talking to people about stuff like this*
>
> C22: *You've done amazingly talking to us - do what you've done with us - be honest and open as much as you can.*
>
> OSU44: *Yeah I guess that's the only way*

Discussion

The current study aimed to explore how counsellors engaged young people in a novel proactive online chat intervention and how, what is traditionally referred to as risk assessment, was conducted in this context. These results were based on the young people who engaged in this intervention. Using a qualitative framework, seven key themes highlighted how counsellors used

counselling micro-skills to facilitate supportive conversations and encourage building the young person's confidence and capacity for change. A change in approach from risk assessment with the intent of risk classification to conversations about suicidality allowed the counsellors to continue to utilise the effective structured questioning of risk assessment practices (Silverman & Berman, 2014), but with the scope of identifying interventions with the young person. These conversations around suicidality included first seeking permission, ensuring confidentiality due to the nature of Instagram, and validating the young person's experience of suicidality.

As this was not a traditional help-seeking model, proactive outreach meant counsellors needed to overcome the initial barrier that the young person may not be as receptive as those who present at a mental health service. This proactive outreach approach demonstrated a 47% response rate and a 26% engagement rate, which is the first data of its kind for a proactive online counselling intervention. This is lower than other areas of proactive approach with adolescents (Heffner et al., 2016). However, these lower rates are consistent with the literature demonstrating that young people engage in mental health services at a lower rate than adults (Cuffe et al., 2001) and that they prefer informal support from friends and family (Evans et al., 2005; Rickwood et al., 2007)

This approach also highlighted the benefit of being online in a space where young people are disclosing distress and suicidal ideation to peers. Proactive support was offered by counsellors within an average of 10 minutes and 48 seconds of the creation of the post. This ability to respond to distress when occurring results in a highly accessible service, which young people have previously cited as a barrier in traditional mental health care (Hanley, 2009). By providing almost real-time support and, therefore, early intervention with young people, this proactive counselling model demonstrates best practice (Colizzi et al., 2020) and potentially

reduces the risk of further distress and the development of psychological disorders (McGorry & Mei, 2018).

The proactive nature meant that the first interaction with the young person focused on creating a supportive conversation, allowing the person autonomy to engage and disclose as they wished. This invitation allowed for a transfer of power to the young person as they could decide on their level of engagement, contrary to power dynamics that often favour the adult or professional in face-to-face services (Hanley, 2009). The anonymity offered by Instagram resulted in an equalising of power in the therapeutic relationship (Fletcher-Tomenius & Vossler, 2009) as the young person was able to discuss topics that they may not ordinarily discuss (Hanley, 2009; Suler, 2004).

Counsellors used counselling micro-skills like those used in in-person services to construct therapeutic alliance; however, they required some adaption to an online chat environment. Both counsellors and young people used emojis to express emotion and replace non-verbal cues (Donovan, 2016). Counsellors were able to build trust through validation and reflection to encourage the young person to build on their existing strengths and coping strategies. Using validation as the method of connection with the young person became the core of the relationship, demonstrating care rather than giving advice (Gibson & Trnka, 2020).

Counsellors used a structured approach to conversations about suicidality and self-harm behaviour with the intention of focusing on intervention with the young person and not as a risk screening tool, in line with recent evidence (Fortune & Hetrick, 2022). Counsellors had conversations about suicidality using a person-centred approach by listening, understanding, empathising, and helping the young person find solutions they could connect with in a meaningful way. Risk assessment in services can sometimes discourage disclosing important

information about suicidality due to a young person's concerns about the consequences of disclosure (Blanchard & Farber, 2020). By moving away from risk assessment for the purpose of risk classification, the associated consequences of being classified in a certain way are removed, for example, being deemed low risk and, therefore, not eligible for treatment (Fortune & Hetrick, 2022; Large et al., 2011). LFT facilitated a real movement toward understanding the distress leading to suicidality and strategies to mitigate that distress instead of focusing on assessing the 'risk' of future self-harm and suicide alone. This approach allowed young people to discuss and understand their suicidality and focus on intervention strategies with the counsellor.

Data availability

The data sets analysed during the current study are available from the corresponding author upon reasonable request.

Limitations

A key limitation of this study is that the data were extracted from transcripts and not interviews, which limited the exploration that could be conducted. The transcripts themselves ranged in length, from a brief conversation that would last thirty minutes to a continued conversation over many days. This analysis did not examine how the young person experienced this interaction and whether it was effective from their perspective. LFT managers gathered feedback on their service six months post-intervention, which may have affected recall. Furthermore, as LFT staff themselves gathered feedback, this may have influenced the young person's desire to provide honest feedback.

Conclusions

This study provided important insight into how counsellors engage users, use counselling micro-skills and move beyond traditional risk assessment to meaningful conversations about suicidality and intervention for that in an innovative, proactive approach to mental health intervention on Instagram. This study found that LFT counsellors could use different micro-skills to facilitate supportive conversations and encourage self-efficacy in young people. Counsellors used a structured approach to understanding suicidality in a permission-seeking, validating, and confidential manner to identify interventions with the young person. These practices allowed the young person to retain autonomy and power in the conversation as well as demonstrate that a proactive, person-centred approach is possible within an online text-based environment. Services like LFT have an important place in the range of services that must be available to young people in distress.

Chapter Five: General Discussion

"😔 there's only so long you can bottle all those emotions up huh" (Counsellor)

"Yep I've been keeping them bottled up for a long long time" (Young Person 17)

In this thesis, I explored the experience of a proactive online intervention, including both the experiences of the young people and the way counsellors engaged young people in this intervention. This study was the first of its kind to explore the novel approach of a proactive online intervention, Live For Tomorrow chat (LFT), using Instagram to reach young people in distress. The two research aims were "to explore the young person's experience of distress and a proactive intervention in an online context" and "to explore how counsellors engaged young people in a proactive online intervention and how risk assessment was conducted in this context". The findings of this project contribute to the growing literature on digital interventions being delivered on social media platforms. Furthermore, as this service appears to be the first of its kind in the world, this understanding could have implications for the future development of similar online interventions, particularly those that proactively reach out to users who may be in distress instead of relying on user-initiated contact. In this discussion, I weave together the results and discussion from Chapter Three and Chapter Four. I initially discuss the key findings, then turn to the clinical implications of these findings and some of the current study's limitations.

The research I undertook has raised a number of important issues for the way that we think about youth distress and suicidality and how best to intervene. This study demonstrated a novel insight via exploring the real-time experiences of young people's distress and suicidality and how a proactive intervention can be delivered on a social media platform. LFT's proactive

outreach approach operated on the basis that young people are already using social media to disclose distress, and therefore, proactively took intervention to them. LFT's proactive online chat intervention allowed for support to be delivered to young people in their moments of distress. LFT counsellors were reaching out to young people on average 10 minutes and 48 seconds following the posting of the young person's content, indicating a faster, more accessible form of support for young people than traditional face-to-face service use, where young people can wait months to be seen (Punton et al., 2022). Waitlist delays often result in young people feeling abandoned, hopeless or develop negative beliefs regarding their worth (Punton et al., 2022), resulting in exacerbation of symptoms (Brown et al., 2002; Punton et al., 2022) and greater rates of drop-out and disengagement from intervention (Westin et al., 2014). The young people in this dataset noted the proactive, real-time approach of a counsellor within LFT as an intervention in itself. These young people repeatedly highlighted that the act of being reached out to by someone gave them a sense of being cared for and important enough to receive support, which was often missing in their offline lives.

Of note is that the results of this study were based on the young people who replied to the initial contact from LFT. This proactive outreach had a lower rate of engagement of young people than other health-based proactive services (Heffner et al., 2016), with only 47% of young people responding to the outreach message and 26% engaging in a conversation. Young people often interact with mental health services at a lower rate than adults (Cuffe et al., 2001) due to multiple service barriers and individual and familial factors that prevent young people from seeking and receiving help (Rothi & Leavey, 2006; Zwaanswijk, Verhaak, et al., 2003). Some young people described that being reached out to by a stranger was unexpected, which may have contributed to concerns that we know young people have regarding privacy and confidentiality,

which strongly affect young people's disclosure and engagement in mental health services (Gibson et al., 2016). However, those who did respond to the proactive approach described being online as protective of their privacy and confidentiality, as the Instagram profiles were mostly anonymous. As this proactive online chat-based approach removed some barriers currently existing to traditional mental health services, the reason behind this low rate of engagement is unclear.

Young people who did engage with the counsellors identified that the counsellor's proactive reach-out message at the time of their post that indicated distress was what had stopped the young person from acting on thoughts of suicide or self-harm. Studies have demonstrated that suicidality is negatively associated with help-seeking (Wilson et al., 2010), and this lack of help-seeking itself can be an indicator of distress (Gilchrist & Sullivan, 2006). As young people are posting content regarding their distress and suicidality, including hashtags that are connected to certain communities (such as #suicidal), this indicates a form of help-seeking and community seeking (Arendt, 2018; Gibson & Trnka, 2020; Maple et al, 2020). Young people are more likely to seek help from peers, and therefore a proactive social media-based outreach like LFT may encourage the young person to engage with services that can adapt to spaces where the young person and their peers occupy. The proactive approach itself allows those who were willing to receive help to be offered support in their time of need.

It is also of note that the generational shift of young people being online, and feeling more comfortable talking and disclosing online, has had an impact on help-seeking and service provision. The digital world is already serving as a place where young people are seeking information and forming communities surrounding their experiences with distress and suicidality

(Andalibi et al., 2017; Burns et al., 2016). In particular young people experiencing suicidal ideation report spending significantly more hours online compared to non-suicidal individuals (Harris et al., 2014), offering an opportunity for proactive interventions to take place. Therefore, this shift of taking help to those disclosing their distress and suicidality is essential as a suicide prevention strategy.

Once the young person was engaged in conversation with a counsellor, the findings demonstrate that young people experience distress due to similar factors identified in previous youth mental health research (Ali & Gibson, 2019; Sweeting et al., 2010). Furthermore, the young people who expressed suicidality highlighted that suicidality was occurring due to unbearable, overwhelming and accumulating levels of psychological distress. This experience of extreme distress created strong feelings of burdensomeness, hopelessness about the future, and the desire to disappear or die. In their offline worlds, young people described that their needs regarding their psychological distress and suicidality were not being met, and that they had experienced little validation, including when they attempted to seek help. These accounts of the young people's experiences appear to confirm the IPTS model in describing the experience of suicidality in youth. When experiencing extreme distress, young people described worries of being a burden on their friends and family, resulting in them withdrawing or using other coping strategies (such as self-harm and drinking) that further created barriers to connection and communicating those feelings with others. Many young people described not belonging in school, with friends or family, and based on the IPTS model, it makes sense that these experiences have led to the development of suicidal ideation in these young people (Joiner, 2005).

While this description of young people's experiences fits well with traditional theories and explanations of suicide, such as the IPTS model (Joiner, 2005), this research extended our understanding of how this plays out in online digital spaces. The desire for belonging translated into engaging in online spaces, such as Instagram, to connect with others and belong to a community (Barker, 2012). The expression of distress and suicidality online allowed the young person to connect with an online community and receive the support they often did not receive in their offline relationships. Belonging and community are key reasons young people use Instagram (Lee et al., 2015). Young people described their efforts to belong to a community by creating content aligned to that community, in this case, content including discussions of their distress and suicidality. Instagram use has also been negatively associated with perceived burdensomeness and thwarted belonging, possibly due to the increased social support that can be found (Unruh-Dawes, Smith, Krug Marks & Wells, 2022). Young people in this study noted how Instagram facilitated the connection with other people like them and that they found information in other people's stories, posts or discussions with them about how to manage their own distress and suicidality.

This study also supported an existing body of research that has demonstrated that young people often offer sympathy, sharing of similar experiences and encouragement to those posting in distress (Brown et al., 2018; Cavazos-Rehg et al., 2017), with only some users encouraging suicidal or self-harm behaviours (Brown et al., 2018). Most of these communities and those within them are there to express their distress and support others which also allows for the development of online friendships, which are as meaningful as face-to-face friendships (Chan & Cheng, 2004; Yau & Reich, 2018).

Online communities were often formed around a particular hashtag (e.g., #suicidal), and those posting and engaging in this content were often suicidal themselves. This highlights another aspect of the expression of distress and suicidality on social media. Young people were able to curate an identity on Instagram around their experiences of distress and suicidality in this online community. This identity required constructing their entire profile around their distress or suicidality. Suicidality, in particular, appeared as a part of the young person's name, biography, tags and posts and who they followed. Identity formation is a core component of psychosocial development in adolescence (Erikson, 1994). Personal identity online is an expression of how the young person thinks of themselves (Frunzaru & Garbasevschi, 2016) and is also formed by the sense of belongingness to social groups (Subrahmanyam et al., 2011). Therefore, the curation of a profile connected to suicidality and in connection with groups, pages and content based on distress and suicidality indicates the development of an identity based around these issues.

This curated identity can become positively reinforced through likes, followers and attention on the content created by the young person. More likes have been shown to positively influence online social identity (Hakkenberg, 2021). Suicide-focused posts, in particular, have significantly higher likes compared to posts that do not contain suicidal content (Carlyle et al., 2018). This becomes a powerful reinforcer for the young person of this identity through receiving validation and attention, reinforcing a sense of belonging. Recovery may therefore not be encouraged as that would require the young person to lose their profile and followers (Andalibi et al., 2017; Fulcher et al., 2020). This curated identity around distress and suicidality may become more acceptable to the young person because of this and the continual exposure to suicidal content, which may result in the de-sensitisation and normalisation of these behaviours

(Daine et al., 2013) and potentially play a role in increasing acquired capability for suicide (Joiner, 2005).

Young people also become highly vulnerable in terms of their identity and social community formed on Instagram because it can be affected by the organisation's policies. The young people in this study spoke about how removing content or banning accounts can be seen as further rejecting and isolating as they lose their followers and have to start over again. As accounts within this domain are anonymous, it is difficult for that person to reconnect with the same community as before, essentially erasing that person's identity and social connections. Losing this belonging and sense of community may increase the young person's suicidality, as this connection is a core motivator for why individuals experiencing suicidality go online (Harris et al., 2014).

The young people in this research spoke to the complexities of this online culture where they needed the ability to express their distress and suicidality and connect with others who had similar experiences online, but there were challenges in doing this on social media. Over and above the effect of their content being removed or banned as described above, these challenges also included their privacy, exposure to distressing content, and the emotional toll of supporting others on Instagram. These findings are consistent with the nuanced relationship between distress, suicidality and social media use demonstrated in the literature. Social media use has been found to be associated with anxiety, depression, loneliness and thoughts of suicide and self-harm (Karim et al., 2020; Sadagheyani & Tatari, 2021). However, with over 90% of young people aged 13-17 on at least one social media platform (Anderson & Jiang, 2018) and with young people being more likely to engage with suicidal content (Carlyle et al., 2018), discourse

needs to change to focus on how to connect with young people who are distressed in these spaces. For example, in Australia, guidelines have been co-designed with young about how to communicate safely about suicide on social media called #chatsafe (Robinson et al., 2018). These guidelines described the type of content and language that may be unhelpful and provide advice on how to respond to suicidal content, providing examples and prioritising self-care when engaging with suicide-related content (Robinson et al., 2018). Alongside guidelines to assist young people in keeping safe in online conversations regarding suicide, intervention delivered to those young people disclosing psychological distress and suicidality is also indicated.

LFT existed and operated within this online context and used Instagram's private messaging online chat function. The findings demonstrate that counsellors were able to translate their traditional counselling micro-skills to this online environment. Many skills such as reflection, validation, open questions, and unconditional positive regard were adapted to the online chat environment. An interesting adaptation included the use of emojis by both the young people and the counsellors to express emotion and care, as well as ‘text’ language to use a more informal, peer-like tone (Troiano & Nante, 2018). In particular, validation was highlighted as being important for developing a connection between the counsellor and the young person because it helped to build trust and establish therapeutic alliance (Gibson & Trnka, 2020). Young people highlighted that having counsellors listen to and validate their experience was critical, complementing research that demonstrates that young people want support that positions counsellors as a friend who is genuine and listens (Gibson, 2016). Validation was described as important as many young people described feeling invalidated in their offline lives, which had contributed to their sense of no one caring for them and a sense of helplessness in being able to

manage their difficulties. Counsellors were able to connect with these young people by increasing their sense of belonging via listening, empathising, and validating their experience. The relief expressed by the young people following the conversation with the counsellor may also represent that the relationship with the counsellor, who provided space to be heard and supported, contributed to a positive therapeutic outcome. These findings are consistent with literature that demonstrates that young people want clinicians who listen and are compassionate rather than being dismissive, patronising or excessively focused on problem-solving (Crocket et al., 2015; Gibson & Cartwright, 2014; Lynass et al., 2012).

LFT counsellors used their positioning from a strengths-based person-centred approach to encourage the young person's ability to make change in their life, reinforcing coping strategies and validating their experiences. Young people identified that the conversation with the counsellors reduced feelings of isolation and provided encouragement, understanding and support to connect with both on- and offline support. Although the exchange between the counsellor and the young person was brief, young people in this study spoke of the relief they felt following the intervention, and literature demonstrates that experiences of belonging can improve health outcomes (Walton & Cohen, 2011) and mitigate suicide attempts (Boccio & Macari, 2013). These findings add to research showing that online chat conversations that contain deep connections between clients and counsellors yield positive impacts similar to offline counselling sessions (Barak & Bloch, 2006). Furthermore, the importance that the LFT counsellor placed on rapport building through validation and other skills, and the young people's responses indicating how important this was for them continues to contribute to the literature on the importance of therapeutic alliance (Karver, Handelsman, Fields & Bickman, 2006; Krupnick et al., 2006).

Risk assessment was also adapted to the online context. It appeared to follow an approach that was more similar to a psychosocial assessment process rather than risk assessment for risk stratification, whereby conversations about suicidality focused on identifying factors for interventions rather than establishing a level of risk. These conversations still contained questions regarding thoughts, plans, intent and access to means which is similar to other risk assessment approaches (Chehil & Kutcher, 2012). However, there was a clear emphasis on listening, empathising and validating the young person. Listening to young people's narratives about their experiences allowed the counsellor to foster trust, for the young person to decide the pace of disclosure (Brophy & Holmstrom, 2006), and maintain active participation in understanding their suicidality and the interventions they could utilise (Michel, 2021). These counselling skills become particularly important in facilitating the disclosure of suicidality, which young people have reported is an isolating experience, that includes fear of being judged by others or a belief that they need to manage it by themselves (McGillivray et al., 2022). Furthermore, LFT counsellors sought permission to ask questions regarding the young person's experience of suicide. This permission-seeking took into consideration that young people are at a developmental stage where establishing identity, autonomy and power are being prioritised and that counselling interactions need to reflect and respect that process (Gibson et., 2016; Sauter et al., 2009). This invitation is contrary to risk assessment practices often seen in mental health services, as it allows the young person to choose not to disclose, shifting the power dynamics that often favour clinicians in therapeutic spaces (Hanley, 2009). The process of giving the young person the power to disclose or not disclose has previously been highlighted to build trust and increase the likelihood of help-seeking and disclosure of suicidality (Podlogar & Joiner, 2020). LFT counsellors non-judgemental, validating responses to any disclosure or non-disclosure of

suicidality appear to have created a positive experience of disclosing for the young person and therefore contribute to encouraging future help-seeking and disclosure of suicidality and distress.

Furthermore, due to the nature of Instagram, LFT had no identifying information about the user making the service entirely anonymous. This allowed the removal of potential barriers that young people have identified as impacting their decision to disclose suicidality or self-harm, specifically the consequences of disclosing self-harm or suicidality that are often perceived as punitive, such as being hospitalised. Young people reported concerns in this study that were consistent with previous literature, such as concerns of confidentiality being broken or being judged (Bellairs-Walsh et al., 2020; McGillivray et al., 2022; Sweeney et al., 2019). Some young people checked with the counsellor about what would happen if they were to disclose suicidality and subsequently received reassurance that the counsellor was here to listen and could not intervene as they had no identifying information. This appeared to facilitate greater disclosure and more in-depth conversations about the suicidality that they were experiencing.

These conversations about suicidality focused on identifying potential interventions and encouraging young people to pull on existing strengths and skills. This shift away from risk classification allowed the time and effort in the conversation to provide support to the young person to use their own strengths to cope with their distress and suicidality. Risk assessment has been continuously shown to be flawed in its ability to predict the risk of suicidal behaviour (Chan et al., 2016; Fortune & Hetrick, 2022; Mulder et al., 2016) as suicide risk can vary in intensity and duration (Michel, 2021). Furthermore, risk assessment models often do not translate into treatment, relegating risk assessments to a purpose that is more aligned to risk aversion and to reassure clinicians and services (Mulder et al., 2016). Therefore, by refocusing

on the young person's experience and working alongside them, LFT counsellor's practices modelled that meaningful formulation of suicidality in collaboration is more helpful for the client and encourages a shift towards focusing on intervention rather than risk prediction.

Limitations and Strengths

There are some limitations to this study. First, this study used pre-existing transcripts that varied in length, with some conversations with young people lasting one hour and others that carried on across days and with different counsellors. This meant that the conversations' depth could vary and would reach different points of the intervention, making consistent analysis of the intervention difficult. However, as this was the reality of intervening in a social media space, this variability was true to the experience of the online intervention and was unavoidable and important to the analysis.

Second, as these were transcripts, the data collection method did not allow for further opportunities to explore the young person's experiences, and no clarifying or follow-up questions could be asked, compared to an interview style of data collection. Information was therefore limited by the counsellor's agenda and what the young person chose to disclose.

Third, this study lacked demographic information such as gender, ethnicity, and sexuality, which limits the representativeness of the sample and the ability to understand the experience of the intervention across different backgrounds. The study also had a lack of representativeness in how this service was utilised, with many young people choosing not to respond and therefore their experience of being actively reached out to remains unheard. However, the aim of this

research was not to generalise the findings across all young people on social media platforms. Rather, the focus was to develop an understanding of how these young people interacted with a proactive online intervention.

Fourth, the young people in the transcripts included in this study were those who replied to the proactive reach-out and chose to give their feedback regarding the intervention. This was 26% of the total reach outs conducted by LFT. Therefore, many groups were not captured in these transcripts, such as those who did not want to engage with LFT and those who did not want to provide feedback, potentially creating a selection bias (Henderson & Page, 2007) and skewing the findings of this study to be more positive than what may be the actual experience of the young people.

Fifth, feedback on the intervention and service was collected by LFT using the same chat where the counselling conversation took place. This feedback was collected within six months following the conversation, which may have affected the young person's recall. As LFT collected this feedback, this may have affected the young person's ability to provide negative or constructive feedback.

Sixth, as this study used pre-existing transcripts provided by LFT, the informed consent process for the young people was very limited. In their feedback conversation, LFT asked the young person if they could anonymise and use their conversation for training and research purposes. However, those research purposes were not specific to this study and did not include facets such as publication or for the purposes of a thesis. Significant consultation occurred with

the ethics committee prior to obtaining ethical consent for the study and measures to de-identify and anonymise the transcripts were completed to protect the user's identity.

Despite these limitations, there are several strengths in this study. This qualitative study focused on both the young person and the counsellor's responses, providing a richer, qualitative account of an innovative, proactive intervention. Throughout the analysis and reporting of the data, I made continuous efforts to honour the language the young people used as the core of the findings. Through prioritising the young people's voices, this research is strengthened by learning from young people's unique perceptions and experiences, offering critical insights into the potential of a proactive online intervention (Leggo, 2004; McDonald et al., 2013). This research also reinforces the importance of using qualitative research as a method of understanding the experience of young people, as this depth and centring of young people's voices in the findings would not have been possible in quantitative research (Denzin & Lincoln, 2011). A part of honouring the experiences of these young people was through being reflexive and transparent in my research processes, including consideration of my subjectivity regarding this research topic and regularly challenging my personal views through supervision (Braun & Clarke, 2019; Hill, 2015).

Another strength is that the counselling conversations provide a real-time account of a counselling intervention and the young person's distress and suicidality in that moment. Real-time data is preferable to using recalled, retrospective data as it eliminates memory-related biases and inaccuracies (Schwarz, 2007). This is particularly salient in individuals experiencing psychological distress and suicidality, where there are reported difficulties in autobiographical

recall (O'Connor & Nock, 2014). Using real-time transcripts is a novel method to understand a more accurate picture of what is happening for young people in those moments of distress. Real-time transcripts also allow us to see real-time intervention and a user's response to that intervention which can better inform future practice.

Due to the nature of Instagram, the young people in this study were from anywhere in the world. This international data increases the richness of the differences and similarities of the young people's experiences of psychological distress and suicidality and the applicability of the structure and skills used by the counsellors. As this study is qualitative, no conclusion can be made regarding the generalisability of these findings to other young people; however, the learnings from these results highlighted what young people identified as important in an online intervention.

Directions for Future Research

This study further supported and expanded on previous research and highlighted a number of areas where further research is needed.

To date, there is very little research on proactive social media interventions, and as this particular intervention (LFT) no longer exists, there is limited scope for future research on this specific intervention, though the research supports innovations like this. As a future direction for research, more information is needed on the generalisability and efficacy of these types of interventions for reducing psychological distress and suicidality. A quantitative analysis of efficacy outcomes would allow further understanding that would add to the data presented in this thesis, particularly to demonstrate the utility of proactive online interventions. Data supporting

efficacy, utility and safety would allow for the funding and existence of more support in this domain. The future development of proactive online interventions should include co-design alongside the young people that the intervention is intended for to ensure that the interventions are set up to meet the actual needs of young people.

Furthermore, this research was based on the transcripts and responses of young people who engaged with this service. Further exploration is needed to understand the motivation and process behind those who engaged with the service. Further research into those who did not reply or engage in the proactive reach-out is equally important. Help-seeking, help-negation and engagement with intervention will differ across the groups of young people who did engage and those who did not reply or engage (Barker & Mikulencak, 2000; Rickwood et al., 2005). Alongside this, more information regarding the young person's gender, ethnicity, culture, and sexuality may provide additional avenues to understanding engagement and who is responding to proactive interventions. Group differences in accessing services across these demographics have been noted for in-person services (Rickwood et al., 2005; Rickwood et al., 2007; D'augelli, 2022) and therefore it is essential to identify whether this pattern translates to a proactive, online environment. An understanding these processes can contribute to the future development of a service that is more likely to meet these needs and overcome potential barriers to engagement.

As these data were analysed with a broad focus, some ideas could not be explored in-depth. For example, the difference in communication and presentations between young people that disclosed psychological distress compared to those experiencing suicidality. Possible communication differences may indicate that these groups have different needs within an

intervention and therapeutic context. This could also include the interaction between the young person and the counsellors themselves, such as what response the young person gave in response to the wording and framing used by the counsellor. Therefore, future research could investigate the different counsellor approaches needed in an online communication environment.

Given this novel area of online identity formation, further research could also focus on the longitudinal impact of this identity formation on Instagram, particularly for those that form their identity around suicide and self-harm and the long-term impact these identities may have on the individual. Research in this area could add further nuance to our understanding of adolescent models of suicidality and acquired capability.

Given the expansion of counselling in a digital world that is occurring, it would be useful for further research to explore how services can work alongside social media businesses and adapt to technological advances. This exploration would increase the understanding of how intervention can complement social media use and inform the counsellors' use of social media platforms and technology to support young people.

Clinical Implications of this Research

This research has a number of important implications when working with young people experiencing psychological distress and suicidality, with implications more broadly for suicide prevention strategies.

It is important that we consider and use knowledge generated in research to create meaningful change in practice. A core of social constructionism in research is acknowledging the interrelation of knowledge and social action, whereby research can be motivated by the potential

to drive action (Burr, 1995). The findings of this project make it clear that proactive online chat intervention is a desired and impactful approach to intervening with young people in times of psychological distress and suicidality. This section therefore does not seek to provide conclusive instructions for how intervention is to be conducted, rather, this section aims to reflect on how the core themes of this research may be integrated into clinical practice.

First, existing research has shown that online counselling is valuable for young people (Greidanus & Everall, 2010; Hanley, 2012; Mallen et al., 2011) and this study extended previous research findings by demonstrating that this is also true for social media chat, which was viewed as valuable by the young person. This research has demonstrated how online counselling can be implemented in a unique, proactive manner, and within a popular social media platform.

Second, it is of added value to the broad field of online counselling to highlight that the proactive nature of this online counselling approach was seen as being valuable in and of itself. Real-time interactions in these moments of distress and suicidality could act as a powerful intervention. The intensity and experience of psychological distress and suicidality can fluctuate and intervening in the moment of extreme distress was met with relief by the young people. It can be therapeutic to have someone reach out proactively and check in about the content indicating distress and suicidality that young people post as this may indicate a form of help-seeking which signifies the need for a response.

Third, LFT as a proactive online intervention delivered via Instagram is no longer operating. This was due to the nature of Instagram meaning that LFT could not only target

intervention towards New Zealand young people and the grant that was funding the service decided to redirect their funding to New Zealand youth. This raises clinical implications for the future sustainability and scalability of proactive online interventions. As the internet is boundaryless, it will be important for governments to collaborate to create an international response to how people are communicating and being helped via social media. An international response would also involve working alongside the forums that are being used for suicidal communication to facilitate more helpful, effective responses to distressed or suicidal content being published on their platforms.

Fourth, counsellors can translate many of their existing therapeutic skills online; however, some specific training may be required to understand the culture and language of online interactions, with a specific focus on the specifics of particular social media platforms being used. Any training should focus on the skills and strategies for conveying validation and empathy online e.g., emoji in line with previous research which has described the value of using validating, reflective responses online to deepen conversations (Gibson & Trnka, 2020). Alongside this, there is a need to address clinician's hesitation to using online methods, which may involve addressing clinician confidence in online counselling and challenging the status quo of how services currently serve young people. Furthermore, counsellors who operate on platforms where there is anonymity and risk ultimately practice in a way that benefits the young person through genuine engagement, validation of the young person's experiences and focussing on strengths-based and collaborative interventions around psychological distress and suicidality.

Fifth, this research complements the evidence regarding suicide risk assessment when used for prediction (Fortune & Hetrick, 2022). Conversations about suicidality should focus on exploring factors impacting on the young person's suicidality, validating the young person's difficulties and focusing on coping strategies and interventions young people can utilise. This model of working with suicidality aligns with what young people want from services and allows them to maintain autonomy and active participation, ultimately empowering them (Gibson, 2016; Michel, 2021).

Sixth, this research demonstrates the pervasiveness of social media in effecting how young people are expressing themselves on social media platforms, the type of content they are accessing and the social communities that they are a part of. All clinicians regardless of working on or offline should be asking young people about their social media use as a point of assessment and intervention for psychological distress and suicidality.

Lastly, this study continued to provide support for the importance of young people's experiences and opinions in informing intervention. Young people responding to LFT's request for feedback regarding the counselling intervention illustrated that young people want to participate in bettering services for themselves and for others. As such, it is important to honour their opinions and reflections on what works for them. The importance of working alongside young people to develop services that are appropriate, relevant and acceptable to young people has been shown to increase engagement. This practice has been supported and reported as essential by the World Health Organisation (World Health Organization, 2014).

Conclusion

Youth suicide has been identified as one of the most common and preventable causes of death in young people internationally (World Health Organization, 2019). A considerable amount of research has been conducted on risk factors, barriers to help-seeking and the efficacy of intervention models; however, there has been limited research involving the voices of young people and on more innovative approaches to addressing some of these barriers. In particular, no research has been conducted on a proactive online intervention operated on a popular social media platform that explores both the experiences of the young person and the counsellor. This thesis highlighted the benefits of a proactive online chat-based intervention, a novel approach to engaging with young people experiencing psychological distress and suicidality. Young people who engaged in this intervention highlighted the importance of the proactive method that demonstrated to them that they mattered, which was enhanced by the counsellor's ability to listen, validate and empower these young people. Furthermore, moving beyond traditional risk assessment practices and into conversations about suicidality allowed for the validation of the young person's experience and exploration of interventions and support that made sense and were seen to be helpful to the young person. The findings have demonstrated the feasibility and benefits of moving mental health intervention to a medium where young people are currently disclosing distress and suicidality and intervening proactively.

Final thoughts

As this thesis was started from a basis of reflection, I find it important to end by considering how my process has shifted while conducting and writing up this research. Primarily, my role in entering secondary mental health services as a clinical psychologist has contributed significantly to my knowledge and understanding of the mental health system than I originally had when this project was conceived. I hold a greater appreciation for the challenges of an over-burdened system, and that the idea of proactively intervening and learning how to intervene within online spaces, which may be very unfamiliar to most clinicians poses great challenges, especially when often the system feels like it is not even meeting the needs of those needing support from a reactive model. I have often felt disheartened after having worked on such an innovative, inspiring way to approach mental health that allows us to help young people immediately when they are in distress, and then sitting in the realisation that the public mental health system in Aotearoa New Zealand feels like it would never accept such a 'ambitious' way of practicing. However, at these times, I found it essential to return to those individuals who were impacted and to my values that mental health systems do need to be challenged to do better. I continue to ground myself in my hopefulness as a clinician and researcher, especially in the face of others who deem any systemic change to be impossible. In particular, I find inspiration in sharing these findings with others, friends, family, professionals, LFT and conferences where I get to speak with passion about how impactful this service was to those young people.

And so, I emerge from this project as a better practitioner and researcher. One who will continually advocate for better options for intervention, and even against a seemingly unmovable system, one who will continue to hold optimism that we are all doing our best and our power is

in ourselves as a community. With that in mind, I end with a quote from one of the young people that made this thesis possible:

> *"suicide isnt the answer and that no matter how hard life gets it's better to hold on because eventually you'll see how beautiful life really is.* 🥰"
>
> Young Person 56

Appendix A

Participant Information Sheet for Live for Tomorrow

PARTICIPANT INFORMATION SHEET

Project title: The new face of youth mental health intervention: an analysis of a proactive digital intervention and risk assessment practices in response to posts of suicidal content on Instagram.

Name of Researcher: Natalie Peart
Natalie Peart is a Doctoral of Clinical Psychology student.
Her primary supervisor for this research is Dr Sarah Hetrick, who is a clinical psychologist and Associate Professor in Youth Mental Health in the Department of Psychological Medicine, University of Auckland.

Conflict of Interest: Natalie Peart has been previously employed by Live For Tomorrow as a Supervisor of Live For Tomorrow chat for 1.5 years and was then moved onto another project FindaHelpline. Natalie Peart is no longer employed at Live For Tomorrow. Her previous involvement with the organisation will allow the researcher to have a more in-depth understanding of the organisation and its processes. As Natalie no longer works there, there will be no undue pressure on the organisation or anyone working at Live For Tomorrow to take part in the research.

What is this research about?
This research aims to explore how young people who express suicidal ideation, which is defined as thoughts of ending one's life, experience the proactive digital intervention administered by the Live For Tomorrow program. By analysing the conversations during a counselling interaction between young people and their counsellors, we aim to gain a greater understanding into how these young people talk about their distress and suicidality, the reasons they give for wanting to end their life and the impact of risk assessment, in particular on rapport building. Because this type of proactive online counselling is a new area within mental health services, the research will also explore what young people who are experiencing suicidality say about their experience of receiving an unsolicited private message from a counsellor, of receiving the support that is offered, and their experience of Instagram in terms of mental wellbeing.

This research will involve the analysis of 20-40 anonymous transcripts of counselling

interactions and user feedback that are routinely gathered by your organisation during the course of normal service delivery. This material will be analysed to explore how young people communicate their experience of psychological distress and suicidality through an online platform when engaged proactively by trained counsellors.

What will taking part in the research involve?

The researcher would like the consent of your organisation to provide us with the required number of transcripts of counselling for analysis. This will require a member to supply the researcher with 20-40 of the most recent interactions from Live for Tomorrow's database. The provided transcripts must be anonymised, so that there are no identifying features in the data, such as the names of the service user and the counsellor. The transcripts will be given to the researcher in electronic form. These transcripts must meet the following inclusion criteria:

- Service users must have declared an age within 13-25.
- The conversation must include the service user disclosing suicidal communication. Suicidal communication is defined as any disclosure of thoughts or intent that involve suicidal content.
- The conversation must include a component of risk assessment. The definition of risk assessment is any question that asks about suicidal ideation.
- The conversation must include feedback from the service user about their experience of the conversation.

The only exclusion in this study would be transcripts that contain self-harm in the absence of suicidal ideation.

The researcher would like the consent of your organisation to provide us with descriptive service data:

- The number of posts reached out to from 1st March 2019 – 1st March 2020
- The average time between user post and reach out message from counsellors from 1st March 2019 – 1st March 2020
- The number of users that responded from 1st March 2019 – 1st March 2020
- The number of users that engaged in a conversation (classified as three or more messages) from 1st March 2019 – 1st March 2020.

What will happen to the research?

The researcher will use this research for her doctoral thesis, which will contribute to knowledge by increasing our limited understanding about how young people communicate their experience of psychological distress and suicidality through an online platform when engaged proactively by trained counsellors. The researcher may publish this information in academic publications and present findings at conferences.

The researcher would like to name Live for Tomorrow in the research as the organisation providing this service.

What will happen to the text transcripts after the research is completed?
The researcher is obliged to keep the data as well as this Consent Form you will be asked to complete for this research. This information will be kept in a locked cabinet in the School of Psychology for 6 years and then will be destroyed.

What are the benefits for your organisation?
The researcher hopes that the research will support the current work conducted in Live for Tomorrow and inform the development of this project. You will be provided with a report on the research when it is finished, and the researcher would also be happy talk with your organisation about the findings.

Are there any risks for your organisation?
The researcher believes that there are very few risks for your organisation as the data is collected and stored anonymously, and the data will be anonymised further by a member of your organisation to ensure there are no identifying features in any of the transcripts. However, the researcher is aware of the need to deal sensitively with the data to protect the reputation that Live for Tomorrow have for providing a confidential and safe forum for young people to discuss their difficulties. In reporting the data, the researcher will ensure that the focus is on general issues rather than highlighting idiosyncratic or individual responses. The researcher will use direct quotes from the transcripts but will ensure that these are reported without any information that might identify a participant through name or specific circumstance.

There is a possibility that the analysis of the data will reveal practices of the counsellors that are unsafe or inappropriate. The researchers will not assist the organisation in any way to identify individual counsellors who may have been involved, but will provide Live For Tomorrow with some broad recommendations designed to address any problems we identify.

Live for Tomorrow is able to withdraw their consent to participate in the research within six months of signing the consent form.

Natalie Peart can be contacted by email at npea145@aucklanduni.ac.nz

Sarah Hetrick can be contacted by email at s.hetrick@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz

Approved by The University of Auckland Human Participants Ethics Committee on 05/08/2020 for (3) Years until 05/08/2023 Reference Number AH2840.

Appendix B

Consent Form for Live for Tomorrow

The new face of youth mental health intervention: an analysis of a proactive digital intervention and risk assessment practices in response to posts of suicidal content on Instagram.

CONSENT FORM (to be held for six years)

Name of Researcher: Natalie Peart

I have read the Participant Information Sheet and have understood the nature of the research and why I have been asked to assist with this. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to assist with this research
- I agree that the required material from Live For Tomorrow's counselling file data can be made available to the researchers.
- I agree that one or more of my staff members can assist with the extraction of the required data for this research.
- I understand that that the data will be anonymised by a Live For Tomorrow staff member before being analysed and that the researchers will ensure that any direct quotes used in the research outputs will not include any information that might identify a service user.
- I understand that I may be asked for advice and feedback on the research as it develops.
- I agree that Live For Tomorrow can be named as the organisation involved in any publications arising from the research.
- I understand that Live For Tomorrow can withdraw their consent to participate within 6 months of signing the consent form.
- I understand that there is a possibility that the analysis of the data will reveal practices of the counsellors that are unsafe or inappropriate. I am aware that the researchers will not assist the organisation in any way to identify individual counsellors who may have been involved, but will provide Live For Tomorrow with some broad recommendations designed to address any problems we identify.
- I am aware that the researchers will provide me with a report on the research findings.

- I agree that the research may be published in academic articles and conference presentations at the researchers' discretion.

Name Andrew Sutherland

Signature Sutherland

Date 27/07/2020

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher Name: Peart

Signature: Natalie Peart Date: 27/07/2020

Approved by The University of Auckland Human Participants Ethics Committee on 05/08/2020 for (3) Years until 05/08/2023 Reference Number AH2840.

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