Suicide among adolescents in 2017: an in-depth study of the background and precipating factors of the 81 suicides among adolescents aged 10 to 20 years old in the Netherlands

Published: 14-02-2019
Last updated: 12-04-2024

The primary aim of the current research is to gain insight into the background, and the precipitating factors of the suicides among adolescents aged, 10 to 20 years old, in 2017 in the Netherlands, by focusing on five domains and the last period...

Ethical review	Approved WMO
Status	Recruitment stopped
Health condition type	Mood disorders and disturbances NEC
Study type	Observational non invasive

Summary

ID

NL-OMON48474

Source
ToetsingOnline

Brief title
Suicide among adolescents aged 10 to 20 years old in 2017

Condition

- Mood disorders and disturbances NEC
- Age related factors

Synonym
suicide and self-murder

Research involving
Human

Sponsors and support

Primary sponsor: 113 Zelfmoordpreventie
Source(s) of monetary or material Support: Ministerie van OC&W

Intervention

Keyword: adolescents, in-depth interviews, suicide, suicide prevention

Outcome measures

Primary outcome

Interview

The interview instrument is partly based on existing instruments from psychological autopsy studies of Portsky, Audenaert & van Heeringen, 2005; 2009), Rasmussen (2013) and Dyregrov (2011), supplemented with open questions made with suicide experts from the multidisciplinary research team (see Appendix B). Our method therefore coincides with the psychological autopsy method that is frequently applied in other countries. By means of triangulation of the interviews with approximately four informants, we*ll have an in-depth overview of the life course of the adolescent, including causes, reasons, events in the course of life, and the meanings that participants give to these factors. This method has already been successfully applied by suicidologists in, for example, Belgium (Portsky Audenaert & van Heeringen, 2005 & 2009), Ireland (Arensman et al., 2016), Israel (Zilsman et al., 2016), Norway (Rasmussen, 2013), and the United Kingdom (Hawton, Houston, Malbergand & Simkin, 2003).

The interview instrument will consist of two components. Firstly, an open

narrative component, in which parents tell their story in their own words, on the basis of a broad, openly formulated starting question about the onset of suicidality in their child, as well as the (possibly) trigger factors in the last four weeks before their death. A second component will consist of several structured questions about the five research domains. The interviews are digitally recorded (voice recording) and are transcribed in exactly the same words as were used originally (verbatim) by a professional typist.

Questionnaires

The questionnaire for parents / caregivers have been developed on the basis of the five domains and the hypotheses of experts from the multidisciplinary research team. The questionnaire consists of structured questions from the interview instrument, standardized questions from the health monitors for adolescents from GGD-GHOR Netherlands and RIVM and CBS (monitorgezondheid.nl/gezondheidsmonitor- youth) and (items from) validated questionnaires. The standardized questions of the health monitor for adolescents are self-report questions about, for example, alcohol and drugs. The questions have been adapted for this study aim and to make it possible that parents could fill in the questions. Furthermore, the validated PHQ-9 will assess recent depressive symptoms (Kleiboer et al., 2016), the parent version of the SDQ is used to determine psychosocial, emotional and behavioral problems (Misterska et al., 2017), and suicidal behavior in the past will be measured by some items from the screening instrument developed for adolescents 'Questions about Suicide and Self-harm' (Huisman et al., 2015). Finally, childhood

life-events events and traumas are being measured (Meerdinkveldboom et al. 2016).

The questionnaire for mental health professionals has largely been derived from the questionnaire for healthcare professionals from Aarensman et al. (2016, 2018) and adapted by experts from the research team to this study aim and the situation in the Netherlands. For adolescents who received mental health care the following factors will be examined: psychiatric diagnosis, physical health, treatment, recent symptoms, medication, substance abuse and medical history. Finally, the KEHR questionnaire is taken among the involved mental health providers. This is a validated tool that has been specially developed to systematically test suicide cases according to the Dutch multidisciplinary guideline for the diagnosis and treatment of suicidal behavior (De Groot et al., 2018). For the adolescents who were not under treatment, we*ll examine to what extent suicidal behavior or depressive symptoms have been identified, and whether there were any problems in the organization of health care.

Secondary outcome

Not applicable

Study description

Background summary

Rationale: Data from Statistics Netherlands showed that in 2017, 81 adolescents aged 10 to 20 years old died by suicide, while an average of 51 adolescents died by suicide in 2012-2016. These worrisome figures ask for a thorough scientific research of the background and precipitating factors of these

suicides among adolescents aged 10 to 20 years old in the Netherlands (Gilissen et al. 2018). In this study, we would like to gain insight into factors that might have influenced the suicidality of these adolescents by means of in-depth interviews and questionnaires with several informants, such as parents and peers, mental health professionals and teachers. In the short term, we*ll use these insights to make policy-related recommendations for suicide prevention. In the long term, we*ll deliver new scientific knowledge about suicide prevention among adolescents.

Research questions

General
1. Were there any key turning points in the life course of the adolescents which were, according to parents and relatives, affected the suicidality of the adolescents?
2. Were there any indications of the suicide in the last four weeks before the death of the adolescents, as noticed by the parents, relatives and professionals involved, and if so which indications? Were there any tipping points?
Domain specific
1. To what extent were there suicidal clusters and did imitation effects play a role through social media, series or games, especially in the regions of Brabant, Gelderland, Zuid-Holland and Noord-Holland?
2. Which culture and migration factors (acculturation stress, honour-related problems, discrimination, gap with respect to 'Western' mental health) played a role in the death of the adolescents with a non-native background?
3. Which problems in their phase of life (educational career, performance pressure, substance abuse) played a role in the death of the older teenagers (16-19 years)?
4. Which factors (minority stress, stigma society) played a role in the death of the group of *lhbtg* adolescents?
5. What health care did the adolescents receive, such as treatment and diagnosis? Were there any problems in the organization and quality of health care and did professionals follow the multidisciplinary guideline? Which characteristics did adolescents have who were not under treatment and did they show any symptoms, and if so, have these symptoms been identified?

Study objective

The primary aim of the current research is to gain insight into the background, and the precipitating factors of the suicides among adolescents aged, 10 to 20 years old, in 2017 in the Netherlands, by focusing on five domains and the last period before their death. A better understanding of the factors that influenced the death of these adolescents may deliver evidence-based (practical) recommendations to improve suicide prevention for adolescents in the Netherlands (secondary goal).

Study design

In this research, we*ll combine qualitative and quantitative research in a mixed-methods design (Palinkas, 2014). The emphasis is on a qualitative research design (in-depth interviews), in addition we*ll use quantitative components (questionnaires). The reason for this research design is that the qualitative approach is suitable for the in-depth research questions and the low (absolute) number of suicides. Qualitative research is also adequate for exploring new phenomena that have scarcely been studied (such as the role of social media) (Silverman, 2000). The research questions are mainly about learning from patterns about the suicide of the adolescents, by closely mapping the interplay between causes, reasons, events in the course of life, the last phase (weeks), and the meanings that participants will give with respect to suicide prevention (Hjelmeland, 2012). The researchers would like to understand how and in what way we can learn from the key turning points and tipping points from the lives of the adolescents (Rasmussen, 2013). A qualitative research design is appropriate for research questions that are tentative, meaningful and asked from a holistic perspective (Wengraf, 2003).

In addition, we*ll use questionnaires (with closed answer categories) from parents and mental health professionals to efficiently gain insight into relevant domain-specific and health care-related factors, which might have influenced the suicide of the adolescents. These quantitative results will be used in September 2019 for the Ministry of Health, Welfare and Sport to make policy-related recommendations for suicide prevention, together with the first insights from the in-depth interviews.

Study burden and risks

Parents will be screened for current suicidality prior to the interview and the GP will be informed about their participation in the study. The interview consists of an open and standardized section and will last 2.5 hours (maximum, included pause). The digital questionnaire (with closed answer categories) will be conducted at the end of the interview, will take 30 minutes to be completed, and parents can also fill in the questions at a later time. There will be a follow-up contact three weeks after the interview to inform whether parents need aftercare. The interview with peers and teacher(s)/employer will take 2 hours (maximum) and will consist of the same components. The questionnaire for mental health professionals will take 30 minutes to fill in and the telephone interview, in which the KEHR will be conducted, will takes 1.5 hours (maximum).

There are several advantages for relatives to participate in this research, such as being heard, to see things in perspective, and that lessons are being learned from the suicide from their child. Relatives will also contribute to a socially relevant and urgent goal (altruism), will have a conversation with specially trained interviewers and extra support if needed.

Moreover, this research will lead to recommendations to improve suicide prevention in Dutch practice, i.e. recommendations for improvement in youth health care, public sector and in the community (regions). Results from the in-depth research will be shared with parties in the field as quickly as possible so that they can adapt suicide prevention policy. In addition, 113 will stimulate GGD-en to continue this research on (context-specific) causes of suicide among adolescents at regional level.

Relatives have a higher risk of suicidal thoughts and will still have to process the loss of their child. The interview can be stressful for them, because of this process of grief and psychological problems,. In case of a suicidal crisis during the interview, we will contact their GP or the GP center.

Contacts

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Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Adolescents (12-15 years)
Adolescents (16-17 years)

Adults (18-64 years)
Elderly (65 years and older)

Inclusion criteria

Parents / primary caregivers who had a child aged 10 to 20 years old living in the Netherlands died in 2017, and a coroner concluded that suicide was committed.
* Brothers / sisters and / or friends / girlfriends who knew this deceased person well and for whom the legal representatives gave permission for participation
* Involved teacher(s) / employer, i.e. teacher who is working in secondary school or other education, where the deceased person followed education at the time of death, or where the deceased person was employed at the time of death
* Mental health care professional(s) involved, i.e. mental health care professional such as psychologist or psychiatrist by whom the deceased person was treated at the time of death or in the year prior to their death., The research focuses on these characteristics of participants. There are no specific inclusion criteria. If relatives do not speak the Dutch language, the interview will be adapted by taking a translator to the interview.

Exclusion criteria

A potential participant is excluded from participating in this study if he / she meets the following exclusion criteria:
* Parents / caregivers and other relatives who are severely affected by suicidal thoughts measured with the SIDAS as a screening instrument (cut-off point total score 21 or higher, maximum total score is 50).
* Parents who are admitted to a psychiatric institution, regardless of the psychiatric complaints they have, at the time of the examination

Study design

Design

Study type: Observational non invasive

Masking:	Open (masking not used)
Control:	Uncontrolled
Primary purpose:	Prevention

Recruitment

NL

Recruitment status:	Recruitment stopped
Start date (anticipated):	15-03-2019
Enrollment:	200
Type:	Actual

Ethics review

Approved WMO Date:	14-02-2019
Application type:	First submission
Review commission:	METC Amsterdam UMC
Approved WMO Date:	27-03-2019
Application type:	Amendment
Review commission:	METC Amsterdam UMC
Approved WMO Date:	14-02-2020
Application type:	Amendment
Review commission:	METC Amsterdam UMC

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
CCMO	NL68348.029.18