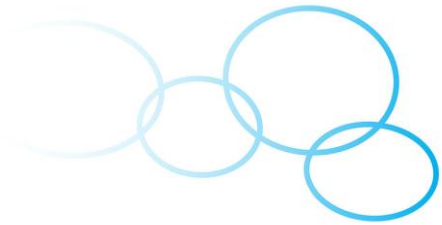

ACT Children & Young People
Death Review Committee

Report prepared for the

Standing Committee on Health, Ageing, Community and Social Services

Inquiry into Youth Suicide and Self Harm in the ACT

April 2016

The ACT Children and Young People Death Review Committee is established under the *Children and Young People ACT 2008*

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About the Children and Young People Death Review Committee

The ACT Children and Young People Death Review Committee is established under the *Children and Young People Act 2008* to work towards reducing the number of deaths of ACT children and young people. The committee reports to the Minister for Children and Young People.

The legislation sets out the requirement for the committee members to have experience and expertise in a number of different areas, including paediatrics, education, social work, child safety products and working with Aboriginal and Torres Strait Islander children and young people.

The committee aims to find out what can be learnt from a child's or young person's death to help prevent similar deaths from happening in the future.

To assist with this aim, we keep a register of all the deaths of ACT children and young people who die before they turn 18, and use the information on the register to learn more about why children and young people die in the ACT.

We can make recommendations about changes to legislation, policies, practices and services to both government and non-government organisations.

The committee does not investigate or determine the cause of death of a particular child or young person. We do not place blame or seek to identify underperformance but seeks to help raise awareness or to spread prevention messages among professionals and in the broader community.

The Committee is keen to receive advice and feedback from interested ACT community members

Executive summary

Youth suicide is an increasingly prevalent concern for modern society. Inextricably linked to mental health, suicide and self harm remain a critical challenge for services and programs supporting young people.

Despite research pinpointing the risk factors leading to suicide, more young people are taking their lives each year.

In the ACT and since 2004, 10 young people have taken their own lives. From their deaths we have learned that among the risk factors there was no one individual that experienced all the risk factors nor was the experience of any of the risk factors a common one. Each young person experienced their own mix and severity of the factors known to contribute to a risk of suicide. The most common risk factor among all young people was a previous attempt at ending their own lives.

On average, one young person takes their own life each year in the ACT one young life ended before their time. It is not possible to know if these deaths could have been avoided if someone close to them knew to ask whether they had thoughts of hurting themselves. It is certainly not possible to know if someone did ask them. What is known is that asking a person if they have thoughts of hurting themselves and if they have an intention to hurt themselves can prevent the attempt.

For all the information that is available on risk factors leading to suicide there is a growing consensus that while the risk factors can be known, these are a poor tool for predicting who will and who will not act on suicidal thoughts. The exception being previous attempts where the evidence suggests that this is one of the strongest factors predicting suicide attempts.

Friends and family can be the first and best defence in preventing suicide. One of the most frequently occurring risk factors is that of previous attempts and of the few strategies we can identify for effective prevention, one is to support and encourage people in the community to: **Look for signs and be aware of the children and young people you interact with. Understand how you can support them.**

In conclusion the Committee suggests that one of the strongest predictors of completed suicide is a previous attempt; other risk factors have been identified, however they are not shared across people who complete suicide; and family and friends are key supports to prevent suicide.

Approaches for minimising the rate of suicide in the ACT should include mechanisms to build knowledge in the community of warning signs and the skills to communicate and support young people at risk of suicide; inform, educate and empower families and friends to recognise when their loved ones need help and how to help them, particularly when there is evidence of a previous attempt. To that end, the Committee recommends the *Care After a Suicide Attempt* report.

Introduction

Youth suicide is an increasingly prevalent concern for modern society. (Rhodes, et al., 2014) Inextricably linked to mental health, suicide and self harm remain a critical challenge for services and programs supporting young people. (Renaud, Seguin, Lesage, Marquette, Choo, & Turecki, 2014)

Across Australia in the 10 years from 2005 there have been over 24,000 deaths from intentional self harm, among which were 1,299 young people. (Australian Bureau of Statistics, 2014) Each year the number of young people who complete suicide increases, on average, by 6. (Australian Bureau of Statistics, 2014)

Table 1: Deaths of young people 0-19 years due to intentional self harm, 2005-14, Australia

Year	Deaths	Change	CI	CI
	No.	Year on year	Lower	Upper
2005	101		80.25	121.75
2006	118	17	95.95	140.05
2007	128	10	104.71	151.29
2008	109	-19	87.42	130.58
2009	108	-1	87.34	128.66
2010	130	22	106.44	153.56
2011	133	3	108.90	157.10
2012	147	14	121.83	172.17
2013	174	27	146.34	201.66
2014	151	-23	125.04	176.96

Source: ABS, 3303.0 Causes of Death, Australia, 2014

Table 1 shows the number of deaths among young people aged between 0 and 19 years in the 10 years up to 2014. The difference in completed suicides from 2005 to 2014 is significant[1] indicating that the increase in suicides is a very real and very present concern for our society.

Evidence suggests that while more females attempt suicide, males are more likely to complete. (Australian Institute of Health and Welfare, 2014) Of the 1,299 young people in Australia who have taken their own lives since 2005, roughly two thirds of them were male. Sex is one of the factors that can help us identify young people who are more likely to attempt suicide. These factors also include whether or not the young person is experiencing a mental health condition; if they have a history of harm, self-inflicted or otherwise; precipitating events occurring around the time of the attempt; the presence of alcohol or other substances; and so on. Combined, these factors increase the risk of an individual considering, attempting and often completing suicide. (NHMRC Centre of Research Excellence in Suicide et al, 2014; BoysTown, 2015)

Despite the research pinpointing the risk factors leading to suicide, more young people are taking their lives each year. Does knowing the risk factors help in overcoming the hopelessness, lack of feelings of belonging and acting in the moment that leads a young person to attempt suicide with the intention of causing death?

[1] 95% confidence interval

Suicide on the ACT Register

The primary function of the CYPDRC is to maintain a register of all the deaths of children and young people residing in the ACT. From the information housed on the register, the Committee is charged with identifying trends and conducting research to learn what it can from the deaths of ACT children and young people in an effort to prevent further deaths in the future.

The following relates to the information held on the *ACT Child Deaths Register* that pertains to the deaths of children and young people by suicide.

Since 2004, in the ACT, 10 young people have completed suicide.

Please note: The following has been edited to remove potentially identifying information.

Age

The majority of young people were between the ages of 15 and 17 years.

Sex

Deaths due to self harm in the ACT are evenly distributed between males and females, however nationally; males are more likely to complete suicide than females.

Education

In around half of the cases, the young person was enrolled at school. Most were completing their senior years (ie years 11 and 12).

Parental relationship status

In over half of the cases the individuals parents were married and living together.

Child Protection

In half of the cases there was some involvement of child protection services. However, in most instances child protection involvement comprised single mandated reports with no follow-up action.

Mental Health

Diagnosed mental health issues were present in over half of the cases, including diagnoses of depression, bipolar disorder and anxiety.

Precipitating events

Where information is held on the register regarding precipitating events; mental illness, grief, guilt, loneliness, bullying and relationship breakdown were included.

Social Disadvantage

In all cases, the individuals resided in areas with the least disadvantage. The Index for Relative Social Disadvantage provides an indication of the level of disadvantage within an area from most disadvantage (low score) through to least disadvantage (high score). The deciles for the areas where each individual resided range between 7 and 10; indicating the

least amount of disadvantage present within those areas. This does not provide an indication of the individual household level of advantage or disadvantage.

Medical/Non-Medical toxicology

In all cases a toxicology report was carried out and in half a positive result was returned. Findings included prescription medication and cannabis.

Mechanism

The main mechanism adopted was asphyxia due to hanging.

Location of completion

The majority of individuals completed suicide in or around their place of residence, including: bathroom; spare room; shed; or other outside area. In some instances, locations are not recorded on the register.

Previous attempts and self harm

Seven out of the 10 individuals had previously attempted suicide. These statistics provide further support for previous attempts being one of the strongest predictors of completing suicide.

Discussion

The inquiry is likely to receive plenty of evidence detailing the risk and protective factors related to suicide; the theoretical frameworks that link research and practice; and the range of interventions, underpinned by those frameworks, which are likely to be effective in any given context. These are important components in the overarching systemic response to reducing the incidence of suicide.

In this response, the Committee would like to focus on the ability of friends and family to act as the first best defence against suicide as well as the evidence that a previous suicide attempt is a strong predictor of a completed one (7 out of the 10 cases in the ACT).

For all the information that is available on risk factors leading to suicide there is a growing consensus that while the risk factors can be known, these are a poor tool for predicting who will and who will not act on suicidal thoughts. (BoysTown, 2015) The exception being previous attempts where the evidence suggests that this is one of the strongest factors predicting further suicide attempts. (Kuo & Gallo, 2005; Suominen, K., et al 2004) The evidence provided in the previous section illustrates that while there are risk factors for suicide, no one person experiences all the factors. Nor even those factors that are in common, are they experienced in the same way. However, as noted above, it can be seen that a high number of individuals who died by suicide in the ACT had made a previous attempt.

It has been the committee's long held view that services and people in the community should be encouraged to:

Look for signs and be aware of the children and young people you interact with. Understand how you can support them.

Friends and family can be the first and best defence in preventing suicide. While it is expected that frontline workers in support services would be able to recognise and respond to the risks of a previous attempt or the potential signs of suicidal ideation it is not always so for friends and families.

On average, one young person takes their own life each year in the ACT; one young life ended before their time. While classed as an avoidable death, it is not possible to know if these deaths could have been avoided if someone close to them knew to ask whether they had thoughts of hurting themselves. It is certainly not possible to know if someone did ask them. What is known is that asking a person if they have thoughts of hurting themselves and if they have an intention to hurt themselves can assist in preventing the attempt. (Gordon & Melvin, 2014; Victorian Department of Health, 2010)

There is no structured mechanism, no checklist tool that can be run across a population to allow for the identification and intervention of people who intend to act on suicidal thoughts. Understanding the risks, knowing the frameworks of what will and won't work for the young person and being able to implement these to support all young people who have thoughts of suicide across the community is important. But on an individual level, when one young person is hurting and feels they are alone and a burden to the world, having friends and families with the knowledge, skills and confidence to intervene when it is needed can potentially save a life. Any one person can never know when they will be the difference for one young person in distress.

This is particularly relevant in terms of the stigma that is attached to suicide and the fear among families of individuals, especially young people with suicidal ideation, that talking

about suicide will make it happen. (Gordon & Melvin, 2014) There is anecdotal evidence suggesting that within the small population of ACT, pressure from families combine with an unwillingness of medical practitioners to rule a death as being the result of suicide. Subsequently, the CYPDRC has concerns about the accuracy of death certificates and the under-reporting of suicides, in particular.

Moreover, the lack of completed suicides involving the mechanism of poisoning after a drug overdose was surprising to the committee. Again, there is anecdotal evidence to suggest that some deaths from overdose are ruled as accidental when they are the result of intentional self-harm. Whether it is through a misguided belief that the altered ruling will help the family grieve misreporting suicide is directly perpetuating the fear and stigma that surrounds suicide and self-harm by limiting our ability to understand it on a population scale, denying people close to the young person the opportunity to talk about the experience in terms of their own thoughts and behaviours and, therefore, hampers our collective ability to effectively address a considerable social issue. (De Leo, et al., 2010)

There is no formal evidence from the ACT that the committee can provide on this matter, other than the experience, expertise and connection to the community that members possess. The implication that follows however is this: the fear and anxiety that family members or friends feel in regard to suicide attempts and self harm is precisely the barrier that will impede the necessary action–that is, asking about thoughts and intent–that can potentially prevent it.

The committee recommends to the inquiry the following resource which details the contemporary models of care for those who've attempted suicide, reports on the findings of a mixed-methods research study and provides a number of recommendations for a systems approach to caring for people after a suicide attempt.

Care After a Suicide Attempt: A report prepared for the National Mental Health Commission by The NHMRC Centre of Research Excellence in Suicide Prevention, Black Dog Institute, the University of New South Wales, in partnership with The University of Melbourne, Lifeline, and the Australian National University.

Conclusion

In conclusion the Committee suggests that one of the strongest predictors of completed suicide is a previous attempt; other risk factors have been identified, however they are not shared across people who complete suicide; and family and friends are key supports to prevent suicide.

Given the complexity of suicide and self-harm and the inability to accurately predict who will and will not act on suicidal thoughts; approaches for minimising the rate of suicide in the ACT should include mechanisms to build knowledge in the community of warning signs and the skills to communicate and support young people at risk of suicide; inform, educate and empower families and friends in particular to recognise when their loved ones need help and how to help them, particularly when there is evidence of a previous attempt. To that end, the Committee recommends the *Care After a Suicide Attempt* report.

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