



## Focus on prevention: Youth suicide in the ACT

This fact sheet is a summary of key findings from the Committee's 2021 [Review of Children and Young People Who Have Died as a Result of Intentional Self-Harm](#).

### Review commissioned because of suicide increase in 2018

On average, 2 young people die by suicide each year in the ACT. When this rose to 5 in 2018, the ACT CYPDRC looked into the deaths of 8 young people who died between 2017 and 2019.

The review demonstrated there were common challenges faced by the young people who died by suicide, their families and friends as well as protective factors and services in the ACT community that promoted their wellbeing.

### Findings focus on role of community and design of support services

- Preventing youth suicide is a community responsibility for all of us in the ACT.
- Young people who have thoughts of suicide often turn to friends and family first, so taking their concerns seriously and assisting them to access specialised mental health services can help.
- Involving young people and their families who have lived experience of suicide to design and deliver prevention services is essential.

### Common challenges of ACT young people consistent with wider research

Risk factors of young people who died by suicide, included:

- emergence of mental health issues in adolescence
- history of self-harming behaviours
- previous suicide attempts
- breakdown of relationships with friends, romantic partners, family or bullying.

Other risk factors included: traumatic childhood experiences, such as abuse or neglect, alcohol or drug use and experiencing homophobic or transphobic abuse.

### Protective factors and social supports key to prevention

For these young people, often it was only a young person's peers and family who were aware of their distress.

The review found:

- the most common protective factor was a connection to family and friends
- the role of at least one supportive parent was evident in most cases
- parents accessed specialised help for a young person who expressed thoughts of suicide
- peers encouraged their friends to seek professional help and discouraged them from attempting suicide.



# ACT Children & Young People Death Review Committee

## Systemic gaps found

Findings indicated:

- a gap in service provision for young people in the ACT with moderate mental illness
- limited and/or sporadic engagement with support services
- inadequate follow up after a suicide attempt
- greater need for risk assessment and safety planning with young people following a suicide attempt.

## ACT CYPDRC recommendations based on the review

- Co-designing and delivering suicide prevention services with young people and their families who have lived experience of suicide.
- Evaluating whether current youth mental health and suicide prevention programs in the ACT meet demand.
- Using a support plan process in clinical settings that actively engages young people following a suicide attempt.
- Implementing evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide.
- Running information campaigns that focus on young people at risk and include practical intervention skills for peers and families.

Learn more about youth suicide prevention in the ACT at the Office of Mental Health and Wellbeing [website](#).

## Facts on youth suicide from the ACT Child Death Register (2018–2020)

- Suicide is the leading cause of death for young people in the ACT aged 13 to 17, similar to national data trends.
- The majority of deaths occurred between the ages of 15 and 17.
- Slightly more young males than females died by intentional self-harm.
- There were no recorded suicide deaths of Aboriginal and Torres Strait Islander young people during the review period.

## Contact us

If you have comments about this review, the ACT Children and Young People Death Review Committee is keen to receive feedback from interested ACT residents.

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