REVIEW OF CHILDREN AND YOUNG PEOPLE WHO HAVE DIED AS A RESULT OF INTENTIONAL SELF-HARM

ACT CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE

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ACT Children & Young People
Death Review Committee

Letter of transmission

Minister for Families and Community Services
ACT Legislative Assembly
London Circuit
CANBERRA ACT 2601

Dear Minister

In accordance with section 727T (1) of the Children and Young People Act 2008 I am pleased to present to you the report 'Review of Children and Young People Who Have Died as a Result of Intentional Self-Harm'.

I hereby request that this report produced by the ACT Children and Young People Death Review Committee be tabled in accordance with section 727T (3) of the Children and Young People Act 2008.

The Committee would like to thank Dr Elizabeth Moore for her valuable contribution to the development of this report.

The Committee acknowledges the grief for the families and friends of young people who have suicided and puts forward recommendations to improve practice and potentially reduce preventable deaths, like suicide.

Yours Sincerely

M Carmody

Ms Margaret Carmody PSM
Chair,
ACT Children and Young People Death Review Committee
11 January 2021

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Executive summary

Since 2004, on average one to two young people take their own life each year in the ACT. Sadly, in 2018 this number was five. The Children and Young People Death Review Committee (the Committee) therefore decided to examine death by suicide in the ACT between 2017 and 2019, to explore significant systemic factors that may surround the suicide deaths of young people and to offer key insights to support services, schools, family and peers to reduce the future likelihood of young people dying by suicide. There is a long history of research on the risk factors for suicide and self-harm. However, no single factor is sufficient to explain why a person died by suicide. The literature highlights a broad consensus that suicide is preventable and that there are different types of interventions that lend themselves to different contexts.

Efforts to reduce youth suicide remain a national priority, and recent research and policy initiatives have focused on finding new ways to protect people at risk of suicide and build interventions to prevent suicide. Over the past five years, significant funding has been provided by the Australian Government to support suicide prevention programs.

In 2018, the ACT Government committed to implement a high-fidelity research trial of the Black Dog Institute's Lifespan Integrated Suicide Prevention Framework. There are currently several projects and programs under the Lifespan trial that have been implemented or are being rolled out across the ACT.

A life course framework has been used in this review. This included the development of 'life charts' to identify the underlying biological, behavioural and psychosocial processes that operate across the life span. This method was chosen to maximise the value of source information available. The charts were reviewed by the Committee and informed the recommendations made in this report. Given the small data cohort, information that would enable the identification of an individual is not publicly available.[1]

Consistent with previous reviews that have used this methodology, for most young people, their suicidal pathway was characterised by an emergence of mental health issues in adolescence. Several common risk factors were also identified that are consistent with previous research, including previous suicidal attempts, self-harm and interpersonal issues.

For most young people, their presentation would not have been dissimilar to many of their peers. They were attending school, had at least one engaged parent and a strong peer network. Often it was only their peers and family who were aware of the distress they were in. The review highlights that it is crucial for parents, educators and peers to have information and training so that they are able to effectively respond to young people in distress.

When reviewing service involvement for the young people in this review, the analysis focused on key components of service availability, suitability and continuity. Again, several common themes were identified, including access to appropriate services, sporadic or limited engagement, help-seeking behaviour through family and friends, limited outreach after a suicide attempt, challenges with risk assessment and safety planning, and communication between services and with young people.

[1] As per s. 727S(3) of the Children and Young People Act 2008, the Committee must not disclose the identity of a child or young person who has died or allow the identity of a child or young person to be established.

The Committee recommends the following improvements for future suicide prevention service and program design:

- Involve young people with lived experiences of suicide in suicide prevention service design and delivery.
- Evaluate current youth mental health and suicide prevention programs to determine effectiveness including in meeting demand.
- Implement information campaigns that target young people at risk and include practical intervention skills for peers and family.
- Implement and evaluate the Connecting with People program. Consider implementation in education and non-government organisation settings.
- Implement a support plan process in clinical settings that actively engages young people following a suicide attempt.
- Implement evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide.
- Train staff from relevant organisations on responsible information sharing.

Introduction

Youth suicide is an increasingly prevalent concern and, as a community, it is something for which we are all responsible (Rhodes, et al., 2014). Addressing suicide and self-harm remains a critical challenge for services and programs supporting young people (Renaud, et al., 2014). Yet, despite research pinpointing the risk factors leading to suicide, more young people are taking their lives each year. In 2019, across Australia, 3,318 people died from suicide, rising 5.7% from 3,138 in 2018 (Australian Bureau of Statistics, 2019). Suicide accounted for more than one-third of deaths among people aged between 15 and 24. Suicide was the leading cause of death for Aboriginal and Torres Strait Islander children (5 to 17 years) between 2015 and 2019 (Australian Bureau of Statistics, 2019).

The World Health Organization (WHO) reports that for every suicide there are many more people who attempt suicide every year. Significantly, a prior suicide attempt is the single most important risk factor for suicide in the general population (World Health Organization, 2014). Furthermore, individuals with a history of self-harm are at a far greater risk of suicide than the general population (Han, et al., 2016).

Since 2004, in the ACT, on average between one and two young people take their own life each year. Sadly, in 2018 this number was five. While the numbers of death by suicide are small, the effects are devastating for relatives, friends and the healthcare professionals involved. When a suicide takes place, the Children and Young People Death Review Committee (the Committee) needs to understand what happened and learn from any lessons identified. The lessons learnt are important to improve services and help the ACT community, ACT services and those working with young people to recognise where risk exists. This review enables the Committee to analyse the circumstances surrounding these events and recognise where efforts can be made to make things safer for other young people at risk.

This report is divided into four chapters. Chapter 1 provides a brief literature review on the topic of suicidality, self-harm, suicide prevention and post-intervention support. This chapter looks at the extent of the issue and the associated risk factors and provides an overview of the ACT context and current availability of supports. Chapter 2 outlines the aims and

objectives of the review and describes the methodology used. Due to the sensitive nature of the information and out of respect for the young people and their families, a description and analysis of the reviewed data will not be publicly available. Chapter 3 provides only the key findings of the review and Chapter 4 outlines the recommendations for consideration based on the data available to the Committee and from consultation with key stakeholders.

1. Youth suicide

The tragedy of a young person dying because of overwhelming hopelessness or frustration is devastating to family, friends and the community. The WHO has called on nations to make suicide prevention a 'global imperative' (World Health Organization, 2014). In Australia, youth suicide is a significant public health concern, with suicide being the leading cause of death of children and young people between 5 and 17 years of age (Australian Bureau of Statistics, 2019).

Efforts to reduce youth suicide remain a national priority, and recent research and policy initiatives have focused on finding new ways to protect people at risk of suicide and build interventions to prevent suicide. The prevalence of youth suicide and the significant burden accompanying it have led to a notable increase in the volume of research about the causes and risk factors for suicidal behaviour. There is now a large amount of information that gives a comprehensive and consistent picture about the risk factors for suicidal behaviour.

1.1 The extent of suicide in children and young people

The deaths of children and young people by suicide is a sensitive issue, with the number of deaths of children attributed to suicide being influenced by coronial reporting practices (Australian Bureau of Statistics, 2019). Differing reporting practices across the jurisdictions may lead to differences in counts.

For children (0 to 14 years), death by suicide is rare in Australia. In 2019, the Australian Bureau of Statistics (ABS) reported there were no recorded suicide deaths of children under the age of 5 years. However, suicide remained the leading cause of death for children between 5 and 17 years of age, with 96 deaths (Australian Bureau of Statistics, 2019).

More deaths by suicide occur in young people aged 15 to 17 years than in younger age groups. In 2019, 78.8% of youth suicides were in people aged between 15 and 17, leading to an age-specific death rate of 8.8 compared to a rate of 0.6 for children aged 5 to 14 (Australian Bureau of Statistics, 2019). The age-specific rate of suicide for those aged 5 to 17 years was 2.4 per 100,000 in 2019, with the male rate of 3.0 almost double the female rate of 1.7 (Australian Bureau of Statistics, 2019).

In the ACT, suicide is also the leading cause of death for young people aged 13 to 17 and, similar to national data, the majority of these deaths occurred between the ages of 15 and 17 (Children and Young People Death Review Committee, 2018). While the small number of deaths each year is subject to year-on-year fluctuations, there is an average of two deaths by suicide occurring each year in the ACT. Five deaths by suicide occurred in 2018.

From 2017 to 2019 across the ACT, there were slightly more males than females who died where intentional self-harm was recorded as the cause of death. There have been no recorded suicide deaths of Aboriginal or Torres Strait Islander young people. Culturally and linguistically diverse (CALD) status is not collected consistently, but there has been a small

number of young people identified as CALD recorded on the Child Death Register over the past 12 years.

1.2 Understanding suicide

Attempts to understand suicide from a theoretical/conceptual perspective have grown notably over the past few decades, and a range of theoretical frameworks have been proposed to examine and explain suicide and suicide research. Selby, Joiner and Ribeiro (2014) report that this interest has supported a better understanding of the causes of suicide behaviour and helped identify the individuals who may be more likely or capable of suicide. Such theoretical frameworks have included sociocultural, psychological, developmental, psychodynamic and moral perspectives (Durkheim, 1897; Beck, Berchick, Stewart, & Steer, 1990; Baumeister, 1990; Joiner, 2005; Beauchaine & McNulty, 2013). More recent contributions have come from disciplines such as psychiatric epidemiology (Bachmann, 2018), behavioural genetics (Zalsman, 2012) and injury prevention (Stone, et al., 2017).

No single factor is sufficient to explain why a person died by suicide. Suicidal behaviour is a complex phenomenon that is influenced by several interacting factors: personal, social, psychological, cultural, biological and environmental.

Different theories to understand suicide have, in turn, led to the development of different strategies for suicide prevention. Specifically, sociological and macroeconomic theories have led to an emphasis on population-level change in the social, economic and related structures that are believed to foster the development of suicidal behaviours. In contrast, mental health and psychiatric explanations of suicide have tended to focus on the better identification, treatment and management of psychiatric disorders as the primary route to suicide prevention. Finally, injury prevention perspectives have tended to focus on restricting access to the means of suicide.

1.3 Risk and protective factors

Australian and international research highlight that suicidal behaviour results from a multifaceted interaction between psychological, social and biological factors (Kinchin & Doran, 2018). Although there is no definitive way to predict suicide at an individual level (Large, 2018), there are many antecedent factors related to a suicide death, including mental health issues, financial difficulty or relationship distress.

In 2017, the ABS completed a pilot study using 2017 suicide data to test methods of enhancing existing cause of death data by incorporating psychosocial risk factor and other contextual information. Certain psychosocial factors were coded as associated factors to the death. For young people aged 5 to 24 years, mood disorders, mental and behavioural disorders due to a psychoactive substance and other symptoms and signs involving an emotional state were the top three noted causes of death, and International Classification of Diseases codes were attributed to these deaths.

Significant differences in the rates and risks of suicidal behaviour between the sexes has been consistently identified in the literature. This phenomenon is referred to as 'the gender paradox': there is a higher rate of suicide attempts in females but more completed suicides in males (Lee, et al., 2019).

Numerous distal or historical risk factors have been identified that increase an individual's susceptibility to proximal or imminent risk factors for suicide (Hawton K, 2009). These risk

factors can occur simultaneously in environmental, family and individual domains (Mościcki, 1997).

Most research has identified two particularly strong risk factors for youth suicide: mental illness (Bridge, Goldstein, & Brent, 2006) and a previous suicide attempt (Goldstein & Brent, 2016). Family factors, including parental mental illness, parental substance use and completed or attempted suicide within the family, can also be significant risk factors for suicide in young people (Mcnamara, 2013; Van Orden, et al., 2010), as are adverse childhood experiences such as abuse and neglect (Dube, et al., 2001). Personality characteristics, such as impulsivity, poor problem-solving skills and poor mood regulation, have also been identified in multiple studies as a risk factor for future suicide behaviour (McHugh, et al., 2019; Williams, Does, Barnhofer, Crane, & Segal, 2008).

Specific life events such as a relationship break up, school- or family-related stress, access and availability of means and exposure to suicide within peer groups have been identified as proximal risk factors for young people who are vulnerable to suicide (Hawton K, 2009).

In contrast, protective factors are those attributes in a young person's life that increase the individual's ability to address difficult circumstances. Having a connection to education, peers and family, access to quality supports, life skills and a strong sense of purpose have frequently been identified as protective factors (Beautrais , Collings, & Ehrhardt, 2005; Robinson, et al., 2018).

However, the use of these factors as a type of checklist to assess young people for risk of suicide is not recommended (Chan, et al., 2016)). Rather, understanding risk factors is important when targeting preventive strategies. Research suggests that professionals need to steer away from attempts at risk prediction and, instead, use a more personalised approach that is tailored to individual risk and needs (Chan, et al., 2016).

1.4 Suicide and self-harm

Self-harm is generally understood to be intentional, self-inflicted tissue damage. Self-harm generally encapsulates cutting, scratching, biting, burning and causing bludgeoning damage to oneself (Fliege, Lee, Grimm, & Klapp, 2009). Self-harm is usually, though not always, defined as harming oneself without an intent to die (Fliege, Lee, Grimm, & Klapp, 2009). Most self-harm occurs without the intent of dying (Moran, et al., 2012).

Various reasons have been cited for this behaviour, such as wanting others to know the extent of one's psychological pain, to frighten others or to make a cry for help (Edmondson, Brennan, & House, 2016). Averting emotional distress has been identified as a common reason for self-harm, as the act itself helps individuals calm down, distract themselves and deal with physical pain over emotional pain (Edmondson, Brennan, & House, 2016).

Self-harming behaviours have been found to be more common in somewhat older adolescents, but this may differ for certain population subgroups where no significant difference was found between younger and older adolescents (Lee, et al., 2019). Female adolescents are significantly more likely to engage in self-harming behaviour than male adolescents (Zubrick, et al., 2016; Australian Institute of Health and Welfare, 2020).

There is a well-established link between the experience of psychiatric disorders and self-harm (Zubrick, et al., 2016; Haw, Hawton, Houston, & Townsend, 2001). Adolescents who have a history of depressive symptoms are more likely to self-harm (Moran, et al., 2012). Many of the risk factors for self-harm are also risk factors for suicidality (Lee, et al., 2019). While self-harm

and suicidal behaviour have been found to be related (Carroll, Metcalfe, & Gunnell, 2014), it is important to note that these behaviours do not necessarily co-occur (Lee, et al., 2019).

1.5 Assessment

Assessment of suicidal ideation should include attention to both severity (intent) and pervasiveness (frequency and intensity) (Goldstein & Brent, 2016). Suicide risk assessments are widely practised and endorsed (Chan, et al., 2016) and are often conducted by general practitioners, psychologists, psychiatrists, social workers, mental health professionals and hospital-based health professionals. Risk assessments often examine the individual's mental health, personality, physical health, interpersonal relationships, social environment, significant life events, suicidal ideation and history of suicidal behaviour to determine whether they are at risk of future suicide. This classification is then used to allocate resources aimed at preventing these behaviours (Chan, et al., 2016).

There are various ways to conduct a suicide risk assessment. Assessment scales and tools are commonly used, such as those that directly measure suicide risk, like the Suicide Intent Scale and the Columbia-Suicide Severity Rating Scale, or indirectly measure suicide risk, like the Beck Hopelessness Scale and the Depression, Anxiety, and Stress Scale. Other risk assessments are conducted using organisational or practitioner standards, such as the Mental State Examination.

Despite their widespread use, risk assessment scales and tools may not provide an accurate measure of suicide risk (Runeson, et al., 2017). When administered to children and young people experiencing a mental health crisis, these tools may not be valid or reliable due to differences in cognitive ability, perception and understandings of suicide in this demographic (Carter, et al., 2017).

1.6 Prevention and treatment

There is a broad consensus that suicide is preventable and that different types of interventions lend themselves to different contexts (Calear, et al., 2016). The WHO recommends that suicide prevention should be achieved by the systematic consideration of risk and protective factors and related interventions.

Youth suicide prevention efforts are delineated into three distinct approaches. The first approach is a universal approach to suicide prevention that is delivered to all youth before the onset of suicidal thoughts or behaviours. Typically, universal programs employ capacity-building techniques to foster resilience in young people and promote protective factors against suicidality. Reducing stigma about mental illness is also viewed as a goal of these interventions (Lindow, et al., 2019).

Selected or secondary programs are targeted towards youth who are identified as being at risk of suicidality. These programs are primarily focused on addressing precipitating factors of suicidality through pharmacological treatment, therapy or changing language and coverage of media regarding suicide (Lindow, et al., 2019).

Indicated interventions are delivered to youth who have ongoing concerns of suicidality or a history of suicidal behaviour. Young people in these programs are typically treated with targeted therapy with a view to reducing suicidal behaviours (Lindow, et al., 2019).

Within the clinical management of at-risk individuals, safety planning is considered best practice (Goldstein & Brent, 2016). Suicidal crises are often a temporary period of strong

suicidal desires and urges, followed by a marked decrease in the desire for suicide. Safety plans prevent individuals from acting on these urges, as they encourage the individual to stay safe while the crisis dissipates and passes (Goldstein & Brent, 2016).

There are smartphone applications that are available for young people, such as the Beyond Now smartphone app developed by Beyond Blue and Monash University. The app encourages individuals to create, edit, access and share a personal safety plan and enables users to list warning signs, reasons to live, ways to limit access to lethal means and coping strategies to use in times of crisis. The app has been shown to be linked to a significant decrease in severity and intensity of suicidal ideation and a significant increase in the use of coping strategies, thereby demonstrating the effectiveness of safety planning for suicidal individuals (Melvin, et al., 2019).

While inpatient hospitalisation can provide safety for young people experiencing a suicidal crisis, there is limited research to demonstrate that it reduces suicidality (Goldstein & Brent, 2016). Studies have found differing experiences of psychiatric hospitalisation. Some people described a hospitalisation as part of the recovery process, which was safe and therapeutic (Adnanes, et al., 2018), whereas others described hospitalisation as a negative experience with no support and found it to be chaotic, alienating and hierarchical (Chevalier, Ntala, Fung, Priebe, & Bird, 2018).

The time following discharge from hospital represents a period of increased risk for suicide attempts. Qin & Nordentoft (2005) found that suicide risk peaks immediately after hospital discharge. They argued that this demonstrates the importance of conducting a systematic evaluation of suicide risk before discharge and ensuring that adequate outpatient treatment and support is initiated immediately after discharge to prevent suicide.

Common psychotherapeutic treatments for suicidality are cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT). The core of these approaches is to challenge unhelpful thinking patterns (Spirito, Esposito-Smythers, Wolff, & Uhl, 2011). In a systematic review, Carter, et al. (2017)found that while half of the reviewed programs showed a reduction in suicide attempts, no one treatment was considered more effective than any other.

Concerns about increased suicide risk among children and young people taking antidepressants have existed since 2003 (Hawton, Saunders, & O'Conner, 2012). More recently, an Australian study (Whitely, Raven, & Jureidini, 2020) led to the Australian Government Minister for Health engaging their department to review these concerns. There is debate about the safety of using antidepressants in youth (Gold & Frierson, 2018). It is argued that the use of antidepressants should be limited to young people with moderate to severe depression where psychotherapeutic interventions are unsuccessful (Vitiello & Ordóñez, 2016).

The WHO advocates that universal strategies should target whole populations, selective strategies should target higher-risk groups and indicated strategies should protect individuals at risk. In recognition of this complexity, suicide prevention policies and practices need to be multisectoral and interdisciplinary and cover the spectrum from primary to tertiary prevention.

1.7 National and local policy context

Suicide prevention is a whole-of-community responsibility that does not just include specific mental health and suicide prevention programs. Broader strategies that improve quality of life and address known risk factors are required to sit alongside targeted programs. The

following summary of the national policy context provides information on only specific mental health and suicide prevention strategies. The review of the ACT context includes broader community initiatives that relate to the overall wellbeing of young people.

1.7.1 National

Over the past five years, a significant amount of funding has been provided by the Australian Government to support suicide prevention programs. There has been an increased focus and concerted effort in government policy and funding for suicide prevention in recent years; this has largely been led by the health portfolio and the Department of Social Services.

The National Suicide Prevention Strategy, which was implemented in 2015, is the national policy on suicide prevention agreed by the Australian Government and state and territory governments. It has an emphasis on promotion, prevention, early intervention, Aboriginal and Torres Strait Islander communities and effective follow up, with a focus on systems-based regional solutions through a health framework. The joint commitment to these strategies by states and territories is established in the Fifth National Mental Health Plan, which was endorsed by the COAG Health Council in August 2017. This plan has eight priority areas, including suicide prevention. The plan notes that suicide prevention approaches were previously fragmented with unclear roles across government (COAG Health Council, 2017).

In 2019–20, the Australian Government committed $461 million for a national strategy for suicide prevention for youth and Indigenous Australians. This includes an expansion of the Headspace network, funding for Indigenous-specific suicide prevention strategies and increased funding for childhood and parenting support programs. In addition, the Australian Government established the Prime Minister's National Suicide Prevention Adviser role[2] to report on the effectiveness of current programs and to embed suicide prevention policies across government. In December 2020, 13 interim recommendations were released, which focused on designing an approach from lived experience and a coordinated, comprehensive national approach.

The National Mental Health Commission is developing Vision 2030, which is a national ten-year plan for mental health and suicide prevention. The plan aims to develop a connected suicide prevention system which is delivered through a whole-of-community approach focused on community-based early intervention services.

1.7.2 Local

In 2018, the Office for Mental Health and Wellbeing (OMHW) was established in the ACT to develop better coordination and integration across mental health services, provide system-wide oversight, drive opportunities for quality improvements and create a more person-centred approach to mental health and wellbeing.

The ACT Government committed $1.545 million over three years in the 2018–19 ACT Government Budget to implement a high-fidelity research trial of the Black Dog Institute's Lifespan Integrated Suicide Prevention Framework. The framework is being implemented by ACT Health in partnership with the Black Dog Institute and Capital Health Network.

LifeSpan is an evidence-based approach to integrated suicide prevention. It uses nine specific strategies that address youth suicide but is also concerned with suicide in the wider community. Lifespan seeks to address previous concerns that suicide prevention programs

[2] Ms Christine Morgan (currently appointed as the Chief Executive Officer of the National Health Commission)

were disaggregated and required an integrated approach that facilitated continuity of care (Black Dog Institute, 2017).

LifeSpan aims to create a whole-of-government and community approach, ensuring that care is comprehensive and continuous according to the needs of an individual, their family and their community. LifeSpan is particularly concerned with training and educating community members and professionals to recognise and respond to individuals in distress (Black Dog Institute, 2017).

Since the Lifespan trial began, two reviews in 2020 have considered mental health services and supports in the ACT:

- In March 2020, the OMHW released a review of Children and Young People in the ACT (Office for Mental Health and Wellbeing, 2020). This review heard from more than 800 children, young people and their carers about mental health concerns. It provides three recommendations on access to services, education addressing stigma and fear about mental health and the need for new services to target moderate to severe mental illness.
- In August 2020, The Legislative Assembly Standing Committee on Education, Employment and Youth Affairs finalised an inquiry into youth mental health in the ACT. The report provides more than 60 recommendations, with a focus on access to mental health supports in schools and improved access to community mental health (ACT Standing Committee on Education, Employment and Youth Affairs, 2020).

The ACT Government's submission to the standing committee inquiry into youth mental health provides a thorough overview of the current mental health support landscape in the ACT (ACT Government, 2020).

There are currently several projects being led by the ACT Health and Education Directorates which have been implemented or are being developed across the ACT. The implementation of the Youth Aware of Mental Health (YAM) program in ACT high schools:

- The planned development of program guidelines to support ACT schools to select appropriate mental health programs that build resilience in the 8-to-12-year-old age group.
- The development of an online navigation portal to help young people and their families access mental health support.
- The development of a working group to identify the needs of children and young people with moderate to severe mental health issues.
- The establishment of two safe haven cafes, the first of which will be at the Canberra Hospital, which will provide an alternative to people accessing emergency departments.

A list of ACT suicide prevention programs can be found at Appendix A of this report.

The current youth mental health system in the ACT has a vast range of services available to children and young people, and this makes navigating the system challenging. The 2020 OMHW Review identified 178 services and programs for people up to 25 years of age within the ACT and online. The difficulty in navigating and accessing these services was a key finding of this review, with the above-mentioned online youth navigation portal being recommended (Office for Mental Health and Wellbeing, 2020).

The ACT Government has also recently undertaken projects that look to improve young people's quality of life. Recognising the critical period of development for children in the first

two years of life, the ACT Government is currently developing a 'first 1000 days' strategy that seeks to provide children and families with services and programs to promote a healthy start to life. The Family Safety Hub and the Children and Young People's Commissioner undertook a project in 2020 where young people were consulted about their experiences of domestic and family violence. This project has provided key insights that will inform a co-design support service process with young people.

ACT Education currently has two integrated ten-year plans aimed at supporting students from early childhood education through their schooling years. The Future of Education and Set up for Success: An Early Childhood Strategy for the ACT provide core foundations and principals to improve the life opportunities of all children and young people. These plans acknowledge the importance of quality education for all children, particularly for those experiencing vulnerability and disadvantage.

2. Scope of the current review

The review was initiated by the Committee following an increase in 2018 in deaths of young people in the ACT attributed to intentional self-harm. The review undertaken relates to all deaths of young people reported as being caused by intentional self-harm in the ACT between 2017 and 2019. The review is limited to the consideration of (completed) suicide as determined by the Coroner.

For the purposes of this review, suicide is defined as death caused by self-directed injurious behaviour with an intent to die as a result of the behaviour (Nock, 2014).

The Committee recognises that suicide deaths are the rare end point of self-injurious behaviour. Self-harm for this review is defined as behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself (Nock, 2014). The review considered all recorded episodes of self-harm for those who completed suicide.

The review considered young people's contact with services throughout their lives. This included Education, Community Services, ACT Health (including community mental health), general practitioners and private psychologists and counsellors.

Understanding the types of support and services young people engage with as well as the barriers to effective support assists with the development of more appropriate and targeted prevention and early intervention strategies aimed at reducing the incidence of intentional self-harm and suicide among young people.

2.1 Aims and objectives

The overarching aim of this review is to explore significant systemic factors that may surround the suicide deaths of young people and to offer key insights to support services, schools, family and peers to reduce the likelihood of young people dying by suicide. Reducing intentional self-harm and suicide is everyone's business, and understanding how to prevent these deaths is critical if we are to stop the further loss of lives by suicide.

The aim of this review is not to consider the cause of death of young people, as this was determined by the Coroner. The objectives of this review are to:

- examine the key risk and protective factors evident in each young person's life up until the time of their death

- identify the types of interventions offered and/or provided by support and statutory services
- contribute to wider learnings to improve policy, program or practice responses, including recommendations of any procedural, administrative and legislative changes that may reduce the likelihood of deaths as a result of intentional self-harm.

2.2 Review methodology

A life course framework has been used in this review (Fortune, Stewart, Yadav, & Hawton, 2007). The life course approach aims to identify the underlying biological, behavioural and psychosocial processes that operate across the life span. It emphasises critical periods, such as sensitive developmental stages in childhood and adolescence, when social and cognitive skills, habits, coping strategies, attitudes and values are more easily acquired than at later ages. This approach has been used in a number of other reviews of death by suicide, including a review in South Australia that used a model of 'life chart analysis' as a way of maximising the value of the source information that it held and as a means of identifying opportunities for intervention and prevention. The review uses the above categories and pathways.

Previous studies of youth suicide that have used a life course approach have identified themes categorised into broad suicide pathways. The benefit of considering common themes across a cohort is that it may help identify patterns of individual risk and engagement with systems. This review has considered these groups of suicide pathways in the analysis of the individual cases.

The seminal research of youth suicide using a life chart analysis process by Fortune et al. (2007) used life charts to review the suicidal process of 27 young people in the United Kingdom. The results of the research identified three groups of suicidal pathways:

- Group 1 — Seven young people characterised by longstanding life problems, poor school engagement, family relationship problems, childhood sexual abuse, family violence and poor peer relationships.
- Group 2 — Fifteen young people with the emergence of challenges to mental health, such as depression and/or anxiety. Two subgroups have been identified, namely those individuals with a protracted suicidal process and those with a brief suicidal process.
- Group 3 — Five young people characterised by the emergence of the suicidal process as an acute response to life events in the absence of criteria for Group I or Group II (Fortune, Stewart, Yadav, & Hawton, 2007).

The South Australian Child Death and Serious Injury Review Committee (CDSIRC) 2018–19 annual report provides a summary of a review into 44 suicide deaths using a life chart methodology. Within this review, four distinct groups of commonly occurring themes were identified:

- Group 1 – Thirteen children and young people who faced family, learning and social challenges in their lives from an early age.
- Group 2 – Twenty-three children and young people who engaged normally with family, school and friends until the emergence of challenges to their mental health, such as depression and/or anxiety.
- Group 3 – Five children and young people who had stable home lives and no evidence of mental health challenges, but who had experienced challenges in romantic/sexual or social relationships immediately prior to the event.

- Group 4 – Three Aboriginal children and young people who lived in rural and remote regions of the state. From an early age, these children and young people were often in the care of extended family. They had frequent absences from school and faced challenges with learning, communicating and understanding. They were said to be users of marijuana and alcohol (Child Death & Serious Injury Review Committee, 2019).

2.3 Sources of information

Because young people access a range of formal and informal supports, the Committee reviewed information from the following sources:

- National Coronial Information System
- Emergency Services
- ACT Policing
- ACT Health
- Canberra Health Services
- ACT Education Directorate
- Children, Youth and Families
- Housing ACT
- Family Law Court.

The Committee does not request family members or significant persons to become involved in in-depth review processes directly and relies on family members or significant persons to approach the Committee and voluntarily offer information. Family members or significant persons may decide to contact the Committee as a result of reading the Committee's brochure or website or by word of mouth from health and community service professionals.

2.4 Limitations of the review

There are limitations on how the data provided in this report may be appropriately interpreted and used. While the review benefited from access to detailed records and official reports, it is based upon administrative and file data only. Not all young people reviewed were engaged in services immediately prior to their death, and no interviews or consultations were undertaken with the key people in their lives who may have been able to provide further information. As a result, for some young people there is limited information available to review. Furthermore, not all official records for all young people were available to the Committee and this may have resulted in gaps in information.

2.5 Protecting confidential information

This report draws on in-depth case studies of the deaths of eight young people in the ACT. It is designed to provide useful information to the public while, at the same time, meeting the requirement of section 727T (2a and 2b) of the *Children and Young People Act 2008* to report data in a manner consistent with protecting the identity of a child by not disclosing their identity or allowing their identity to be worked out. Therefore, in accordance with statutory requirements designed to protect confidentiality, the analysis of the file data is excluded from the report and only broad themes are reported.

3. Key findings

The following findings are not intended to be an exhaustive list; rather, they identify themes of both risk and protective factors and service engagement that were prominent within reviewed files.

3.1 Life chart analysis

The analysis considered nine young people (12 to 18 years) who died from intentional self-harm in the ACT between 2017 and 2019. One young person was excluded from the review as coronial proceedings had not been finalised at the time of writing. Of the eight young people included, the median age was 15 years and 3 months.

The life chart analysis of young people in this review was consistent with previous research, with most young people considered to be in Group 2 of both Fortune et al. (2007) and South Australian CDSIRC studies. Some or all had common features in their life charts, which were characterised by:

- emergence of mental health issues in adolescence
- a relatively stable home life that included at least one supportive parent
- consistent engagement in school and education prior to the emergence of mental health issues
- challenges in interpersonal relationships in the months and years before their death
- disclosures of self-harm and suicidal ideation (including previous attempts) to family, friends and services
- some level of engagement with mental health services.

The young people in this review were predominantly connected with their peers, had at least one engaged parent and were engaged in their education. For many of the young people, their presentation would not have substantially stood out from those of their peers. Their distress was most often shared with peers and family, while contact with mental health services was generally minimal.

Within this review, the pathway to suicide for young people was, on average, less than one year. People around the young person were generally aware of their suicidal ideation and in most cases, family had supported them to engage in services. However, this engagement was most often limited or sporadic.

A small group of young people in this group had a longer than average suicidal pathway. There was a more pronounced impact of their mental health on their peer and family relationships. For these young people, engagement with mental health services was more intense and prolonged and involved inpatient care.

Consistent with previous research, using a life chart approach, a small group of young people in this review were characterised by longstanding family, learning and social challenges. These young people grew up in an environment with chronic adverse childhood experiences, including abuse, neglect, parental alcohol and substance use, exposure to family violence and parental poor mental health. For this small group, there were extensive issues across multiple life domains.

No reviewed cases would be considered an acute response to life events (considered as a key characteristic of Group 3 from previous studies).

No Aboriginal or Torres Strait Islander children are known to be part of the review's cohort (Group 4 of South Australian CDSIRC study).

Individual pathways to suicide are complex and the extent of an individual's mental health challenges, interpersonal conflicts, alcohol and drug use or minority stress associated with gender and/or sexuality identity are not fully captured in file records. This is exacerbated in many cases by the limited and/or sporadic engagement with support services, which reduces the amount of information a review of this nature can draw upon.

3.3 Case example

The following case example has been developed to illustrate the most common themes observed within the reviewed files. An illustrative case study has been used to ensure no details of any particular young people can be identified.

> *Gavin was a 16-year-old male who died in December 2017. The manner and cause of death was hanging.*
>
> *Gavin was the oldest of two children. He had a younger brother who he was close to and his parents separated when he was eight years old. Gavin's parents had a 'good relationship'; he lived with his mother and spent every weekend with his father. He had a close group of friends through his high school and his school attendance and achievement was sound. Gavin was an avid sportsman who played for the local AFL team. There was no family involvement with Children and Youth Protective Services (CYPS) and no history of alcohol and drug use.*
>
> *At the start of 2017, when Gavin was entering year 11, he commenced a relationship with a girl, Stacey, who was the same age. This relationship lasted a short period before it was ended by Stacey. Following the separation, Gavin's family noticed a change in his mood and behaviour. He began to disengage from his family, his school attendance dropped and he quit football. Gavin spoke to his friends about not seeing the point in living anymore and that he had hidden a rope under his bed. In July, Gavin went to the School Youth Health Nurse (SYHN) and advised that he was feeling depressed and wanted to reduce his subjects. On his second visit to the SYHN, Gavin reported that he had thought about killing himself and, if he did, he would hang himself.*
>
> *The following week Gavin was taken to hospital by ambulance after he overdosed on his father's medication at his home. He was assessed in hospital and released into the care of his parents. He was advised that Child and Adolescent Mental Health Services (CAMHS) would contact him in the coming days. Two days later CAMHS contacted Gavin and spoke to him and his mother. Gavin's mother told the worker that he had told her several years ago that he self-harmed (cutting), he had engaged with a private psychologist for a short period who had told the family he was suffering from depression and anxiety due to some bullying at school. Gavin's mother reported that she spoke to the school and everything seemed fine until a few months ago. Following the phone call, a CHOICE appointment pack was sent to the family.*
>
> *CAMHS attempted to contact Gavin one week later but was unable to reach him. After attempting to contact Gavin over several days, CAMHS contacted*

his mother and she advised that he was planning to engage with a private psychologist after seeing the GP and getting a Mental Health Treatment Plan. CAMHS closed the case.

A week later Gavin texted his best friend late at night and told him that he didn't see the point in living anymore and wanted the pain to end. The next day he died by suicide.

3.4 Common themes associated with suicide within the review

There were several common themes identified within the cohort that could be considered as risk factors for suicide. The following themes were identified through the review of file information and, unless specified, were also identified in most young people's life charts.

3.4.1 The emergence of mental health issues in adolescence

Most young people in this review displayed symptoms of mental illness in their teenage years. Predominantly, concerns were identified about anxiety or depression in the months or years before their death. An increase in symptoms of mental illness was common during significant life changes for these young people.

For more than half the cohort, there was evidence of a diagnosed mental illness. For the other young people, professionals had observed emerging depression or anxiety symptoms impacting on their day-to-day functioning. In these cases, family and friends of the young person had also identified changes in behaviour, including changes in grades, disengagement from friends and family and out-of-character behaviours.

As many as half of all mental health conditions start by 14 years of age (World Health Organization, 2014), and there is a significant body of literature that identifies mental health as a significant risk factor for suicidal behaviour (Cavanagh, Carson, Sharpe, & Lawrie, 2003). Major Depressive Disorder has been shown to be a particularly strong risk factor for suicidal ideation or behaviour (Cavanagh et al., 2003; Zubrick et al., 2016). It appears that depression is a more common contributor to suicidality; however, there are also associations between other mental illnesses and suicidality.

Anxiety, for instance, was also found to be a risk factor for suicidal ideation and behaviour in the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Zubrick, et al., 2016). Anxiety frequently co-occurs with depression, leading to some difficulty in determining the precise aetiology of these suicidal ideations (Hill, Castellanos & Pettit, 2011). Suicide has a more complicated aetiology than simply the experience of psychiatric disorders (Van Orden, et al., 2010). Most people with ill mental health will not present with suicidal behaviour (World Health Organization, 2014). Most of the young people in this review presented with mental illness comorbidity.

3.4.2 Previous suicidal attempts

A previous attempt of suicide, defined as a record or report in which a young person had engaged in self-injury behaviours with any wish, expectation or probability of death (Lee, et al., 2019), was a common factor identified among the young people in this review. This included suicide attempts that resulted in hospital admission and suicide attempts that were disclosed by young people to family and friends. The most common suicide attempts were Panadol overdose and attempted hanging.

Prior suicide attempts constitute a substantial risk that an individual will complete a future suicide attempt (Gold & Frierson, 2018). Indeed, previous suicide attempts are one of the most potent predictors of a completed suicide among adolescents (Goldstein & Brent, 2016;

Hawton, Saunders, & O'Conner, 2012; Van Orden, et al., 2010). The period immediately after a suicide attempt has been identified as a period in which effective interventions are critical, as negative outcomes can eventuate if the individual is not supported during this time (Hill, Halliday, & Reavley, 2017).

3.4.3 Self-harm

Most reviewed files had evidence of the young person engaging in deliberate self-harm in the months or years leading to their death. The type of self-harm was predominantly instances of superficial cutting. Young people who had engaged with support services had communicated self-harming behaviours and/or suicidal thoughts to professionals.

The intent of self-harm by young people is generally to hurt themselves, rather than suicide (Moran, et al., 2012). While self-harm is not suicide, it shares many common risk factors, and research shows that children and young people who engage in self-harming behaviours are more likely to attempt suicide in the future (Robinson, et al., 2018). It has been hypothesised that deliberate self-harm can act as a 'gateway' to completing suicide in the future (Lee, et al., 2019). This is consistent with the interpersonal theory of suicide, which proposes that an individual acquires the capacity for self-harm through habituation (Van Orden, et al., 2010) and that this can lead to suicidal behaviour in the future.

3.4.4 Challenges in interpersonal relationships

The term 'interpersonal issues' encapsulates a variety of challenges in relating to others and creating meaningful connections (Van Orden, et al., 2010). It can include issues around bullying and the breakdown of relationships (King & Merchant, 2008). There was evidence in most of the reviewed files that interpersonal issues were present in the lives of young people in the years before their death.

Identified interpersonal issues within the cohort occurred in romantic, peer and family domains. For a significant number of young people, the breakdown of a romantic relationship was considered by professionals and family to correlate with a deterioration in their mental health. This was particularly prominent for young males.

Bullying was also evident, which included young people who were bullied and those who engaged in bullying. There is a strong body of literature showing that experiences of bullying during childhood and early adolescence increase the risk of suicide in the years after the experience. This is consistent with the cases reviewed, whereby bullying incidents were not a direct antecedence to a suicide attempt. Rather, the experience of bullying impacted on the young person's mental health.

Bullying has also been linked to suicidal behaviour. Adolescents who were bullied and who engaged in bullying are at a greater risk of suicidal thoughts and behaviour, with these findings being significant and irrespective of sex (King & Merchant, 2008). In recent years, cyberbullying has also been independently linked to mental illnesses such as depression and anxiety and associated with suicide (Elgar, 2014).

Evidence of conflict between parents and young people was common in the reviewed cohort. Research shows that younger children are more likely to complete a suicide attempt in the context of conflict with others at school and bullying (Lee, et al., 2019). Parental conflict is also identified as a more significant risk factor for younger adolescents than it is for older adolescents (Lee, et al., 2019). Older adolescents are more likely to complete a suicide attempt in the context of relationship difficulties that they have voluntarily formed. It has been observed that peer groups become more important to young people as they progress through adolescence. Relationship breakdowns are far more likely to feature as a risk factor in older adolescents than younger adolescents (Lee et al., 2019).

3.4.5 Adverse childhood experiences

For more than half of the cohort, there was documented evidence of one or more adverse childhood experiences. In 1998, a major US study investigated the impact of adverse childhood experiences on physical and mental health problems in more than 17,000 adults (Dube, et al., 2001). Adverse childhood experiences encapsulate a broad range of traumatic experiences that occur before the age of 18. This includes all types of abuse and neglect, parental mental illness and substance abuse, family incarceration, divorce and exposure to domestic violence. (Mersky, Topitzes, & Reynolds, 2013). Research shows that having more of these events correlates to an increase in suicide risk (Dube, et al., 2001).

3.4.6 Alcohol and drug use

In a small number of cases, alcohol and/or drug use by the young person did appear to be of a significant concern that could constitute a contributing factor. Marijuana was the common drug used. Alcohol use was also identified in some cases. This appeared to be generally one-off incidents, noting that experimental use of alcohol and drugs is not uncommon in the age group of this review. For a small group of young people, toxicology reports showed that there was alcohol and drugs in their systems at the time of death.

Substance misuse among some populations of adolescents presents a risk factor for suicidality (Clapperton, Newstead, Bugeja, & Pirkis, 2019; Lee, et al., 2019). Alcohol has been shown to be more commonly found in older adolescents who completed suicide compared to younger adolescents (Lee et al., 2019), and substance misuse has been associated with male adolescent suicides but not female (Clapperton, Newstead, Bugeja, & Pirkis, 2019).

3.4.7 Lesbian, Gay, Bisexual, Transgender, Intersex, Queer+ (LGBTIQ+)

In some reviewed cases, there was evidence that young people had spoken to family and friends about their sexuality and/or gender identity. However, there was limited information to establish the impact of these experiences on the individual's suicidal process.

There is general agreement within the literature that members of the LGBTIQ+ community face a greater risk of suicidal behaviour (Skerrett, Kõlves, & De Leo, 2015). However, it is identified that research is impacted by methodological and practical issues (Bryan & Mayock, 2017). For example, obtaining data relating to suicide from the LGBTIQ+ community is notoriously difficult, as characteristics such as sexual orientation are not regularly recorded at the time of death (De Leo et al. 2010).

Research demonstrates that LGBTIQ+ youth face a particularly difficult period in which they simultaneously withstand the significant and prolonged challenge of forming and accepting their identity and discrimination from others (Newcomb & Mustanski, 2010). Survivors of homophobic and transphobic abuse are also at a greater risk of suicidal behaviours (Hillier, et al., 2010). Additionally, it was found that rejection from one's peers based on sexuality and/or gender identity could be particularly challenging and present a risk factor for suicidal behaviour (Skerrett, Kõlves, & De Leo, 2015).

3.5 Common protective factors

3.5.1 Social connectedness

The most common protective factor identified was social connectedness. The role of a supportive parent (normally the mother) was evident in most cases. These parents played an active role in supporting young people to access supports and were involved in supporting them to engage in education and extracurricular activities.

For many young people, connections with peers, generally within school, also appeared to be a protective factor. Peers had supported young people by encouraging them to seek professional assistance and/or discouraging young people from attempting suicide. Increasing young people's connection to education, peers and families has been shown to be an effective protective factor against suicide (Donald, Dower, Correa-Velez, & Jones, 2006). For the young people in this review, the disengagement from these social supports was associated with an increase in their risk of suicide and often was a proximal risk factor to the event.

3.5.2 Mental health care

All young people in this review had sought help from professionals and peers about their suicidal ideation. This had involved contact with general practitioners, education mental health supports and both community and private mental health supports. They had also reached out to friends and family who had supported them to access professional supports.

3.6 Systemic themes

When reviewing service involvement for the young people in this review, the analysis focused on key components of service availability, suitability and continuity. This was done by using the life chart process and mapping service involvement and considering interventions and communication between separate systems across critical periods of support. This included both formal and informal supports.

In most cases, the engagement with formal supports was limited to brief periods. More commonly, informal support networks of friends and family were involved in supporting young people through periods of crisis.

3.6.1 The missing middle

For many young people in this review, there appeared to be a gap in service provision at crucial periods due to issues around accessibility and follow up. The inability to access the right service at the right time may have had an impact on their future willingness to engage with both formal and informal supports.

Many of the young people in this review could be considered to be part of the 'missing middle' (Stavely, Redlich, & Peipers, 2018). This refers to individuals who are too unwell to access the care needed through the primary mental health system but are not acutely unwell enough to access services for severe mental illness. In the reviewed cases, characteristics included presentations to emergency departments for mental ill-health, a lack of assertive follow up from services, disengagement due to long wait lists and not utilising mental health treatment plans following GP appointments (Stavely, Redlich, & Peipers, 2018).

This current review has confirmed the previously identified gaps in ACT mental health service provision for this group of young people. Consistent with current literature, the development and design of any future services would benefit from involving young people with lived experiences of mental health and suicidal behaviour.

3.6.2 Help-seeking behaviour

The communication of suicidal thoughts to friends, families and professionals by young people was common. Adolescents who do seek help are far more likely to seek it from familiar supports as opposed to mental health professionals, and they are most likely to confide their feelings with a peer or family member (Goodwin, Mocarski, Marusic, & Beautrais, 2013; Rickwood, Deane, & Wilson, 2007).

For this review, generally, someone knew about the young person's suicidal ideations and in most cases, this was a peer. Peers were aware of the distress their friends were in and encouraged them to access supports through school and their families. When parents were aware of their child's suicidal thoughts and behaviour, they attempted to access supports.

The communication of suicidal thoughts was mainly by text and digital media messaging and contained both general statements about hopelessness and contemplation of suicide and disclosures of attempts. In many cases, young people communicated to friends in the hours before suiciding. Consistent with previous research (Rasmussen, Hjelmeland, & Dieserud, 2018), male adolescents within this review appeared less likely to seek help from professionals or informal supports.

3.6.3 Limited or sporadic engagement with support services

Engagement by services predominantly occurred following suicide attempts, suicidal ideation or an observed decline in mental health. There was a common pattern of a longer period of attempted engagement by service providers with young people following a crisis that would taper off when they stopped engaging. In most cases, involvement with services was for less than 6 months.

Service engagement varied significantly. For most young people, it consisted of either infrequent or one-off conversations with professionals such as school counsellors or Child and Adolescent Mental Health Services clinicians or a short period of intervention with a private psychologist or counsellor. School counsellors and School Youth Health Nurses had more ongoing contact with young people; however, the required referral to more tailored supports often led to a breakdown in service engagement by the young person.

3.6.4 Follow up after a suicide attempt

The review found that the young people who presented at hospital following a suicide attempt were discharged into the care of their parents, and the obligation to engage with future supports was placed on the young person rather than proactive engagement by services. Community follow up from services consisted of phone calls to the young person (or a family member) and an invitation to engage with the service. This included multiple attempts by services to contact the young person or family. There was no evidence of face-to-face outreach with young people after a suicide attempt.

None of the young people received a face-to-face home visit from a mental health service after a suicide attempt. It is acknowledged that there are several barriers to providing such a service, including shortages of staffing, training and the time required to conduct these interventions (Ridani, et al., 2016). A proportional response following a suicide attempt is a critical component of any effective suicide prevention model, as the acute point of care is a moment of both exceptional danger and an opportunity for effective interventions (Hill, Halliday, & Reavley, 2017; Ridani, et al., 2016). A lack of follow up and delays in treatment are known barriers to future engagement.

Within youth mental health in the ACT, CAMHS uses a Choice and Partnership Approach model of engagement with young people. This widely used collaborative approach invites young people and their families to 'CHOICE' appointments for initial assessments to determine their needs (Robotham & James., 2009). In this model, young people and their families are empowered to engage in the service by booking the appointment after initial contact from the service. For the young people in this review, the opportunity to engage appeared to often be limited and not all CHOICE appointments were taken up.

In contrast to the Choice and Partnership Approach model through the Towards Zero Suicide initiatives, the NSW Government has recently committed to establish Suicide Prevention Outreach Teams in all local health districts. These teams will include clinicians and Suicide Prevention Peer Workers with a lived experience of suicide who provide proactive care in the community (NSW Ministry of Health, 2020). Although there is limited research on the effectiveness of such programs, the involvement of people with a lived experience of suicide in service design and implementation is seen as essential (Ridani, et al., 2016).

3.6.5 Risk assessment and safety planning

In the reviewed files, suicide risk assessment tools were commonly used. In many cases, these tools appeared to be incomplete, lacking significant detail and a procedural document that potentially limited clinicians' ability to engage with young people in crisis. Reviewed assessments often failed to provide clear management plans. Assessment with suicidal individuals is a process, not an event (Gold & Frierson, 2018). In line with this approach, risk assessment can also be reimagined and embedded as an ongoing conversation about suicide.

It was unclear from the records what strategies were implemented following young people's disclosures of self-harm to mental health professionals. The presence of self-harm in young people should prompt further examination of potential stressors in their lives before the behaviour progresses (Moran, et al., 2012). Rather than relying on identifying risk factors, comprehensive psychosocial assessments of the risks and needs that are specific to an individual should be the focus of management for people that have self-harmed (Chan, et al., 2016).

Safety planning primarily involved conversations with young people (or their family) about means restriction, strategies to keep safe and key crisis contact services. Safety planning was not documented in all cases of discussions about suicide with young people and in some cases only single notes of 'safety planning' were documented. It was unclear from file records how young people were provided with details of the safety plan after it was agreed upon. From the limited file information available, it appeared that the process of safety planning was individual rather than a collaboration and it was often led by clinicians.

3.6.6 Communication between services and with young people

The sharing of information between services is critical to ensure that young people receive the right support at the right time. Within the reviewed files, young people often accessed multiple services that at times had individual support plans. Due to the fragmented nature of the service delivery, there was evidence of delays in information sharing or failures to communicate risks between services.

Often, discussions about a young person's mental health was had with their parents. In some cases, this was due to the young person not engaging with the service, while in other cases there was no evidence that attempts were made to engage the young person in the first instance. In cases where child protection was involved, case planning and assessment was conducted without input from the young person.

At times, insufficient information was shared between services which meant that the level of risk was not known by clinicians working with young people or that there were delays in young people accessing the appropriate level of support.

4. Recommendations

Based on the above findings, key recommendations for future practice have emerged. The Committee makes the following recommendations to complement existing activities aimed at addressing youth suicide in the ACT:

1. **Involve young people with lived experiences of suicide in suicide prevention service design and delivery.**

The Committee recommends that any future design and delivery of suicide prevention services include young people and their families who have a lived experience of suicide. The Committee believes that the involvement of people with a lived experience of suicide in service design and delivery is essential.

The Committee supports the OMHW working group on the responses to the needs of children and young people with moderate to severe mental health support needs. The Committee recommends the inclusion of young people with lived experience of suicide within the analysis and co-design process.

2. **Evaluate current youth mental health and suicide prevention programs to determine effectiveness including in meeting demand.**

The Committee recommends that the ACT Government evaluate current youth mental health and suicide prevention programs. Gaps in youth mental health service provision for young people not acutely unwell enough to access services for severe mental illness were identified in this review. The Committee supports the work proposed in the OMHW Review of Children in the ACT which seeks to conduct an analysis of existing programs in schools. The Committee believes that an evaluation of all youth specific programs in the ACT is required to determine their effectiveness including in meeting demand.

3. **Implement information campaigns that target young people at risk and include practical intervention skills for peers and family.**

The Committee recommends that targeted information campaigns be implemented. All young people in this review had spoken to peers and/or family about their suicidal thoughts before their death. Families and peers of young people identified at risk of suicide should be provided with specific information on risk factors, warning signs and available services so that those closest to young people in distress can provide support. The Committee believes that providing families and peers with knowledge of how they can best support suicidal young people is an essential component of a whole-of-community youth suicide prevention model.

The Committee supports the proposed implementation of the Youth Navigation Portal and considers this a critical piece of work to assist young people navigate the complex ACT support system.

4. **Implement and evaluate the Connecting with People program. Consider implementation in education and non-government organisation settings.**

The Committee supports the proposed implementation of the Connecting with People program within ACT clinical settings. The Connecting with People program contains a model of person-centred assessment and safety planning that uses peer-reviewed clinical tools. Within this review, risk assessment and safety planning with young people appeared to often be a procedural process rather than a method to inform treatment and supports. The Committee believes that the Connecting with People program provides clinicians with the tools to engage young people more effectively in risk assessment and safety planning.

Following the initial rollout, the Committee recommends that evaluation of the program's effectiveness be conducted, which includes consideration of establishing the program in education and non-government organisation settings.

5. **Implement a support plan process in clinical settings that actively engages young people following a suicide attempt.**

The Committee recommends the implementation of a proactive support plan for all young people following a suicide attempt. Within this review, treatment planning was inconsistent and there were often delays in accessing community-based supports following a suicide attempt. Young people and caregivers should be supported to be involved in the development of a support plan before discharge from clinical settings. Continuity of care with clear timeframes and an identified key person who will follow up on service engagement should be identified. This plan should be shared with all individuals and organisations identified as a support to the young person.

6. **Implement evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide.**

The Committee recommends that assertive follow up occur for young people after a suicide attempt. A previous suicide attempt is one of the most consistent predictors of a completed suicide among adolescents. Any support plan developed in conjunction with young people and their families should include contact within the first 24 hours, frequent contact, face-to-face visits and support that includes intense case management. Where possible, contact with young people and their families should be flexible, with the preference for professionals to meet with young people in their own environments.

The Committee recommends that the ACT Government monitor the effectiveness of the Suicide Prevention Outreach Teams in NSW to inform future planning of ACT suicide prevention outreach programs.

7. **Train staff from relevant organisations on responsible information sharing.**

The Committee recommends that people from organisations who are likely to encounter suicidal young people be trained on responsible information sharing. This training should be followed with a communication strategy that provides clear guidance to professionals on information sharing guidelines. Legislation and organisational policy are clear that information can be shared between services and to families when there is an immediate risk to an individual. It appears that failures to share information are due to professionals not understanding their responsibility to share information.

This Committee's 2018 report into children who died aged between 0 and 3 years identified similar issues with information sharing between services. It argued that for information sharing arrangements to operate effectively, they must be supported by organisational and professional cultures with strong governance and leadership that observe and understand the guiding legislation (ACT Children and Young People Death Review Committee, 2018).

4.1 Conclusion

This review set out to highlight risk, protective and systemic factors that surrounded the suicide deaths of eight young people in the ACT between 2017 and 2019. The review used a life chart approach to make maximum use of the information available. The analysis identified a common pathway to suicide for most young people, which was characterised by the emergence of mental health issues in adolescence. The review also identified several consistent themes for improving those systems that young people interact with.

The Committee recognises the significant work being undertaken in the ACT to review systems that are used by young people who are suicidal and note that some initiatives are still at planning/implementation or pilot stage. The evidence-based prevention strategies being developed through the Lifespan trial in the ACT are a significant step in providing better supports to children and young people in need. There is a vast amount of research internationally and in Australia that provides a solid framework for government and non-government services to provide best practice in this area.

The implementation and evaluation of government and non-government support services is critical in effective suicide prevention. This review has identified that informal supports that surround young people are equally important. Parents, educators and peers need information and training that will help them keep young people safe until effective therapeutic support is available. This requires a whole-of-community response to suicide prevention that provides guidance and tools to those closest to young people in distress so that they can intervene and access specialised support.

The ability to consider individual cases through this review has demonstrated that there are common challenges faced by young people, their family and friends and support services. These challenges are not new or unique to the ACT. There is an opportunity to address these issues as there is momentum in the ACT and across all Australian jurisdictions to implement meaningful change that will better support those at risk of suicide. The Committee recognises that every death of a young person is a tragedy and puts forward the recommendations to improve practice and reduce preventable deaths, like suicide. The Committee acknowledges the grief for the families and friends of young people who have suicided.

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Appendix A

Youth Aware of Mental Health

The Youth Aware of Mental Health program is a universal program intended to increase awareness of youth regarding mental health, stress and coping techniques, suicidal behaviour and risk factors related to suicide. The program is intended to provide psychoeducation regarding mental illness, self-harm and keeping well. It is targeted to young people aged 14 to 16 and has been implemented in ACT public high schools from Term 1 2020.

Question, Persuade, Refer

The ACT Education Directorate has purchased licences of the online Question, Persuade, Refer tool. This program equips 'gatekeepers' with the requisite knowledge to identify a potentially suicidal person and to offer support through active listening and a subsequent referral. The online resource can be used by the school community.

Applied Suicide Intervention Skills Training

Within schools there is also the Applied Suicide Intervention Skills Training program, where participants are trained over two days in the skills necessary to stage an effective suicide intervention. This training is targeted at leadership and student welfare staff to help them respond to a student who is contemplating suicide.

Mental Illness Education ACT

Mental Illness Education ACT is a mental health and wellbeing education provider, delivering education to youth, adults and professional audiences. It is primarily concerned with reducing the stigma around the discussion of mental health and associated help-seeking behaviour. Mental Illness Education ACT uses volunteer lived-experience educators, providing knowledge about mental illness and the trainer's personal experience of mental illness (MIEACT, 2019).

School Youth Health Nurse Program

The ACT Education Directorate in partnership with Canberra Health Services supports children and young people through the School Youth Health Nurse program, which provides access to nurses in ACT high schools. School psychologists are also located in ACT Public Schools and often play a role in referring children and young people to community-based support services.

ACT Health Children and Adolescent Mental Health Services

Children and young people who are at risk of suicide are generally assessed and treated through ACT Health Children and Adolescent Mental Health Services, which provide a suite of services for moderate to severe mental illness, including outreach, liaison, therapy and case management. In addition to community-based mental health services, children and young people also engage with private psychologists and psychiatrists.

Way Back Service

The Way Back support service, which is operated by Woden Community Services and funded by ACT Health and Beyond Blue, is a support service for people after they have attempted suicide. The program provides support coordination for up to three months following a suicide attempt.

Lifeline

Lifeline is a non-government, national telephone service primarily addressing suicide. Lifeline's crisis telephone hotline is available at all hours throughout the year. Lifeline offers counselling to the general population, regardless of age. Lifeline offers a crisis intervention service, but also releases mental health promotion material. Lifeline is concerned with both the provision of crisis support and addressing the causes of suicide. Lifeline offers both universal and targeted programs to build community cohesion and strength in order to reduce the incidence of suicidality.