Ms Megan Mitchell
Children's Commissioner
National Children's Commissioner
GPO Box 5218
Sydney NSW 2000.

Dear Commissioner

I wish to make a submission regarding your current inquiry regarding suicide amongst children and young people.

I am mindful of the volume of material you must be receiving on this issue, so thought I would write a letter and you can ask for more information if you so require. I would like to make a verbal submission so as to expand upon various successful suicide prevention initiatives that I come across over the years.

I also strongly encourage you to contact Ms King is a close friend who has also very ably implemented a wonderful school-based resilience building and good mental health program. It is well worth a visit.

As for myself, my professional education includes I have worked with young people in a range of settings, including the ; leaving in the middle of . I have since taken to various things including teaching fledgling Community Services workers in . I would also stress that I have close personal relationships with those who have suicided including my own father.

I wish to primarily discuss issues around interpretation of statistics around suicide, as this is a particular professional interest. I have often noted professionals assert that suicide is a worsening social problem and that young people are particularly vulnerable. The attitude is also expounded in the wider media. I am astounded by this view as the converse is the case.

According to Joanne Simon-Davies Suicide in Australia, Parliamentary Library, 29/7/2011:

- Suicide rates for both males and females have generally decreased since the mid-90s, with the overall suicide rate decreasing by 23% between 1999 and 2009.
- For men this saw a reduction of 24 per 100,000 each year in 1996 to 14 per 100,000 or 2,000 fewer deaths each year by 2008.

- With regard to suicide rates among young people, the age group 15-19 years has the lowest incidence of suicide for both males and females (Males 9.3 per 100,000 and Females 3.4).
- In contrast, for men over 85 the figure is close to 30.

Despite these decreases, suicide remains a major external cause of death for young people (15~19), accounting for more deaths than transport incidents between 1995 and 2009. The operative word is "external" cause of death. If children survive infancy, where perinatal and congenital factors feature in most deaths, their innate health reduces the impact if not yet an precludes most deceases, and degenerative conditions that effect older person are not an issue. Moreover, their capacity to survive injuries from poisoning, exposure to fire, drowning, vehicle crashes and other typical dangers of adolescents is much greater than older persons. Coupled with fantastic advances in medicine and social support structures, we have seen the number of injury deaths of children aged 1-14 years for all causes has significantly declined over the past two decades, from 553 deaths in 1983 to 231 in 2003. (Mortality and Morbidity: Children's Accidents and Injuries, ABC, 2006).

An example of this is the decline in injury deaths is illicit drug-related deaths in Victoria from 257 in 1999 to 85 in 2007. While various research has indicated substance abuse has declined amongst young people, this is not to the degree that would explain this change. Of course, the explanation is simple; from 2001, paramedics in Victoria routinely carried and administered Narcan (naloxone). Young people can seem to immediately return to a fully conscious following the administration of Narcan; less so with older persons. Having worked as a volunteer Ambulance officer in I can attest to having this dramatic effect. I've heard young people declare they are now better and don't need to go to hospital. They are often safe to discharge from hospital within hours. Although, they might need social supports to follow up.

The reduction in the incidence of suicide has been the resulted of concerted public policy. There was a series of public enquires; eg, the Royal Commission into Aboriginal Deaths in Custody (1987), The Burdekin Report into Mental Illness (1993), and the National Action Plan on Mental Health (2006). Moreover, from the 1980s large mental asylums were closed and community and locally based services developed, including specialist medical services for young people. One of the topic I teach is the

. The best account that I have found in the first half of Melissa Sweet's Inside Madness, 2006 about the late Dr Margaret Tobin pivotal role in reforming mental health services in Victoria, NSWs and SA. Deinstitutionalization corresponded with increasing advocacy from families, health and welfare professions and mentally ill themselves. The issue of suicide has emerged from private spheres into the public domain.

Improvement over this period included:

- Better pharmlogical treatment of mental illness.
- Development of community-based medical and social support services; particularly for young people.
- Training of teachers, community workers, Police and others in how best to respond to mental illness.
- Reduction of means; eg, tighter laws about firearms, removing hanging points in jails.
- Diversion of young men from prison; especially Aboriginals.

I want to reinforce that understanding data allows us to develop better public policy responses. There is often a risk with public safety reviews that they focus on individual tragedy and look backwards at events. This is, best summed up by the Latin phrase "Post hoc ergo propter hoc" (after this, therefore because of this). Except it rarely is! There are great limitations in scientifically predicating outcomes in social welfare. Some things appear to be stronger risk factors than they are, but we are looking at weak correlations at best. It can be more instructive to look at what might have reduced adverse outcomes over a class or people of shared characteristic, so we can reinforces successes. That is, to take time looking at what explains the dips in data, who isn't suiciding and the strengths. A quote I often give my students is the renowned English

astronomer, Fred Hoyle *"It's no good doing a lot of experiments first and the discovering a lot of correlations afterwards, not unless the correlations can be used for making new predictions. Otherwise it's like betting on a race after it's been run."*

I confide to finding writing this letter difficult. Among recollection is a young woman who I was delegated to draft a briefing when she suicided. I knew her and her family as they had long been clients of child protection. There were the inevitable examination of the event, which my briefing was only a tentative beginning. I could only summarise that the case workers appeared to have been very diligent, closely following the required procedures and clearly documented their actions. But this was not going to change how devastated the workers, family and acquaintances would feel. Statistics and analysts can feel so inadequate.

Equally, I remember perplexing my colleagues a couple of years ago while helping establish a suicide prevention strategy in a small town in far north . I had offered that the two already had at least two excellent suicide prevention programs; these being the Touch-Football Association and the Go-Cart Club. I was drawing on the eminent work of about creating social connectedness and resilience amongst young people. I had the privilege of working with when would debate the significance of data on youth suicides – whether the figures indicated high suicide rates or we were better than other countries at collating data. I had suggested that perhaps along with a new Hip-hop program (the favourite idea for responding to suicides in the town) that we might also create links with these other groups and draw them into the fold and help them improve access and equity - there almost no indigenous youth in the go-chart club, although ridding motorised vehicles was a popular past time amongst all youth in the town.

I had also sensed that there was a silo attitude between agencies in the town and they needed to learn to reach out; even if it were uncomfortable. For example, the air-ambulance service automatically sedating involuntary mental health patients for transfer, but that others were unaware of the practice or that this measure was only used as required in other parts of the country due to both health risks and contravention of patients-rights to have a say over their care. The air-ambulance had such status that few were willing to even discuss the matter with them. More importantly, the awareness of the connection between treating mentally ill patients with dignity and them developing self-esteem and mastering more control over their lives was a critical part in reducing suicides. I often challenge my students with the spectre of Dr Philippe Pinel, the French physician who unchained the asylum patients in the 1790s. I want them to more aware of the traditions they inherit.

I apologise that my letter has become much longer and a chore for the staff member who must peruse it. I wish you well in your inquiry and I am confident you will greatly add to the good work being done to prevent suicides amongst young people.

Finally, I have attached an article f mine about the work of TrackSafe; the railway industries program to reduce sucides and other preventable deaths around their infrustructure.While it repeats some of the material in the letter, it also includes comments that I don't imagine your inquiry will receive otherwise.

Yours faithfully