Response to the National Children's Commissioner's Inquiry into intentional self-harm and suicidal behaviour in children

Background

Since 2005 the Child Death and Serious Injury Review Committee has had a statutory obligation to keep a register of all child deaths in South Australia.

The Committee's annual reports provide information about the circumstances and causes of these deaths.

Between 2005 and 2012, the Committee has recorded and reviewed the suicide deaths of 30 young people. Two thirds of these 30 young people were male. Three were under 15 years of age. Equal numbers came from the most and least disadvantaged areas of the State.

Seven were Aboriginal. Five of these Aboriginal young people lived in very remote areas of the State. The death rate for suicide amongst Aboriginal young people is approximately 7 times higher than it is for non-Aboriginal young people in South Australia.

Other States, for example Queensland, have noted that suicide is the leading cause of death for young people 15-17 years of age. This is not the case in South Australia. In the period between 2005 and 2012, suicide was the third most common cause of death.

South Australia 2005-2012 Deaths of 15-17 year olds from all causes	
Transport	54
Natural causes – including cancer, congenital and chromosomal disorders and nervous system diseases and other illnesses or diseases	41
Suicide	**27**
Other causes – including accidents, fatal assault, drowning and other external and undetermined causes	18
TOTAL	140

The most common mechanism of death in the 27 suicide deaths (over 90%) was hanging. CDSIRC notes that hanging is a method of 'high lethality' and that it is almost impossible to 'restrict access to means' when these can be pieces of rope, electrical cable, garden hose, shoe laces or handbag

straps.   In contrast to the high percentage of suicides by hanging that occur now – between 1995 and 1999 hanging was the mechanism of death in only one third of suicides of young people.[1]

The Committee has yet to receive all information about the deaths of children in 2013; this information will form part of its next Annual Report that will be released in November 2014.

CDSIRC's review of suicide deaths and young people

CDSIRC recognizes that suicide deaths are the rare end point of self-injurious behavior. There are many forms of this behavior. Self-harm is 40-100 times more prevalent than suicide in young people who use it as a coping strategy that allows them to continue to live.[2,3]

Analysis of the reasons for suicide in young people is often based on knowledge of the risk and protective factors operating in their lives.

 Models that consider risk factors, warning signs, tipping points and imminent risk are often used as the basis for suicide prevention strategies, and models for intervention e.g. the SA Suicide Prevention Strategy

In its current review of the suicide deaths of young people, all available records for the suicide deaths of 21 young people were considered. In addition to its access to demographic information, CDSIRC routinely collects information about each young person's health, education and where relevant their mental health, child protection and juvenile justice history. The access to these written records provides CDSIRC with a great deal of contextual information about each young person. Coronial records provide further information that usually relates to events proximal to the young person's death.

The goal of the current review was to identify intervention and prevention points in the life of a young person that may have altered their decision to suicide.

CDSIRC chose a model of 'life chart analysis' as a way of maximising the rich source of information that it holds about each of these young people and as a means of identifying opportunities for intervention and prevention. This methodology was outlined in a paper by Fortune, Steward, Vadav and Hawton (2007)[1]   The Committee is committed to ongoing refinement of its methodology and analysis, however it has already provided a unique perspective about intervention and prevention and we urge you to consider it.

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[1] Austin, A, E., van den Heuvel, C. & Byard, R (2011) Cluster suicides in the young in South Australia, *J Forensic Sciences* (56) 1528-30.

[2] Fox, C. & Hawton, K. (2004) *Deliberate self-harm in adolescence.* Jessica Kingsley Publishers: London

[3] Nock, M.K., Prinstein, M.J. et al. (2009) Revealing the form and function of self-injurious thoughts and behaviours: A real-time ecological assessment study among adolescents and young adults. *J Abnormal Psychol.* 118(4): 816-827

This life chart analysis has found that there were four distinct groups of life histories within the cohort of 21 young people:

Group 1

This group was characterised by multiple and complex problems occurring since birth or early childhood.   Some of the significant factors in the life charts of these eight young people, all males, were:

- Limited parenting capacity in their home and little or no support available from home for the child/young person

- Significant upheaval in the family and lack of attachment and later, engagement with family

- From early school years - multiple assessments, learning problems, multiple changes of school

- Challenging relationships – family, peers, romantic

- Poor transition to high school followed by increasing frequency and severity of school-based problems – truancy, suspensions, expulsion

- Housing insecurity, transience, homelessness

- Disengagement from home, school and family

- AOD use, often juvenile justice system involvement

- Multiple services involved including housing, welfare, child protection, mental health, juvenile justice

CDSIRC has observed, in its analysis of 'risk-taking (non-suicide) deaths within the same age group, a similar patterns of multiple and complex problems, often occurring since birth or early childhood.

Group 2

This group was characterised by emerging mental health issues such as depression and anxiety, which appeared to start in the teenage years. There were six young people in this group, 3 males and 3 females. Some of the significant factors in their life charts were:

- Some instability in family circumstances but one parent perceived as engaged and supportive

- Parental capacity limited (mental health, AOD use, attempted suicide)

- Positive primary school years - actively engaged, good learner

- Issues emerging after transition to high school

  - challenges in peer relationships

  - emergence of mental health problems

- deliberate self-harm and/or suicide attempt(s)
- Involvement with school counsellors/mental health services
- Changes of schools
- Suicide notes

Group 3

This group had no recorded problems at home or at school and had no previous contact with services about mental health issues. There were five young people in this group, 2 males and 3 females. The life charts of these young people included:

- Unremarkable early years
- Stability at home, in friendships, at school
- Non problematic transition to high school
- Friends described them as having a 'positive' approach to life
- No contact with services
- May have been exposed to suicide in their school communities

'No group'

This group was formed because it was recognized that that the Committee did not have sufficient information to be able to construct a life chart for these young people. There were two young Aboriginal men in this group and they lived in remote or very remote locations. The Committee also recognized that it did not have a sufficient understanding of cultural issues and influences to decide how to interpret the life history of these young people.

Opportunities for prevention and intervention

Analysis of life events lends itself to consideration of the young people's experiences of 'help-seeking' and why it was not sought or was rejected, the proximal events or lack of them, and the challenges encountered throughout their lives. The life charts illustrate that the suicide of young people cannot be characterised by any one 'set ' of risk factors or even one homogenous life history.

This analysis highlights the importance of considering many different avenues of intervention – many of which are not aimed specifically at young people at risk of suicide. The Committee has considered the following intervention and prevention issues in relation to each of the three groups:

Group 1

Intervention and prevention efforts should be focused on:

- Infancy – strengthening parenting capacity within families

- Early childhood – when learning problems are identified

- Transition to high school - assistance with 'learning challenges'

- Youth specific programs to promote/create engagement

- Integrated service delivery

- 'Risk –takers' have similar life histories

This group can often be missed by suicide prevention strategies focussed on risk factors, tipping points and imminent harm.

Group 2

Intervention and prevention efforts might build on existing engagement and include:

- Adult and youth mental health services providing support for families

- Assertive outreach

- Support for schools

- Coordination between school and mental health service support

- Exploring the role of work place

- Youth specific services to address romantic challenges, support for sexually active young people

Group 3

There were few if any indicators of potential challenges in the life charts of these young people and intervention and prevention might need to encompass:

- Population based prevention programs

- Providing information about 'crisis' support

- Access to help for young people during the critical hours when they appear to decide to suicide

- Consideration of the role of social media and suicide publicity

- Providing support for friends and advice to parents of children within the community

Summary

Child death review is a unique endeavour. The Committee's current review illustrates how analysis of this kind ensures that each story counts and recognises that each young person's story is different. The analysis has sought to reconstruct key events in the lives of these young people as a means of identifying opportunities for intervention and prevention across the life span rather than just at the point of 'imminent risk.'

The Committee's responses to the Commissioner's questions

This analysis has informed the Committee's responses to the questions posed by the National Children's Commissioner.

Question 1

Why children and young people engage in intentional self-harm and suicidal behaviour.

It is the Committee's view that there is no one reason why young people suicide.

CDSIRC's interest is in prevention and intervention. Its current analysis using life charts illustrates where in the child's life intervention or prevention might be placed in order to reduce the risk of suicide. Suicide is a rare event and is not always preceded by self-harm. Self-harm does not always lead to suicide and can serve a very different purpose (a coping strategy that provides young people with a means of continuing to live) so these questions need to be asked separately and so the same question may be asked of self-harming behaviours.

This analysis does not support the notion that there is an answer to the question of 'why' that allows us to choose one particular kind of intervention and prevention, but highlights how important it is to broaden our understanding of suicide and be open to considering intervention and prevention across the life span, not just at the point of imminent risk.

In addition, 'self-harm' is a very generic term that covers a variety of different forms of self-directed violence. King, Foster and Roglaski (2013) offer one of many ways of differentiating between various kinds of self-harm including:

- Non-suicidal self-directed violence

- Suicidal self-directed violence

- Undetermined self-directed violence

- Non-suicidal self-injurious behaviour

- Interrupted (by other) self-directed violence

- Interrupted (by self) self-directed violence

- Other suicidal behaviour, including preparatory acts

- Suicide attempt

- Suicide[4]

Question 2

The incidence and factors contributing to contagion and clustering involving children and young people.

The Committee has not found any predominance of 'contagion' or 'clustering' except in 'Group 3.' In this group we have recorded four cases occurring in the same geographical area and in a relatively short time frame. The 'contagion' factors contributing to these four cases were sometimes quite distal associations between young people. Eg – X (who suicided) knew someone's friend who was a friend of X (another young person who suicided), and sometimes a more proximal association – both X and X attended the same school.

If epidemiologically robust answers to questions about clustering and contagion are sought, then definitions of what is meant by clustering and contagion need to be provided.

In addition, the information available is not sufficient to know when, where, at what times or with what frequency some association between X young person and X young person was known to occur. This requires a much more detailed analysis and access to more comprehensive information than is available to the Committee.

Most importantly 'contagion and clustering' were not a factor in Groups 1 and 2 where two thirds of the suicides occurred.

Question 3

The barriers which prevent children and young people from seeking help.

This question seems to be framed around seeking a 'solution' to the suicide behaviour of young people that is located in the weeks or months prior to the event, and seems to presume that the young person was cognisant of the need to seek help.

The Committee's analysis suggests that 'help' can and should come in many forms. For example:

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[4] King, C.A., Foster, C.E. and Rogalski. K (2013) *Teen suicide risk.* London: The Guildford Press.

- Intervention and prevention should begin, for some children in early childhood, when they are not in a position to 'seek help' independently of their parents

- Capable, engaged parents and strong connections to school through childhood and youth are protective factors for children and young people and opportunities to strengthen these forms of help should be sought.

- It is equally important to recognise the need for 'assertive outreach' for young people, especially those with emerging mental health issues – from specialist mental health services and more general services that support young people - as young people may 'seek' help or be offered help but then may not maintain ongoing contact with services.

- Many young people who suicide consider that they are making a choice and will go to some lengths to 'hide' their intentions from people around them (e.g. only sending text messages at the time of the event, telling no-one of their intentions but leaving detailed suicide notes) and consideration needs to be given to the best ways in which to provide access to information

- In contrast, as demonstrated by the life charts of some 'Group 1' and the 'Group 3' young people, there are young people for whom suicide is not a premeditated act and 'help' needs to be thought about and configured differently for these young people.

The Committee would also want to see recognition of the need for 'barriers' to help being considered in the context of the young people who are the 'friends' of those who are considering a suicide attempt or have suicided. Our work suggests that some young people will use some kind of social media – facebook, chat rooms, text messages – to communicate their intent to friends – sometimes days or hours before the event. It seems crucial to understand the 'barriers' that might prevent these young people from seeking help. We also then read about the impact that the suicide can have on the young friends and would want the 'barriers' to their access to support recognised and addressed after the suicide event.

Question 4

The conditions necessary to collect comprehensive information which can be reported in a regular and timely way and used to inform policy, programs and practice. This may include consideration of the role of Australian Government agencies, such as the ABS and the AIHW.

The 'conditions' necessary for Australian Government agencies to collect comprehensive information are probably best illustrated in the recent discussion paper that the Victorian Coronial Committee has developed. This paper illustrates the difficulties in collecting accurate statistics about suicide deaths that are associated with the ways in which coroner's in each State and Territory determine a young person's cause of death.

The other alternative is to consider the possibility of collecting these statistics from the registers kept by child death review teams in each State and Territory. The problems associated with this option are:

- Each State/Territory has legislative restrictions about the kinds of information it can 'share'

- Each State/Territory has developed its own set of coding rules about suicide death

There is considerable potential in acquiring and using the richness of information such as that held by the Committee here in South Australia. In the absence of a national, funded body to undertake the work necessary to access and standardise this information it remains relatively inaccessible.

A third option is the National Coronial Information Services which holds information from all States and Territories about suicide deaths. Again, to harvest this information would require dedicated and ongoing resources.

In each case, the timeliness of data availability is another issue.

Question 5

The impediments to the accurate identification and recording of intentional self-harm and suicide in children and young people, the consequences of this, and suggestions for reform.

The Committee has no comment about the accurate identification and recording of intentional self-harm as this would be the domain of hospital separation data collections.

With regard to identification and recording of suicide – these answers are similar to those given in Question 4.

Question 6

The benefit of a national child death and injury database, and a national reporting function.

Views about the benefits of a national injury database are probably best sought from injury surveillance units in each jurisdiction and from the National Injury Prevention Unit at Flinders University. South Australia does not routinely publish an annual report about childhood injuries.

The benefits of a national child death database are currently being debated at the ANZCDR&PG. Again, in the absence of national funding to advance this project, it is difficult to determine the benefits that exist outside of current national collections.

Question 7

The types of programs and practices that effectively target and support children and young people who are engaging in the range of intentional self-harm and suicidal behaviours. Submissions about specific groups are encouraged, including children and young people who are Aboriginal and Torres Strait Islanders, those who are living in regional and remote communities, those who are gender

variant and sexuality diverse, those from culturally diverse backgrounds, those living with disabilities and refugee children and young people seeking asylum. De-identified case studies are welcome.

The Committee does not engage in the delivery of programs. However, our analysis suggests that young people who suicide are not a homogenous group. The programs and practices that are needed to support them, their families and friends are varied but need to be considered across the life span and not just concentrated on the point of imminent risk. For example, our analysis would suggest that strengthening the supports provided to children who have experienced learning difficulties in primary school, when they transition to secondary school may help to ensure that these young people do not disengage from the school system during their adolescence. Strengthening the capacity of schools to support young people with emerging mental health problems may provide a source of help and support for these young people. Strengthening the ability of adolescent mental health services to provide assertive outreach may ensure that when help is offered it is accepted and followed-through. Ensuring that adult mental health services monitor and take steps to link the children of parents with mental health problems to appropriate services may lessen the risk of mental health problems and suicide for these young people.

Question 8

The feasibility and effectiveness of conducting public education campaigns aimed at reducing the number of children who engage in intentional self-harm and suicidal behaviour.

Our research, which has been about young people who have suicided – some may have engaged in deliberate self-harm, others did not – would suggest that public education campaigns may be relevant to some young people, but not to others. For example, young people who are risk-takers, disengaged from school, home, community and education will probably not benefit from these types of campaigns. Conversely, young people who are engaged in home or education or community may benefit from these campaigns, especially those young people whose suicide appears to not be premeditated. Again, we would like to draw attention to exploring the benefits of these kinds of programs for the young people who are the recipients of information about the suicidal intentions of their friends and who are then affected by the suicide of their friends.

Question 9

The role, management and utilisation of digital technologies and media in preventing and responding to intentional self-harm and suicidal behaviour among children and young people.

The Committee bases its views on the analysis it undertakes of the circumstances of suicide deaths of young people. Death scene investigations do not routinely collect information about the use of social media by young people. We have been told that it is expensive and time consuming to access and analyse this information, for example the messaging between young people prior to an event or their use of facebook and other social media.

For these reasons we find it difficult to comment on the role, management and utilisation of social media in prevention as we are not yet certain of the extent of the use of social media or of the ways in which it influences a young person's decision to suicide.