commission for children and young people and child guardian

Promoting and protecting the rights, interests and wellbeing of all Queenslanders under 18

Advice to: National Children's Commissioner
Topic: Intentional self-harm and suicidal behaviour in children
Date due: 2 June 2014

Thank you for inviting comment from the Commission for Children and Young People and Child Guardian (the Commission) in relation to the National Children's Commissioner's examination of intentional self-harm and suicidal behaviour in children.

Background

The Commission is an independent statutory body charged with responsibility for protecting and promoting the rights, interests and wellbeing of Queensland children and young people under the age of 18.

The Commission has held a statutory responsibility to review child deaths registered in Queensland since 2004, and reports annually on trends and patterns in child mortality identified from the analysis of information contained within this register. Under Chapter 6 of the *Commission for Children and Young People and Child Guardian Act 2000*, the Commission is responsible for:

- maintaining a register of the deaths of all children and young people in Queensland
- reviewing the causes and patterns of deaths of children and young people
- conducting broad research in relation to child deaths
- making recommendations for improvements to laws, policies, procedures and practices to help reduce the likelihood of child deaths, and
- preparing an annual report to Parliament and the public regarding child deaths.

Key Issues

Suicide as a leading cause of death for young people

In performing its statutory responsibility, the Commission has identified that there were a total of 187 suicide deaths of children and young people registered in Queensland between 2004 and 2013. An examination of the figures from the Queensland Child Death Register indicate a gradual increase in the number of youth suicides per year, with an average of 21.3 deaths for the period of 2010–11 to 2012–13 compared to 16.3 deaths from 2004–05 to 2006–07.

Of the 187 deaths, a total of 50 suicides of children and young people under the age of 15 years have been recorded by the Commission since 1 January 2004. In the recent *Annual Report: Deaths of children and young people, Queensland*, *2012–13*[1], suicide was identified as the leading external cause of death for children aged 10–14 years. Suicide has been the leading or second leading external cause of death for children and

[1] The *Annual Report: Deaths of children and young people Queensland* series can be accessed from the Commission's website at: www.ccypcg.qld.gov.au.

young people aged 10–14 in Queensland for six years (non-consecutive) since the inception of the Commission's Child Death Register in 2004. Of particular concern in the 2012–13 reporting period is the rate of suicide for 10–14 year olds was the highest since reporting commenced in 2004 (4.1 deaths per 100,000 children aged 10–14) and was the leading external cause of death for this age group[2].

Suicide prevention programs have traditionally focused on older adolescent and young adult populations as this cohort has very high suicide rates compared to other age groups. Encouragingly, suicide prevention strategies are starting to target younger children in recognition of vulnerabilities and risks specific to the 10–14 age group. The Commission supports this more inclusive conceptualisation of at risk youth populations.

Additionally, the Commission has participated in research partnerships with several academic institutions to better understand suicide deaths of children under 15 years. One of these research projects is through an Australian Research Council Linkage Grant with the Australian Institute of Suicide Research and Prevention and other Queensland government agencies. This research provides comparative analyses of the suicide deaths of children under 15 years and their older peers. The findings identify less gender differences with the younger cohort, a higher proportion of Indigenous children suicide in the younger cohort, and the older adolescents have more experiences of transitions[3].

The over-representation of Aboriginal and Torres Strait Islander children and young people

The over-representation of Aboriginal and Torres Strait Islander children and young people continues to be a significant issue, with the suicide deaths of Indigenous children and young people at a rate that is 5.5 times higher than the rate for non-Indigenous children and young people in Queensland. Aboriginal and Torres Strait Islander youth also suicide at a younger age than other Queensland youth. Of the 50 suicides of Aboriginal and Torres Strait Islander children and young people that occurred between 2004 and 2013 in Queensland, 20 occurred among children aged 10 to 14 years.

In addition to dying at a younger age, the Commission identified Aboriginal and Torres Strait Islander children and young people had different risk factor profiles than other youth in the lead up to their suicide. The most frequently cited risk factor for Aboriginal and Torres Strait Islander youth was that they were known to be alcohol or drug users at the time of their death. The second most common risk factor was having behavioural and disciplinary problems, followed by previous suicidal thoughts and behaviours. This finding aligns with other Australian research, recognising the complex interplay of factors that build positive social and emotional wellbeing and the importance of research and intervention services considering this in the context of their work of Indigenous children and their communities.

[2] Other external causes of death, such as transport-related deaths, have remained relatively stable for children 10–14 years over the past five reporting periods.
[3] Soole, R, Kõlves, K, & De Leo, D. (2014). Factors related to childhood suicides: Analysis of the Queensland Child Death Register: *Crisis* (*in print*).

Relatedly, when reviewing the suicide profiles of Indigenous children, the Commission's research has identified several differences in the risk factor profiles of Aboriginal and Torres Strait Islander children and young people who suicide compared to their non-Indigenous peers. These included: 1) a younger age 2) higher instances of alcohol and drug use consumed prior to suicide 3) higher likelihood of prior offence related contact with police and/or youth justice 4) less likely to have identified mental health issues, and 5) an absence of suicide notes. The profile of risk factors for Indigenous children and young people contradicts conventional evidentiary risk factors linked to suicide and suicidal behaviours.

The Commission's evidence needs to be considered in the broader social context in which Indigenous children live. These findings highlight the significant, ongoing disadvantage experienced by this vulnerable group of the community. Reviews of known risk factors and vulnerability characteristics of Queensland youth suicides indicate Aboriginal and Torres Strait Islander children and young people are more often from rural and remote communities (using ARIA+ measures), live in communities with a low socioeconomic status (using SEIFA measures), and experience social and environmental factors that are known to increase risk of suicidal behaviours such as young maternal age, parental substance misuse, history of maltreatment and chaotic social circumstances.

In addition to reporting Indigenous suicide data in the Annual Report, the Commission has undertaken other research activities that review suicide risk factors and prevention strategies for Indigenous children and young people, such as:

- the *Reducing Youth Suicide in Queensland* (RYSQ) initiative to reduce deaths of children and young people due to suicide, through enhancing the available evidence base of suicide risk factors. This included addressing the over-representation of Aboriginal and Torres Strait Islander children and young people and reviewing the similarities and differences between these children and young people and other Queensland youth suicide (www.ccypcg.qld.gov.au/resources/publications/Reducing-Youth-Suicide-in-Queensland-Final-Report.html), and

- the publication of our Trends and Issues paper series to target the over-representation of Aboriginal and Torres Strait Islander youth who suicide (http://www.ccypcg.qld.gov.au/resources/Trends-and-Issues-Papers.html).

As part of the Commission's RYSQ project, we developed a discussion paper and questionnaire to enable key stakeholders to provide responses and comment on a number of key discussion points. Of potential interest to your consultation process may be the responses received regarding considerations for developing an effective training program for Aboriginal and Torres Strait Islander community members to support young people bereaved by suicide, including:

- ensure training is culturally appropriate and demonstrates respect for cultural beliefs and practices
- engage in consultation with Elders, the community and young people during the development and implementation of any initiatives
- employ Aboriginal and Torres Strait Islander people or appropriate personnel with experience and knowledge of the local community
- focus on suicide prevention through education about the risk factors and warning signs of suicide ideation and behaviour, and
- provide support to extended family and recognise the importance of family structures in bereavement and suicide prevention.

The incidence of suicide among Indigenous people is hindered due to some well recognised data quality issues with Indigenous death data and population estimates as reported by the Australian Bureau of Statistics. Under-counting the Aboriginal and Torres Strait Islander population diminishes the quality of reliable comparison rates and sufficient identification of those within the population to structure services and resources. The Commission encourages continued efforts from Commonwealth and State governments to establish improved methods of identification of Australia's Aboriginal and Torres Strait Islander population. This includes greater participation of Aboriginal and Torres Strait Islander people through community awareness, improved access to government services and increased supports to engage in government processes (e.g. assistance with completion of forms, using support officers who can liaise in the local language, etc.).

It is important for children and young people to have a voice in the issues that affect them. By bringing together the views of Aboriginal and Torres Strait Islander children and young people with other sources of information collected through government and non-government research and data collections, Commonwealth and State governments will be able to make much stronger assessments about the needs of this vulnerable group.

The participation of children and young people in research and strategy monitoring activities will provide a critical perspective on the effectiveness of the Framework and to help identify systemic issues requiring further resources.

The Commission supports the development of strategies and actions that will help achieve more equitable outcomes for Aboriginal and Torres Strait Islander children and young people and their families, with the expectation that improved social and emotional wellbeing, through improved opportunities for connection to culture, will significantly contribute to closing the gap on Indigenous child and youth suicide rates.

Children known to the child protection system

Children known to the child protection system die due to suicide at a rate nearly 4 times higher than all Queensland children. An increased risk of suicide has been identified among this cohort of children and young people as they are often living in circumstances that are characterised by substance misuse, mental health problems, lack of attachment

to significant others, behavioural and disciplinary problems. The complexity of issues faced by families of at-risk children is likely to contribute to the disparity between outcomes for children known to the child protection system and those for other Queensland children. The fact that this group comes to the attention of an established service system means that there are opportunities for referrals to secondary and tertiary level intervention programs to be initiated.

Understanding the profiles of children and young people who suicide

The Commission's evidence base has a rich source of risk factors relevant to the deceased young people, their families and broader social circumstances. A qualitative review of these deaths yields emerging typologies that can be organised into three profile groups[4].

The first group includes those children and young people who live in complex and chaotic circumstances. These young people have lived with multiple and complex life challenges since childhood. They are more likely to engage in high risk and rule breaking behaviours, such as alcohol and drug use, criminal activity, and engaging in physical activities with a disregard for their personal safety. This group has poor school engagement, experienced disciplinary issues such as school suspension, and may have learning issues. These young people typically present with externalising behaviours, impulsivity and may not display any suicidal behaviours or ideation.

This cohort will have had multiple contacts with government services and opportunities for prevention and intervention. Further, the parents of these young people will also have multiple contact points, including services related to drug and alcohol, mental health, domestic and family violence, unemployment and housing.

The second group includes those children and young people with emerging and/or complex mental health issues. This cohort may have previously accessed mental health services for depression, anxiety or stress-related issues. Some of these stresses are age-specific events that are related to transitions (e.g. transition to high school, transition to work) or complex emotional responses to developmental experiences alien to the young person (e.g. relationship breakdown with romantic partner, parental separation). For some of these young people, their family has limited knowledge in recognising the young person's mental health issues and/or how to access appropriate services. For example, parents may describe symptoms and behaviours the young people are experiencing without actually knowing that it is depression and requires intervention. This, in part, may be due to communication issues within the family structure, an increase in negative interactions between the young person and their parents, or negative influences due to the parent's own lived experience of mental health issues and mental health services.

[4] See the South Australian *Child Death and Serious Injury Review Committee Annual Report 2012–13* for further analyses of groupings similar to those identified from Queensland suicide data.

It is important that a young person's experience with mental health services is inclusive and youth-specific, and the provision of support extends to the young person's family (either within the service or through appropriate referrals). Assertive outreach to these young people is also necessary, as their family may struggle to engage with the service and/or not recognise the young person's risks. For example, parents may not appreciate the significance of romantic attachments and the impact of a relationship breakdown for a young person. It is important that youth-oriented services that are attuned to the stressful events that can be 'tipping points' for suicidal behaviours are available for young people and their families. Prevention and intervention points for this group need to build on opportunities where the young person is already engaged with a service – typically, this is through the school as a first point. Schools may be able to recognise and support these young people when mental health issues affect their learning and school participation. Further, having suitable support models linking the school with the young person's mental health provider can help the young person make easier transitions during periods of increased stress and/or after a self-harming incident or suicide attempt.

The third group includes a smaller cohort of children and young people who have few identified risk factors. These young people often have few, if any, indicators in their life histories of any issues or challenges that would lead to suicidal behaviour. These young people may have been secretive about any suicidal ideation and friends and family may comment the young person's behaviour as being 'normal'. For some of these young people, there is a single event that creates a 'crisis' or intense situation that the young person cannot cope with. For example, this may be failing end of year exams.

These young people are often not engaged with services due to presenting as low risk. Universal, population-based programs that focus on resilience building and help-seeking behaviours may assist in providing these young people with additional supports when a crisis situation occurs. Further, if these young people communicated their intent to suicide, it is typically to a peer. Universal programs can provide peers with information on suicide, reporting suicide risk, and seeking help.

In consideration of these different profile groupings, suicide prevention and intervention strategies would benefit from having heterogeneous approaches that recognise the importance of fitting the intervention to the needs of the young person, rather than trying to fit all young people into a single service or program.

Contagion

There is considerable evidence to suggest that the suicide or suicidal behaviour of one person may trigger suicidal behaviour in those associated with that person or in vulnerable people who become aware of the suicide. For example, the onset of suicidality in children is suggested to be particularly high after the suicide of a relative. The reasons for this familial aggregation are complex. Research has indicated the presence of genetic influences, as the association with familiar suicidal behaviour has been shown to increase suicide risk even after studies have controlled for

psychopathology and poor parent-child relationships[5,6,7]. It is therefore essential that careful analysis of the impact of a relative's suicide (or suicidal behaviours) on children should be part of preventative intervention to reduce contagion effects.

Contagion extends beyond familial influences and can also include imitative contagion. One feature of suicidal behaviours is the tendency for contagion and clustering. There are numerous reports in the contemporary suicide literature on the occurrence of suicide clusters in prisons, psychiatric services, schools, religious sects and geographically defined communities[8]. Specifically, research has demonstrated a small but statistically significant number of youth suicides occur in time-space clusters, consistent with mechanisms of contagion and imitation[9]. These effects have been identified for clusters of both completed and attempted suicide, and appear to be limited to young people and young adults. Consequently, one completed suicide may provide the model for subsequent suicides by means of imitation and identification.

The contagion process which leads to suicidal behaviours in vulnerable young people is something all schools need to be aware of, as research has shown that up to one-quarter of 16–17 year olds had someone at their school who died by suicide[10]. When assessing the impact of exposure to a suicide, it was found that children aged 12–13 were five times more likely to be thinking about suicide or had attempted suicide themselves compared to 12–13 year olds at schools where there had not been a suicide. For young people aged 14–15 years, they were three times more likely. The contagion effect was equally strong for students who knew the deceased intimately or who did not personally know the deceased student. These effects were maintained over multiple survey periods occurring over two years.

Students, especially those who may already be experiencing difficulties, might identify with the destructive solutions adopted by the deceased, thus raising the notion of suicide as an option to respond or cope with difficulties. It is therefore essential that, in any postvention response, schools have a tiered approach that provides intensive support for those intimately linked to the deceased young person, but also have additional support services available for those students identified as having other vulnerabilities – even if they did not know the deceased personally and heard of the death through broader social connections (e.g. via social media). These deaths reinforce the need for, and importance of, having detailed suicide prevention, intervention and postvention guidelines available to schools. Programs such as *headspace* School Support are a

[5] Beautrais, A.L. (2001). Child and young adolescent suicide in New Zealand. *Australian and New Zealand Journal of Psychiatry, 35,* 647-653.
[6] Bridge, J.A., Goldstein, T.R., & Brent, D.A. (2006). Adolescent suicide and suicidal behaviour. *Journal of Child Psychology and Psychiatry, 47*(3/4), 372-394.
[7] Gould, M.S. & Kramer, R.A. (2001). Youth suicide prevention. *Suicide and Life Threatening Behaviour, 31*, 6-31.
[8] See publications from the Australian Institute of Suicide Research and Prevention for specific examples.
[9] Gould, M.S., Wallenstein, S., & Kleinman, M. (1990). Time-space clustering of teenage suicide. *American Journal of Epidemiology, 131,* 71-78.
[10] Swanson, S.A. & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. *Canadian Medical Association Journal, 185*(10), 870-877.

positive example of providing localised support to secondary schools affected by a suicide[11].

The Commission has evidence of contagion influences for approximately one-third of suicide deaths of children and young people in Queensland. The circumstances of contagion surrounding children and young people who have suicided in Queensland include:

- finding the person who suicided and being involved with the police investigation following the death
- having talked to (including through social media) or seen the person on the day of the suicide
- belonging to the family of the person
- being a close friend of the person or in their broader peer group
- being in the same school or a neighbouring school, and
- learning of the attempted or completed suicide of a respected community member.

Many of these children and young people used the same method as those who suicided or attempted suicide before them, with hanging being the most frequently used method. These findings indicate that a suicide or attempted suicide can provide a model for subsequent suicides by means of identification and imitation, demonstrating the far-reaching impact that suicide has on others.

The role of social influences on suicide

The risk factors associated with youth suicide are constantly evolving as environmental, contextual and social influences also evolve. The role of social media is emerging in new contexts. There are increased public awareness and education campaigns targeting suicide prevention and reducing stigma. There are changes to concepts of privacy and the importance of having an online presence that extend the generation gap between young people and their parents. The concept of linking with the 'local community' now has the potential for worldwide membership. In these contexts, it is important to understand how social media is changing the face of youth suicide risks and related prevention strategies.

Research has found that 26% of people believe suicide cannot be prevented[12]. It is unknown what proportion of young people believe this. Such beliefs can be associated with constrained help-seeking behaviour. Suicide has a history of public invisibility. However, changes to the concept of privacy through increased participation in social media have been influential in changing young people's exposure to suicide. Social networking sites are a boundary-less system of access and engagement. How adults and young people navigate and value this system greatly differ. For example, adults and

[11] See http://www.headspace.org.au/what-works/school-support for more information.
[12] Dudley, M. & Christensen, H. (2012). *Community-based suicide prevention*. Suicide and Self-Harm Prevention Conference. June 2012.

young people think very differently about the online and offline worlds. For parents, they did not grow up with the internet, social media, texting, or instant messaging. The internet was generally introduced through employment and is often seen as something for business or practical purposes. For young people their lives have always involved mobile phones and the internet. The maturation of technology has occurred whilst they have developed and matured. Young people see the online and offline world as seamless. Social media closes the gap on communication, socialisation, play, research and learning. It is not separate, distinct or special. Social networking and having an online presence is simply part of building their identity and social life.

This has brought a change in how privacy is conceptualised. Personal thoughts are streamed to a public audience through blogs, with grief and loss being shared with strangers. This change in how privacy is conceptualised can be illustrated by an increased trend identified by the Commission of young people using social media and SMS text messages to communicate their intent to suicide rather than traditional suicide notes. The intimacy of what was often communicated in suicide notes to close loved ones is now shared with friends, acquaintances and strangers.

A second example of the growing interaction between social media and youth suicide is the relatively new introduction of memorial pages on sites like Facebook. For adult suicides, research has found an average of 15 people are 'intimately and directly' impacted by a single suicide but this can increase to 20 when broader social circles are considered. For young people research has found 80 people are directly impacted. This can widen to 425 people "exposed" to the suicide, including school students and staff, community and sports club members, etc.[13,14] However, consideration of how social media can further increase the network of people impacted by a youth suicide is important. Several online memorial sites for recent youth suicide deaths in Queensland have each had over 2,000 members. This is five times the number of exposed people from what is found in the research. Understanding who these people are and their links to the deceased young person is important.

Interestingly, many of these people do not know the deceased young person. They often post statements like, "I have never met you but rest in peace". Why many of these people are actively seeking out memorial pages may be indicative of the impact of the changes in how privacy is perceived and further heightened by status in being part of the collective grief process. By simply not wanting to be excluded from something garnering social attention, young people are actively engaging in activities that expose them to youth suicide such as seeking out suicide tribute pages online. The fear of missing out and the status of participation outweigh any negative stigma in being associated with a suicide death.

[13] Berman, A.L. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life Threatening Behavior, 41*(1), 110-116.
[14] Crosby, A.E. & Sacks, J.J. (2002). Exposure to suicide: Incidence and association with suicidal ideation and behaviour. *Suicide and Life Threatening Behaviour, 32*(3), 321-328.

In the Commission's review of a recently established memorial page, there is a post from a young person who was not in the deceased's social group; however, she was indirectly informed of the death through social connections via her school. The post described the person's view that the deceased was 'an angel' and offered condolences to the deceased's family and friends. The post received 190 'likes' from other page visitors. It can be interpreted that there is clearly a social status in not only knowing that a suicide occurred but even more so in contributing and participating in the shared grief. There is a social reward for this behaviour.

Also on this memorial page are dozens of posts from young people not known to the deceased asking what happened and searching for information regarding the death incident. The broader tabloid media environment in the Australian community has filtered to memorial pages where young people are already immune to traditional concepts of privacy. Young people asking questions about the death incident does not appear to be viewed as an invasion of privacy or morbid, but more of a benign process of wanting to participate and be included.

The search for social status via a suicide death can go to extreme lengths. For example, the Commission became aware of a case study where a young person died by suicide and there was a large community response at the funeral and through social media. A second young person who had no prior association with the death or lived in the local community, heard about the death through the ripple effect of their social networks. This second young person made statements prior to their death of being amazed by the social status of the deceased following the suicide. They attempted suicide and died a short time after the first death incident. There was evidence the second young person died with the expectation that they would also receive the same widespread response to their own death.

However, the use of social networking sites is not limited to official memorial pages. The Commission has found it is pervasive across the internet. For example, on the official club-sponsored fan page of a National Rugby League club users of the site can post different conversation threads about any topic of interest, whether it is related to rugby league or not. There was a thread with the title 'The right to bag stuff out'. A young person posted about a school postvention response to the suicide death of a student. This post resulted in multiple responses from other site visitors and a discussion regarding bullying and suicide.

The presence of such a post on an irrelevant sports fan page demonstrates the breadth of social media and how young people are exploring issues related to suicide in non-traditional methods. It is hard to envision a similar conversation occurring amongst rugby league supporters at a local match. Social media provides a unique outlet where individuals can voice their fears and anger to other people without having to engage in typical conversational processes and with less vulnerability.

Conversely, there are also sites that are specifically designed for honouring deceased people, such as MyDeathSpace, which allows users to register a death and develop

conversation threads regarding those users' experiences and opinions regarding the death. This is a site where taboo topics are covered and users of the site have a forum to explore their responses to a death. Other examples include the use of blogs where young people are provided with different tools to talk about their feelings and experiences of suicide. As a whole, social media is a medium that can be positive for young people and help reduce the stigma of suicide.

Reducing stigma through social media can result in a pendulum swing that can go too far in the other direction. The Commission has found that a Google search of 'how to hang yourself' immediately brings up thousands of results. Many of these are from online forums where lay people are discussing the effectiveness of various suicide methods. There are pro-suicide forums with content that glorifies and normalises suicidal behaviours. These often cross over with euthanasia forums with messages that death is a relief from pain that could easily be adopted by someone at risk of suicide. Through the Commission's child death reviews, there is evidence of several Queensland young people visited sites that provide information on suicide methods prior to their deaths.

In summary, social media is playing a role in reducing stigma; however, it may be increasing young people's suicide risk due to increased contagion exposure. There are opportunities to harness social media to increase suicide literacy and awareness, as well as provide new avenues for help-seeking behaviours. Most importantly, social media is a benign tool. How it is used is what matters in achieving positive or negative outcomes. The Commission welcomes initiatives such as ReachOut and Kids Helpline that provide innovative and youth-oriented resources for young people using social media platforms[15].

The under-reporting of youth suicide

The under-reporting of youth suicide has been a contributing factor to an under-appreciation of childhood suicide and is therefore a significant issue that requires attention. The Commission has strongly advocated for changes to coronial and national reporting practices to counter historical and legislative influences regarding child and youth suicide. This includes reluctance by coroners to make suicide findings regarding children and young people due to social and religious taboos, cultural attitudes and the influence of family members. The Commission acknowledges improvements in coronial practices in Queensland where a finding clearly indicates intent. For example, as noted in the Commission's *Annual Report: Deaths of children and young people, Queensland*, *2004–05*, coroners made a clear finding of intent in 30% of suicide deaths, and in the most recent *Annual Report: Deaths of children and young people, Queensland*, *2012–13*, coroners made a clear finding of intent in all but one instance (and in that instance, intent was implied). The Commission acknowledges the positive impact of directions from the Queensland State Coroner in improving the clear documentation of intent in coronial findings.

[15] See http://au.reachout.com/ReachOutCentral and http://www.kidshelp.com.au/teens/get-help/web-counselling/ for further information.

An additional issue regarding coronial findings relates to ambiguity surrounding intent for children. Previous suicide research has indicated there may be a reluctance to classify some deaths in children and young people as suicides. The implications of a child's death (regardless of its cause or circumstances) greatly differs from an adult's death, as evidenced in subjective concepts of social values related to the premature end of a life and a sense of 'innocence lost'. This view is based on the conservative belief that children are incapable of formulating concepts of death or understanding its finality and irreversibility[16,17,18]. However, more recent research has consistently found that, from the age of 8 years, children understand the concept of suicide and are capable of carrying it out[19,20]. In the *Annual Report: Deaths of children and young people, Queensland*, *2010–11*, the Commission reported the suicide death of a child aged nine years. This is in addition to the growing number of suicide deaths of children aged 10–14 years discussed above.

A related issue regarding the determination of intent is the reliance on the communication of intent by the deceased. Traditional concepts of communicating intent relied on expectations of a suicide note or the explicit verbal communication of intent by the deceased to another person. The Commission's research has identified evidence of a child or young person stating or implying their intent to suicide 54% of suicide deaths since 2004. The majority of children and young people communicated their intent to a family member, friend or intimate partner. In the majority of instances, intent was communicated verbally, with SMS text messaging and online social media forums as the second most common medium. Suicide notes are found for only 18% of deaths.

Children and young people who communicate their intent to suicide may make statements that appear to be flippant or 'off the cuff'. The Commission's evidence indicates that these statements can be minimised or result in inaction by the recipient. The complexity of suicide is that, in the majority of cases, few people are intent on dying and it is more that they want the pain they are experiencing, or have experienced, to end[21]. Family, peers and support workers may see this as manipulative or attention seeking. This is a dangerous view, as it is likely to result in the underlying pain of the person being ignored. In circumstances where this belief is expressed or implied to the young person, this may make it even more difficult for a person to communicate their need directly and openly to the people who are able to help them.

[16] Agrimis, H., Yayci, N., Colak. B., & Aksoy, E. (2004). Suicidal deaths in childhood and adolescence. *Forensic Science International, 142*, 25-31.
[17] Beautrais, A.L. (2001). Child and young adolescent suicide in New Zealand. *Australian and New Zealand Journal of Psychiatry, 35,* 647-653.
[18] Wise, A.J. & Spengler, P.M. (1997). Suicide in children younger than age fourteen: Clinical judgement and assessment issues. *Journal of Mental Health Counseling, 19*(4), 318-335.
[19] Fortune, S.A. & Hawton, K. (2007). Suicide and the del berate self-harm of children and adolescents. *Pediatrics and Child Health, 17,* 443-447.
[20] Pompili, M., Mancinelli, I., Girardi, P., Ruberto, A., & Tatarelli, R. (2005). Childhood suicide: a major issue in pediatric health care. *Issues in Comprehensive Pediatric Nursing, 28,* 63-68.
[21] Department of Community Development (2005). *Understanding Youth Suicide Information Kit*. Office for Children and Youth, Western Australia.

Of importance are the 46% of children and young people where there is no evidence of their intent to suicide. This high proportion of deaths highlights the complexity of child and youth suicide and the importance of having a detailed knowledge of risk factors for suicide in developing coronial findings. The Commission has actively engaged with the sector, including the Office of the State Coroner (QLD), in promoting the evidence base of suicide risk factor profiles of children and young people. In doing so, the Commission has advocated that suicide risk factors for children and young people differ from adults, and the gathering of evidence should incorporate these differences. The Commission has identified specific cases where coroners do not appear to have identified risk factors from the available evidence, and as such, have not considered these in making their findings.

Adding complexity to determining intent is the use of alcohol and/or other drugs by the deceased at the time of the death incident. The Commission has found that 43% of children and young people who died by suicide had consumed alcohol and/or drugs on the day of the death incident. The impact of intoxication from alcohol or other drugs can range from decreased inhibition, impulsivity and blunted feelings to emotional dysregulation and impairment in reflexes and gross motor control. The indirect effects of alcohol and other drug use on behaviour, in the short term, can be attributed to increased risk of suicidal behaviours. The Commission has identified specific cases where coroners have found a death not to be a suicide due to the presence of alcohol and/or other drugs even though the young person's intent to suicide was clear. The Commission's view is that the potential influence of alcohol and/or other drugs on a deceased's suicidal behaviour may be exaggerated, particularly for deaths of children and young people where there is the presence of other risk factors and the mechanism of injury was self-inflicted.

In response to the under-reporting of suicide deaths by coroners, the Commission has adopted a suicide classification model to classify all cases of suspected suicide into one of three levels of certainty. In classifying these deaths, the Commission considers a number of factors, including whether intent was stated previously, the presence of a suicide note, witnesses to the event, prior suicidal behaviours and/or ideation, and any significant precipitating factors. Information used to classify suicide certainty is based on evidence available to the Commission, including information sourced from the investigating coroner (e.g. the police form, witness statements, autopsy and toxicology reports, coroner's forms) as well as information from other government departments which had a history with the deceased (e.g. education, youth justice, child protection).

Levels of classification are: 1) Possible/undetermined 2) Probable, and 3) Confirmed. For a death to be classified as 'Confirmed', the available evidence refers to at least one significant factor which constitutes a virtually certain level of suicide classification, or coronial investigations have found that the death was a suicide. For those deaths classified as 'Probable', the evidence is not sufficient for a judgment of 'Confirmed', but is more consistent with death by suicide than by any other means. Risk factors for suicide have been identified and/or the method and circumstances surrounding the death are such that intent may be inferred. A classification of 'Possible/Undetermined'

includes deaths whereby the initial police form indicated the death is a suspected suicide but, because of a lack of information on the circumstances of the death, there is a substantial possibility that the death may be the result of another cause, or be of undetermined intent.

When the Commission first introduced this model to its child death review processes in its 2004–05 reporting period, only half of the suicide deaths where coronial findings were made had been classified as 'Confirmed'. This was due to unclear coronial findings regarding intent and the summary of circumstances from the coroner lacked sufficient detail. However, positive changes to coronial practices have resulted in 100% of deaths where coronial findings are available being recorded as 'Confirmed' in the 2012–13 reporting period.

A second issue influencing the under-reporting of youth suicide has been national reporting practices by the Australian Bureau of Statistics (ABS). There has been an absence of national reporting on the number of children under 15 years who suicide. The under-reporting of youth suicide has been a contributing factor to an under-appreciation of childhood suicide. The sensitive nature of suicide has historically been a rationale for not publicly reporting its occurrence in Australia. However, this is no longer valid, as accurate data on the prevalence of youth suicide can not only reduce misinformation amongst media and community stakeholders, but also improve research into prevention and postvention responses for at-risk young people. Further, the ABS' view that suicide of children under 15 years is 'low in relative terms' also does not align with causes of death across that cohort. As mentioned above, suicide has been the leading or second leading external cause of death for children aged 10–14 years for the majority of time the Queensland Child Death Register has existed (since 2004).

In the Commission's *Annual Report: Deaths of children and young people, Queensland, 2005–06* a recommendation was made to the ABS to publicly report suicides of children and young people under 15 years of age, and the Commission continually advocated to the ABS for this change to reporting practices. This included releasing a Trends and Issues Report comparing the suicide data released by the Commission (which includes all children and young people) and the limited data released by the ABS[22].

In response to the Commission's work on advocating for improvements to suicide reporting, a detailed submission was prepared for the Senate Community Affairs Reference Committee's (the Senate Committee) Inquiry into Suicide in Australia and the Commission was invited to appear before the Senate Committee to provide oral evidence on the matter of youth suicide in Queensland. The Commission was pleased to note that the Committee's final report, *The Hidden Toll*, made recommendations addressing the under-reporting of suicide, including the national standardisation of suicide reported in Australia. These recommendations strongly aligned with those submitted by the Commission.

[22] Trends and Issues Paper *Child Deaths: Underreporting of youth suicide* can be accessed from http://www.ccypcg.qld.gov.au/pdf/publications/papers/trends-and-issues/Issues-Paper-no-13-under-reporting-of-youth-suicide.pdf

Since the Senate Committee made its recommendations, there has been some progress towards national reporting amendments. The Commission acknowledges recent improvements in the reporting practices of the ABS, including the publication of suicide data for children under 15 years in its *Causes of Death* series. Whilst the data lacks details that are reported for other age groupings, this marks an important step forward. The importance of creating an accurate understanding of, and greater awareness about, youth suicide is reinforced by Commonwealth and State suicide prevention strategies and policies, which identify suicide as a prominent public health problem in Australia, and acknowledge young people as a specifically vulnerable group.

However, the role of the ABS is to report on statistical data related to the official causes of death and not on the circumstances surrounding the death. Reviewing circumstances of youth suicides is the legislated responsibility of child death review teams and committees within each State and Territory. Whilst child death review functions within agencies throughout Australia are at varying stages of implementation and have individual legislative bases and reporting requirements, all jurisdictions review and report on the suicide deaths of children and young people. The detailed analyses of the circumstances, risk factors and patterns related to youth suicides are a unique contribution from these agencies to the available suicide data in Australia.

In recognition of the need to develop nationally comparable data and multi-jurisdiction prevention messages, agencies with child death review functions have convened the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). The stated aim of the ANZCDR&PG is to identify, address and potentially decrease the numbers of child deaths by sharing information on issues in the review and reporting of child deaths, and to work collaboratively towards national reporting. Whilst the data available to national data custodians (such as the ABS and Australian Institute of Health and Welfare) can provide an overview of rates of youth suicides, the detailed information held by agencies with child death review functions presents a significant opportunity to compare and contrast risk factors and prevention efforts. For example, the Commission's Child Death Annual Report series includes a chapter with comparisons of suicide death numbers and rates for children and young people under 18 years across most Australian jurisdictions[23].

The development of a national youth suicide database would be duplicative of the efforts already completed by state and territory child death review functions. Additional funding and resourcing of these agencies to build capacity and enhance reporting practices would yield a more efficient and timely output then developing a separate database. Advocacy for national youth suicide data could therefore have messages targeted at building on established processes already in place and to develop champions across all tiers of government to support and resource these agencies.

[23] See Chapter 10 of *Annual Report: Deaths of children and young people Queensland, 2012–13* for the latest data.

Summary and Recommendations

The death of a child is a tragic loss, not only to family and friends but also to the broader community. When the death occurs by the young person's own hand the impact in immeasurable – leaving many with unanswered questions and wondering what could have been done differently. Understanding as much as possible about these deaths and using this information to inform prevention efforts is critical. There is a wide breadth of rich information already available in Australia regarding the prevalence of youth suicide and the circumstances in which it occurs.

The suicide prevention sector is large, with a diverse range of initiatives from large national campaigns to grassroots intervention and postvention charitable groups. Unfortunately, there are finite resources available. Using these resources as efficiently as possible is crucial. The next step is to develop coordinated plans to implement the Senate Committee's outstanding recommendations.

The Senate Committee's report was the culmination of extensive research, interviews and submissions. Its comprehensiveness is to be commended, as it covers specific issues related to youth suicide, as well as other vulnerable groups. The Commission supports the recommendations of the Senate Committee and strongly advocates for the timely implementation of its recommendations. Several recommendations have already been implemented or have made significant gains to being finalised.

For example, the Commission is a member of the National Committee for the Standardised Reporting of Suicide and can advise there is already extensive work being undertaken by Chief Coroners in each jurisdiction to develop a standardised national police form (Recommendation 4) and to improve coronial processes and data capture (Recommendations 3, 4, 7). Further, planning is being undertaken in Queensland by the Queensland Mental Health Commission to develop a comprehensive cross-sectoral action plan for suicide prevention that includes frontline government services (Recommendation 15). A recent review of the Mindframe guidelines has also been undertaken with more up-to-date resources available for the media and community (Recommendation 20)[24].

The Commission respectfully recommends the National Children's Commissioner engage with those agencies tasked to implement the Senate Committee's recommendations as well as the National Suicide Prevention Strategy, such as the National Mental Health Commission and Suicide Prevention Australia, to identify opportunities for mutual advocacy and collaboration regarding youth suicide reporting, prevention and intervention strategies.

There is already extensive work being undertaken in this sphere, but it requires ongoing communication and engagement from all interested parties. Mechanisms to promote

[24] See http://www.mindframe-media.info/home/news/news/2014/hon-peter-dutton-mp-minister-for-health-media-release-regarding-the-new-mindframe-media-resources for further information.

alignment with and enhance suicide prevention activities across all tiers of government as well as the non-government sector are a priority. Until 30 June 2014, the Commission will continue to report on youth suicides in Queensland, support research activities by providing data from the Queensland Child Death Register, continue advocacy activities through participation on state and national committees and supporting policy and legislative reviews. From 1 July 2014, child death review functions will transition to the newly established Queensland Family and Child Commission (QFCC). The QFCC has been established as part of the broader activities related to the Queensland Government's implementation of the *Commission of Inquiry into the Child Protection System.* Current Commissioner, Mr Steve Armitage, will transition to the QFCC and serve as Principal Commissioner. The QFCC welcomes future opportunities to collaborate on this important issue.

Thank you for inviting the Commission for Children and Young People and Child Guardian to provide comment on this important initiative.