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Ombudsman New South Wales

nsw cdrt child death review team

Submission to the Committee on Children and Young People Inquiry into current approaches aimed at preventing youth suicide in NSW

August 2017

1. Background: child deaths reviewable by the Ombudsman

Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act), NSW has two independent statutory functions to review the deaths of children:

- The NSW Child Death Review Team (CDRT) was established in 1996 under Part 5A of the Act. The CDRT reviews the deaths of all children aged from birth to 17 years. The NSW Ombudsman is Convenor of the CDRT and Ombudsman staff provide administration and support, including research and reviews. This has been the case since 2010, when responsibility for supporting the work of the CDRT transferred from the former Commission for Children and Young People to our office.
- Separately, and under Part 6 of the Act, the Ombudsman is responsible for reviewing the deaths of children aged from birth to 17 years who die as a result of abuse or neglect, or in suspicious circumstances, and children who die in care or detention ('reviewable deaths').

The purpose of both functions is to help prevent the deaths of children in NSW. To this end, we:

- Maintain a register of child deaths in NSW. The register holds a range of information about each child who has died, including demographic and health data, and information about the cause and circumstances of death. From the information held in the register, we identify trends and patterns and produce public reports are tabled in the NSW Parliament biennially.
- Undertake research – either alone or with others – that aims to help prevent or reduce the likelihood of child deaths.
- Make recommendations as to legislation, policies, practices and services that can be implemented by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.

Our reviews

The main purpose of our review work is to identify opportunities for preventing the deaths of children and young people. This is at two levels:

- At an individual level - the circumstances of death may highlight a particular risk.
- At a population level – we may be able to identify trends that point to the need for action to prevent deaths in certain demographic groups or from certain causes.

The NSW Registry of Births, Deaths and Marriages provides us with initial information about the deaths of children. The Act gives the Ombudsman power to compel certain agencies and individuals to provide information that we reasonably require to fulfil our functions. We seek and receive records from a wide range of sources, including health providers, forensic services, the State Coroner, the Department of Family and Community Services and other government and non-government agencies as relevant.

In most cases, our review takes place after all other inquiries and investigations have

been completed. Information gained from reviews is placed on the child death register.[1] The register informs our biennial reports of child deaths to the NSW Parliament, and research initiatives that focus on the prevention of deaths of children in NSW.

Because our reviews are generally the only point at which information from different agencies is seen together, in relevant cases, our work will also consider how agencies worked together to respond to the needs of a child and their family. This is particularly relevant in relation to deaths resulting from abuse or neglect, and deaths by suicide.

How we determine that a death was due to suicide

We consider that a death occurred as a result of suicide where:

- The State Coroner has made a finding that the cause and manner of death was self-harm with fatal intent, or
- The matter remains open with the Coroner, or the Coroner has dispensed with an inquest without recording a finding in relation to manner of death, and police have identified the death as a suicide and/or other available records provide evidence of suicidal intent.

Evidence of suicidal intent includes circumstances where police identify suicidal intent, often due to the young person having documented or otherwise communicated to someone their intent to suicide. In examining those matters still open with the Coroner or where the Coroner has not recorded a manner of death, we infer suicidal intent from the cause and circumstances of death, and the behaviour of the young person. Factors that we take into consideration include evidence of suicidal ideation, threats or attempts, and the chosen method.

Our reports

The CDRT has reported on the suicide deaths of children and young people over the past 20 years, including in annual reports and its 2003 report on suicide and risk-taking deaths.[2] The Ombudsman's 2017 biennial report of reviewable child deaths in 2014 and 2015 also included a focused review of the suicide and risk-taking deaths of teenagers who were in out-of-home care at the time. All of these reports are publicly available on our website (www.ombo.nsw.gov.au).

CDRT annual reports contain demographic and trend data in relation to the suicide deaths of children and young people in NSW, as well as observations and issues relating to:

- intent and precipitating factors
- risk factors, including mental health concerns, previous suicidal behaviour and self-harm, substance use, childhood trauma, interpersonal and personal stressors, and
- agency contact with the young person and their family.

This submission draws from our review work and information we have previously put forward in public reports. It is focused on the key issues that we believe warrant consideration by the Committee as part of its examination of current approaches aimed at preventing youth suicide in NSW.

[1] The platform for the Register is an in-house database called the 'Death Review System'. This database has been in place from 2014, when the Register from a legacy system.
[2] NSW Commission for Children and Young People (2003), *Suicide and risk-taking deaths of children and young people.*

We note that the observations and issues raised in this submission relate to the deaths of children under the age of 18 years and may not be able to be generalised to older youth.

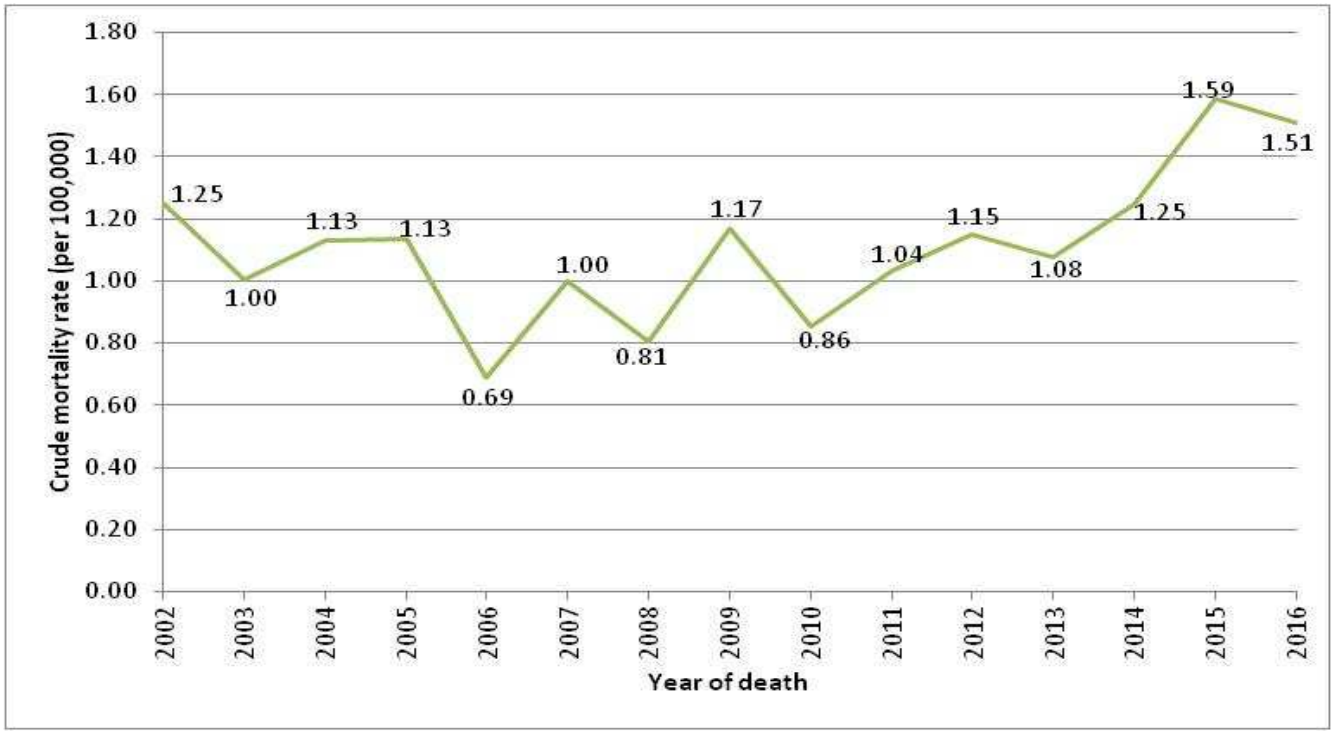
2. Trends in the deaths of children and young people by suicide

Since the CDRT commenced in 1996, the NSW child death register has recorded the suicide deaths of 405 children and young people, ranging in age from 10 to 17 years.[3]

The following section draws on information contained in the Child Death Register for deaths that occurred between 2002 and 2016 (unless otherwise indicated) and relates to children and young people under the age of 18 years.

As shown in the figure below, the suicide mortality rate of children and young people over the 15-year period to 2016 fluctuated between 0.69 and 1.59 deaths per 100,000 persons under 18 years.[4] Over this time, there has been no statistically significant change in the suicide mortality rate of children and young people in NSW.

Figure 1: Deaths by suicide of young people under 18 years, 2002 – 2016



Data on key trends over the past 15 years is included at Appendix A, and summarised briefly below.

Age

The majority of deaths by suicide occurred in the 15 to 17 year age group, and for the

[3] Deaths that occurred between 1 January 1996 and 31 December 2016.
[4] All mortality rates referred to in this submission are crude mortality rates – deaths per 100,000 people under 18 years of age.

past three years, suicide has been the overall leading cause of death for this age group. Notably, the number of suicide deaths of 15 year olds has increased since 2002, rising from 11 per cent to 22 percent of all deaths by suicide of young people over the 15 year period.

While the number of deaths by suicide of children and young people between the ages of 10 and 14 years is comparatively small, it is significant in terms of the mortality rate of all deaths within this age group. For the last five years (from 2012), suicide has been the leading or second-leading injury-related cause of death of 10-14 year olds in NSW.

Gender

Males have been consistently over-represented in suicide deaths of children and young people in NSW, with the suicide rate for males being higher than that of females in fourteen of the last fifteen years. However, the difference between male and female suicide mortality rates for the under 18 age group has reduced in recent years, largely due to an increase in female deaths by suicide.

Aboriginal and Torres Strait Islander status

While Aboriginal and Torres Strait Islander children and young people comprise less than five per cent of all children in NSW[5], they accounted for 10 per cent of all suicide deaths of children and young people over the 15 years from 2002.[6]

The mortality rate for Aboriginal and Torres Strait Islander young people increased substantially in the period 2012-2016 (from 1.57 to 4.65). Over the same period, the suicide mortality rate for Aboriginal and Torres Strait Islander young people was four times that of non-Indigenous young people (4.65 compared to 1.15).

Location and socio-economic status

Sixty-one percent of the young people who died by suicide over the 5 year period 2011-2015 resided in major cities in NSW, primarily in the Sydney metropolitan area. However, the rate of suicide deaths in regional areas[7] was higher than in major cities (1.64 compared to 1.03). There was a relatively even distribution of deaths by suicide across socio-economic quintiles.[8]

Child protection history

In 2014, the CDRT tabled a special report to Parliament on the causes of death of children with a child protection history between 2002 and 2011. The analysis for this report was undertaken by the Australian Institute of Health and Welfare.[9] In relation to

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[5] Australian Bureau of Statistics (2013), *3101.0 Australian Demographic Statistics,* Table 51, Canberra: ABS; Australian Bureau of Statistics (2012), *Indigenous experimental population projections by age, by sex – reference period 2011,* Canberra: ABS.

[6] Since 2012, the CDRT has used a consistent approach to identifying Aboriginal and Torres Strait Islander children and young people, which takes into account a range of records that may make reference to Indigenous status. However, as the approach has not been consistent over time, any description of trends in the deaths of Aboriginal and Torres Strait Islander children is based only on identification of Indigenous status in birth and death records from the Registry of Births, Deaths and Marriages.

[7] In this submission, regional areas include outer and inner regional areas and exclude remote and very remote areas.

[8] SEIFA and ARIA are calculated on the Australian Statistical Geography Standard. This is the Australia Bureau of Statistics' geographical framework, effective from July 2011. Due to the unavailability of data prior to 2011, socio-economic and remoteness measures were unable to be calculated for years 2001 to 2010.

[9] NSW Child Death Review Team (2014), *Causes of death of children with a child protection history 2002-2011,* report by the Australian Institute of Health and Welfare. NSWOmbudsman, Sydney. The report can be accessed

suicide, the analysis identified that over the 10 year period:

- Controlling for other variables, child protection history significantly increased the likelihood of death due to suicide. The suicide rate for children with a child protection history[10] (6.3) was four times the rate of children without this history (1.5).
- While there was a significant decline in suicide mortality rates for children without a child protection history, there was no significant change in the rate for children without this history.

3. Risk factors associated with suicide

There is a complex nexus of risk and protective factors associated with suicide of young people. Relevant considerations include:

- the interplay between individual, social and contextual factors[11]
- the fact that no particular outcome is related to a single pathway[12],
- that causation is complex and generally multi-factorial, rather than a direct event-outcome relationship[13], and
- risks can be both proximal (recent stressful events or 'triggers') and distal (factors likely to increase vulnerability over time).[14]

For young people, it is often the combination of risk factors that poses the greatest risk. Some of the key factors we have identified through our work are set out below.

In 2012, we settled a consistent approach to our reporting of risk factors in the suicide deaths of children and young people. The data referred to in the section below is drawn from the Child Death Register and relates to the 85 suicide deaths that occurred over the period 2012 to 2015.

A history of suicidal behaviour and/or self harm

Consistent with research findings in this area, we have observed a link between previous suicide attempt(s) and increased risk of future attempt(s) or suicide.[15] Records indicated that one-fifth (17) of the young people who died between 2012 and 2015 had previously attempted suicide.

Although self-harming behaviours generally do not involve suicidal intent, there is evidence to indicate that young people who engage in self-harming have a high risk of

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from our website - https://www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-death-review-team/causes-of-death-of-children-with-a-child-protection-history-2002-2011-special-report-to-parliament

[10] Children with a child protection history comprised children, or siblings of children, who were the subject of a report of risk of harm to FACS within three years of their death (2002-2009); and children, or siblings of children, who were the subject of a report of risk of harm/risk of significant harm report to FACS and/or to a Child Wellbeing Unit within three years of their death (2010-2011).

[11] Brofenbrenner, U., & Ceci, S.J (1994), 'Nature-nurture reconceptualised in developmental perspective: a bioecological model', *Psychological Review'*, 101(4): 568-86.

[12] Cicchetti, D., & Toth, S.L (1995), 'A developmental psychopathology perspective on child abuse and neglect', *Journal of American Academy Child Adolescent Psychiatry*, 34: 541-65.

[13] Rutter, M (1998), 'Pathways from childhood to adult life', *Journal of Child Psychology and Psychiatry*, 30: 23-51.

[14] Suicide Prevention Australia (2010), *Position statement: youth suicide prevention*, Sydney: SPA.

[15] Ibid.

suicide than those who do not.[16] Our reviews identified that close to half of the young people who died by suicide (41) had engaged in self-harming behaviour.

Mental illness and other psychological concerns

There are challenges in diagnosing mental illness in young people, and the number receiving treatment for mental illness is rising.[17] Consistent with research findings, our reviews indicate that mental health problems commonly associated with suicidal behaviours include mood disorders, anxiety disorders, adjustment disorders and personality disorders.[18] Between 2012 and 2015, 55 per cent of the young people who died had been diagnosed with a mental illness, predominantly depression and anxiety.

Recognising that many of the psychological factors correlated with increased risk of suicide are experienced to some degree by most young people, research has found that such factors include: low self esteem[19]; poor perception of role within the family (particularly for males)[20]; persistent negative attribution[21]; high risk cognitive style (for example, perfectionist tendencies)[22]; poor body image;[23] and eating disorders (particularly for females).[24]

Problematic substance use

Substance abuse, including cannabis and alcohol, can increase the risk of suicide for young people.[25] Once co-occurring mental health and drug and alcohol problems have been established, the relationship between them is generally one of mutual influence, with each condition serving to perpetuate and exacerbate the other.[26] Our reviews identified that substance misuse was an identified concern for close to a third of the young people who died.

Interpersonal difficulties

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[16] Ibid.
[17] Mental Health Commission of New South Wales (2015), *Medication and Mental Illness: Perspectives.* Sydney, Mental Health Commission of NSW
[18] NSW Mental Health Commission (2015), *Proposed suicide prevention framework for NSW,* prepared by the NHMRC Centre for Research Excellence in Suicide Prevention and the Black Dog Institute, pg 6.
[19] Lewinsohn, P.M., Rohde P., Seeley J.R (1994), 'Psychological risk-factors for future adolescent suicide attempts', *Journal of Consultant Clinical Psychology,* 62(2): 297-305.
[20] Reinherz H.Z., Giaconia, R.M., Pakiz, B et al (1993), 'Psychological risks for major depression in late adolescence: a longitudinal community study', *Journal American Academy of Child Adolescent Psychiatry,* 32(6): 1155-63.
[21] Spasojevic, J., & Alloy, L.B., (2001), 'Rumination as a common mechanism relating depressive risk factors to depression', *Emotion,* (1(1): 25-37.
[22] Alloy L.B., Abramson, L.Y., Whitehouse, W.G., et al (2006), 'Prospective incidence of first onsets and recurrences of depression in individuals at high and low cognitive risk for depression', *Journal of Abnormal Psychology,* 115(1): 145-56.
[23] Stice, E., & Bearman, S.K., (2001), 'Body –image and eating disturbances prospectively predict increases in depressive symptoms in adolescent girls: a growth curve analysis, *Developmental Psychology,* 37(55): 597-607; Paxton, S.J., Neumark-Sztainer, D., Hanna, P.J et al (2006), 'Body dissatisfaction prospectively predicts depressive mood and low self-esteem in adolescent girls and boys, *Journal of Clinical Child Adolescent psychology,* 35(4): 539-49; Bearman, S.K., & Stice, E., (2008), 'Testing a gender additive model: the role of body image in adolescent depression, *Journal of Abnormal Child Psychology,* 36(8): 1251-63.
[24] Stice, E., Burton, E.M., & Shaw, H (2004), 'Prospective relations between bulimic pathology, depression and substance abuse: unpacking co morbidity in adolescent girls, *Journal of Consultative Clinical Psychology,* 115(1): 145-56.
[25] Bromley, E., Johnson, J.G., Cohen, P (2006), 'Personality strengths in adolescence and decreased risk of developing mental health problems in early adulthood', *Comprehensive Psychiatry,* 47(4): 317-26.
[26] NSW Health (2015), *Effective models of care for comorbid mental illness and illicit substance use: Evidence check review.* Sydney, NSW Health.

Family conflict, parental divorce or separation, and history of parental diagnosed depression have all been associated with an increased risk of suicide for young people.[27] Family conflict may present as a trigger event in conjunction with other risk factors for suicide. Bullying at school has also been linked to suicide-related behaviours.[28] Records we reviewed identified that almost two-thirds of the children and young people who died had experienced interpersonal difficulties, including conflict with family and/or with peers.

Childhood trauma

Adverse and traumatic events in childhood can be precipitating factors in suicide attempts or suicides. In particular, physical abuse, sexual abuse and family violence have been correlated with suicidal behaviour.[29] Our reviews identified that around half of the young people who died had experienced trauma as young children.[30] Just over one-quarter of the young people who died had been the subject of at least one child protection report alleging abuse or neglect in their childhood. In some cases, there was an extensive history, including time spent in out-of-home care. For the other young people, trauma was indicated through adverse events, such as the death of a parent or other close relative.

Suicide death of a family member or peer

A family history of suicide is a strong risk factor for suicide and suicide attempts, particularly in circumstances where the young person is already experiencing difficulties and life stresses.[31] Research has found that young people are at increased risk of suicide if they were a relative or close of the person who died, witnessed the death or had recent contact with the person who died and/or have been exposed to suicide deaths or other losses in the past.[32] Our reviews identified that between 2012 and 2015, 14 of the 85 young people (17%) experienced the suicide death of a peer (8), or a family member (6).

4. Nature and extent of identified risks and agency contact

Recognising the multi-factorial nature of suicide risk, and that the presence of risk factors is not predictive of suicide, our reports have noted that the degree to which the young people were identified to be at risk before they died was along a continuum, ranging from those for whom concerns about suicide risk where clearly apparent to those who were not on the radar of services or practitioners as being at risk or needing help.

- **Young people with serious ongoing difficulties, complex needs and a clearly identified risk of suicide:** Some young people had a lengthy child protection history, difficulties with educational engagement, diagnosed mental illness, self-harming and suicidal behaviour and hospital admissions as a result of self harm and/or acute mental illness. In many of these cases, the young person was receiving extensive support from a range of agencies. Other young people

[27] Bromley, E., Johnson, J.G., Cohen, P (2006), 'Personality strengths in adolescence and decreased risk of developing mental health problems in early adulthood', *Comprehensive Psychiatry*, 47(4): 317-26.
[28] Department of Health and Ageing (2007), *Life: Living is for everyone – research and evidence in suicide Prevention*, Australian Government, Canberra, pg 20.
[29] Suicide Prevention Australia (2010), op cit.
[30] Child protection reports or other records indicating traumatic events when the young person was less than 12 years of age.
[31] Suicide Prevention Australia (2010), op cit.
[32] Family & Community Services, Office of the Senior Practitioner, Research to Practice Notes, *Adolescent self-harm and suicide*, September 2014.

refused to engage with therapeutic supports and/or were non-compliant with treatment regimes.

- **Young people with some identified coping difficulties or challenges, but not considered to be at risk of suicide:** Some young people attended school regularly with no or few issues identified in relation to behaviour or academic performance, but had been identified as requiring support for mental health concerns, often depression and/or anxiety. Mostly, this group of young people were reported as responding well to counselling or other treatment, and had disclosed no history of suicidal thoughts or self-harming behaviours.
- **Young people for whom there were no evident indicators that they required support or assistance:** Some young people were reported to have attended school regularly and participated in social and other activities outside of school with no issues identified. Most often, these young people had not previously exhibited symptoms of mental ill-health and no or few concerns had been identified in relation to behaviour prior to death. In some cases, post-death inquiries identified that the young person may have been struggling with depressed mood or other difficulties, however, had not disclosed this to anyone.

Our reviews found that around a quarter of the young people who died experienced serious, ongoing difficulties; close to 50 percent were identified to have some coping difficulties or challenges; and for 28 per cent, there were no prior indicators that the young person required support or assistance.

Notably, our reviews have also consistently found that proximal events[33] were a factor for a significant number of the young people who died, whether they known to be experiencing entrenched difficulties or not.

5. Key observations and issues arising from our work

Taking into account the extent to which individual circumstances vary, and noting that the presence of risk factors are not in and of themselves predictive of suicidal behaviour, our reviews over a number of years have highlighted several key observations and opportunities for prevention and targeted interventions. These include:

- The importance of providing multiple avenues and opportunities for young people to obtain help
- The importance of early identification, and response to, mental health concerns, including:
  - the need for appropriate referral, assessment and therapeutic support for young people identified to be at risk of suicide
  - the need for proactive follow-up of young people who present to health services for assistance
  - strategies for assertive follow up in circumstances where there is lack of follow-through by families or the young person expresses reluctance to engage with therapeutic supports

[33] Proximal factors generally refer to recent stressful events or traumatic events that can serve as a tipping point for young people already experiencing other risk factors for suicide. Examples include relationship breakdown with a boyfriend/girlfriend, death of a family member or friend, bullying, difficulties at school or work, parental divorce or separation and conflict with parents or friends.

- The key role of schools in supporting students at risk, including in relation to:
  - working with families to facilitate referrals to specialist mental health services, and supporting young people to manage risks in the school environment
  - the provision of postvention supports and strategies targeted to young people who have experienced the suicide death of another student, family member or friend
  - de-stigmatising mental health problems through whole-of-school programs designed to promote mental health and wellbeing
- The need to ensure coordination of care and support provided to young people at risk
- That young people in out-of-home care are particularly vulnerable and often experience significant risk factors and unmet need
- The need for an overarching whole-of-government suicide prevention framework that includes a specific focus on measures targeted towards the particular needs of children and young people
- The importance of measuring and evaluating the impact of suicide prevention strategies and initiatives
- The need for effective data collection and reporting on youth suicide

The provision of multiple avenues and opportunities for young people to seek help

Research indicates that young people are amongst those least likely to seek professional help for a mental health problem.[34] Our reviews have found that the young people who died by suicide did not always communicate that they were experiencing problems and/or needed help, and those that did, approached different people in their lives in varied ways.

As noted above, a significant number of the young people who died were not identified as being at risk of suicide. This highlights the importance of universal strategies aimed at increasing resilience and promoting mental health and wellbeing amongst children and young people. It also underscores the need to provide a wide range of options and multiple opportunities for young people and their families to obtain early assistance and intervention as need arises or changes.

In the context of our work demonstrating that young people often only disclose thoughts of suicidal intent to their friends, we note that while there are a number of resources available to people supporting others who are at risk of suicide[35], this does not appear to be the case in relation to resources specific to young people.[36] In this regard, we consider that evidence-based and well promoted strategies that provide young people

[34] For example, a survey of young people aged 15-19 years conducted by Mission Australia in association with the Black Dog institute in 2014 found that over 60% of those with a probably serious mental illness were not comfortable seeking information, advice or support from professional services including telephone or online counselling and/or community agencies. The young people with and without a probably mental illness stated that they were more comfortable seeking information, advice and support from friends and the internet.

[35] For example, Lifeline's toolkit 'Helping someone at risk of suicide'.

[36] In this regard, we note that the NSW Youth Advisory Council and the NSW Mental Health Commission launched the 'Make a Mate's Day' website during Youth Week in 2014. The website was a temporary initiative designed to generate awareness amongst young people around connecting with their friends who may be struggling with mental health issues, and providing advice on how to seek help in these circumstances.

with the tools to recognise and respond to a situation where a friend or peer indicates suicidal thoughts would be of benefit.

The importance of early identification and response to mental health concerns

A substantial number of the young people who died by suicide had a history of mental health problems, suicidal behaviour and/or self-harm. A previous suicide attempt is considered to be the strongest predictor of a future suicide attempt or suicide.[37]

Our reviews identified that many of the young people had accessed some level of mental health support before they died. The main sources of support were school counsellors, general practitioners, private psychologists or counsellors, Child and Adolescent Mental Health Services (CAMHS), NSW Health Acute Care Services and Headspace programs. It is not uncommon for young people to receive treatment or support from one or more services simultaneously. Our work has consistently identified issues and opportunities for improvement in relation to the provision of mental health supports, including the need for:

- timely and thorough assessment, follow-up and regular review of treatment plans by mental health practitioners, particularly following discharge or transfer of care from acute to community based mental health service,
- effective and timely information exchange and coordination of care between health services and with other agencies/professionals involved in supporting the young person and their family,
- effective management of conditions associated with an increased risk of suicide such as depression, anxiety, conduct disorder and substance abuse, and
- assertive follow up, particularly in circumstances where the young person indicates reluctance or refusal to engage in therapeutic supports.

The key role of schools in supporting students at risk

Many of the young people whose deaths we reviewed had contact with school counsellors for assistance with issues including mental health concerns, school attendance, learning difficulties, behavioural issues and bullying. Importantly, for some young people, school counsellors and other school staff were the only services involved with them.

Our work has highlighted the key role that school counsellors and other school staff can play in:

- providing a point of contact for young people to talk about their concerns and obtain advice and assistance
- early detection and intervention to reduce risk of self-harm, and
- facilitating referrals to assist young people and their families access support, including specialist mental health services.

Coordination of care and support for young people at risk of suicide

Multiple service provider involvement, particularly with young people experiencing ongoing serious difficulties presents opportunities for multi-faceted intervention. Our reviews have identified that for some young people, information exchange and liaison

[37] Suicide Prevention Australia (2010), *Position statement: youth suicide prevention,* Sydney: SPA.

between professionals appeared to be well coordinated, but for others service provision and support was at times fragmented.

Collaborative work between involved agencies to support young people and their families/carers is essential – particularly across mental health and hospital emergency department services, and between mental health and education staff. However, some of the barriers we have identified in relation to effective coordination of care and support include:

- lack of clarity about the roles and responsibilities of each involved agency, and identifying those young people who may benefit from having a clearly nominated 'lead agency' responsible for coordinating the provision of services

- inadequate communication between agencies about the progress and outcome of their respective service interventions, and

- lack of discussion or planning between agencies about how to holistically monitor the changing risks and needs of the young person, including how to identify when supports may need to be adjusted.

Young people in out-of-home care are particularly vulnerable and often have high levels of unmet need

Our reviews have consistently identified that young people in out-of-home care are particularly vulnerable and frequently present with high and complex needs. Since our role in examining 'reviewable deaths' commenced in 2004, nine young people in out-of-home care aged between 13 and 17 years died by suicide, accounting for 20 percent of all young people the same age who died in care over the period.

Against this background, our 2017 *Report of Reviewable Deaths in 2014 and 2015* included a focused review of 15 young people (aged 13-17 years) who were in out-of-home care and died by suicide or in a risk-taking context between 2004 and 2015. Nine of the 15 young people died by suicide and all had high and complex support needs, with involvement by multiple agencies to address escalating and significant risks. In the 12 months before they died, most of the young people:

- exhibited challenging and/or risk-taking behaviour of such intensity, frequency and duration that they placed themselves (and sometimes others) at serious risk of harm, and/or
- experienced mental health problems to an extent that impacted their ability to access services and participate in education and other day-to-day activities.

Our review identified problems and challenges in relation to establishing and sustaining the engagement of young people in therapeutic support services, effectively coordinating support across services and practitioners, and managing the risks/meeting the intensive ongoing support needs of these young people. For example, we observed that:

- More than half of the young people referred to relevant support services repeatedly declined assistance or only engaged sporadically with the supports offered. In some instances, persistent follow-up by the support service and/or responsible out-of-home care agency resulted in re-engagement by the young person, but assertive follow-up did not always result in this outcome.
- Almost all of the young people were the subject of multiple reports to FACS during

their time in care. Reports predominantly related to the young person engaging in harmful or risk behaviours, or concerns about the young person's mental health/emotional state. We found that a high proportion of these reports were either screened out by the Child Protection Helpline as not meeting the threshold for statutory intervention or were closed without further assessment due to competing priorities, sometimes on the basis that other agencies or practitioners were providing support to the young person. When cases were allocated for a child protection response, we identified instances where casework practice appeared to be narrowly focused and centred on resolving immediate needs.

- For many of the young people involved with multiple agencies, interagency communication and coordination was less than optimal. In some cases, we found that a lack of effective communication at critical points – for example, following risk of significant harm reports, post-release from juvenile detention or after discharge from a hospital/health service – meant that relevant information was not always drawn together and analysed holistically across the agencies. This impeded the ability of any one agency to fully understand the young perron's circumstances and associated risks, and to use all relevant information to inform case planning and service interventions.

In the context of our review emphasising the need for intensive case management, a consistently supportive and therapeutic care environment and close monitoring and support of placements, we recommended that FACS should consider the issues raised in our report and provide details of current or proposed strategies to address these. We said that FACS should have particular regard to:

- responses to risk of significant harm reports, particularly those that raise concerns about self-harm and risk-taking behaviours (including suicide attempts or threats and substance abuse)
- identification, and response to, escalating self-harm/risk-taking behaviours, and
- lack of placement stability and homelessness.

FACS has indicated to us that the agency accepts our recommendation in full and is currently working on a range of strategies to address the issues we raised.

The need for a whole-of-government suicide prevention strategy with a specific focus on children and young people

We note that there is currently no overarching whole-of-government suicide prevention plan in NSW. In this regard, the *Living Well Strategic Plan for Mental Health in NSW 2014-2024* (the strategic plan) that was developed by the NSW Mental Health Commission states that:

> *At present, there are clear gaps in the co-ordination and integration of suicide prevention activities and programs across all levels of government. There is a need for better governance and more clearly delineated roles and accountabilities for suicide prevention.*[38]

The strategic plan details a range of actions for NSW, including preparation of a NSW Suicide Prevention Implementation Plan, and action to ensure that suicide prevention efforts reflect the unique needs and higher rates of suicide in particular communities and

[38] NSW Mental Health Commission (2014), *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024.* Sydney, NSW Mental Health Commission.

populations, including for children and young people.[39]

The NSW Mental Health Commission has reported that in August 2014, *'government agencies determined that a high level Framework would be preferable to an implementation plan.'*[40] The *Proposed Suicide Prevention Framework for NSW* was launched by the Mental Health Commission in August 2015. The framework takes a systems approach to suicide prevention that is focused on strategies implemented at the local level. The framework states the approach *'represents an all-ages response'* to suicidal behaviour, while noting that this does not preclude services and agencies from using a targeted approach to prevention.

The current status of the proposed framework is unclear. However, we note that in NSW, recent initiatives in suicide prevention are focused on whole-of-community responses tailored to meet the specific needs and priorities identified by local communities themselves, including for high risk groups. For example, *LifeSpan,* which is currently being trialled in four NSW sites, adopts a systems approach to suicide prevention. The aim is for medical, health and community agencies to work together at a local level to implement nine evidence-based suicide prevention strategies. Lifespan notes that *'the nine strategies are suitable for any group within the Australian population. However, the strategies do need to be tailored to the needs of local communities and high risk populations'.*[41]

The delivery of *LIfeSpan* is led by the NHMRC Centre for Research Excellence in Suicide Prevention and the Black Dog Institute in partnership with the NSW Mental Health Commission, NSW Health, Department of Education and Local Health Districts. While Local Health Districts and Primary Health Networks are responsible for implementing local suicide prevention strategies and initiatives at *LifeSpan* trial sites, the extent to which Local Health Districts can effectively drive a genuinely integrated response across the range of government and non-government agencies that have a role in supporting people at risk will be crucial to the program's success. In the context of children and young people being amongst those at highest risk of suicide, and noting that the trial is in the initial stages of implementation, it will also be important for *LifeSpan* to take account of the particular circumstances and needs of children and young people.

While the contribution of community-based suicide prevention initiatives needs to be recognised, it has also been well documented that activities and programs in relation to mental health and suicide prevention and intervention are poorly coordinated and fragmented across all levels of government. In relation to youth suicide, we note that there are a broad range of government and non-government agencies in NSW with roles and responsibilities relating to the support of children and young people at risk, including in relation to the provision of:

- NSW Health services, including acute, community based, and specialist adolescent mental health programs and services e.g. CAHMS.

[39] 'Actions for reform' 3.4.2, 3.4.3
[40] NHMRC Centre for Research Excellence in Suicide Prevention and Black Dog Institute for the NSW Mental Health Commission (2015), *Proposed Suicide Prevention Framework for NSW*, accessed from http://nswmentalhealthcommission.com.au/publications/proposed-suicide-prevention-framework-for-nsw on 29 July 2016.
[41] LifeSpan and Black Dog Institute, *LifeSpan Integrated Suicide Prevention Frequently Asked Questions.*

- Commonwealth services, including those targeted to youth mental health e.g. Headspace.

- Education services, including school counsellors, welfare programs and postvention supports in schools.

- Child protection services, including responsibility for responding to risk of significant harm reports about self-harm and suicidal behaviours, and for the health and wellbeing of young people in the care of the Minister.

In this context, we consider that a focused whole-of-government approach to suicide prevention is warranted. We also consider it imperative that any such strategy has a clear focus on children and young people and includes specific measures that go across the spectrum of need: from universal strategies that promote wellbeing in children and young people to early intervention designed to arrest emerging problems and difficulties to the provision of targeted, sustained and intensive therapeutic support to young people at high risk (including strategies for reaching those who are hard to engage).

Measuring and evaluating the impact of suicide prevention measures

The complexity of causative or contributory factors in youth suicide presents challenges in identifying interventions that are most effective in preventing suicide. In this context, evaluation of suicide prevention strategies is critical to inform best practice and identification of effective strategies to guide future efforts.

There is a substantial amount of existing and developing work in NSW and nationally that is aimed at improving the mental health and wellbeing of children and young people and preventing suicide. As we have noted above, there are multiple services and programs involved in youth mental health and suicide prevention in NSW, and it is not always evident whether, and how well, these activities are coordinated to minimise duplication of effort and maximise efficacy.

In this context, there is continuing need to ensure that there is a clear coordination of activities to identify and target suicide prevention strategies and consistent evaluation of, and public reporting on, the effectiveness and outcomes of the various programs and initiatives.

Data collection and reporting on suicide

Effective collection and use of data is crucial in order to develop well-targeted suicide prevention strategies, and to inform evaluation and meaningful public reporting on the outcome and effectiveness of such strategies and related programs or initiatives. In addition, for a whole-of-government prevention strategy to be effectively operationalised, roles and responsibilities in relation to ongoing system-level data analysis - including mechanisms for linking and exchanging relevant information between agencies – will need to be clearly articulated.

To undertake this work, reliable data in relation to suicide and suicide attempts is necessary. Given the remit of the CDRT, the NSW Child Death Register captures data, and facilitates reporting on, a wide range of information relating to the suicide deaths of children and young people. However, the role of the CDRT and the Register are limited to children and young people under 18 years.

More broadly, we note that there is little publicly available data in NSW on suicide attempts and hospital presentations for self-harm. Given the importance of quality data and rigorous analysis to ensure prevention measures are well targeted and evaluated,

this is an area in which the Committee may wish to give particular consideration.

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Appendix A: Trend data: suicide deaths of children and young people in NSW

Table 1: Deaths due to suicide: children under 18 years of age by key demographic characteristics, 2002-2016

	2012 - 2016				2007 - 2011				2002 - 2006			
	Number	Percent	Crude Mortality Rate	95% Confidence Interval	Number	Percent	Crude Mortality Rate	95% Confidence Interval	Number	Percent	Crude Mortality Rate	95% Confidence Interval
Total	**111**	**100**	**1.32**	**1.07 - 1.56**	**79**	**100**	**0.97**	**0.77 - 1.21**	**83**	**100**	**1.04**	**0.83 - 1.29**
Gender												
Female	49	44	1.20	0.88 - 1.58	23	29	0.58	0.37 - 0.87	26	31	0.67	0.44 - 0.98
Male	62	56	1.43	1.10 - 1.83	56	71	1.34	1.01 - 1.74	57	69	1.40	1.06 - 1.81
Age												
Under 1 year	0	0	-	-	0	0	-	-	0	0	-	-
1-4 years	0	0	-	-	0	0	-	-	0	0	-	-
5-9 years	0	0	-	-	0	0	-	-	0	0	-	-
10-14 years	19	17	0.84	0.51 - 1.32	12	15	0.54	0.28 - 0.94	18	22	0.79	0.47 - 1.26
15-17 years	92	83	6.70	5.40 - 8.22	67	85	4.88	3.78 - 6.20	65	78	4.84	3.73 - 6.17
Aboriginal and Torres Strait Islander status*												
Aboriginal or Torres Strait Islander	17	15	4.65	2.71 - 7.45	7	9	1.57	0.63 - 3.24	3	4	0.72	0.15 - 2.11
Not Aboriginal or Torres Strait Islander	93	84	1.15	0.93 - 1.41	70	89	0.91	0.71 - 1.15	80	96	1.06	0.84 - 1.32

* Aboriginal and Torres Strait Islander status was not known in one case.

Table 2: Deaths due to suicide: children under 18 years of age by remoteness and socio-economic indicators, 2011-2015[42]

		Number	Percent	Crude Mortality Rate	95% Confidence Interval
Remoteness					
	Major cities	62	61	1.03	0.79 - 1.31
	Regional areas	36	36	1.64	1.15 - 2.28
	Remote areas	3	3	-	-
Socio-economic status					

[42] Note that SEIFA and ARIA are calculated on the Australian Statistical Geography Standard. This is the Australian Bureau of Statistics' geographical framework, effective from July 2011. Due to the unavailability of data at the time of writing, socio-economic and remoteness measures were only able to be calculated for 2011 to 2015.

	Quintile 5 (highest)	16	16	0.88	0.50 - 1.43
	Quintile 4	19	19	1.22	0.73 - 1.90
	Quintile 3	18	18	1.18	0.70 - 1.86
	Quintile 2	21	21	1.33	0.82 - 2.03
	Quintile 1 (lowest)	26	26	1.46	0.95-2.14

Figure 1: Deaths by suicide of young people under 18 years by gender, 2002 - 2016

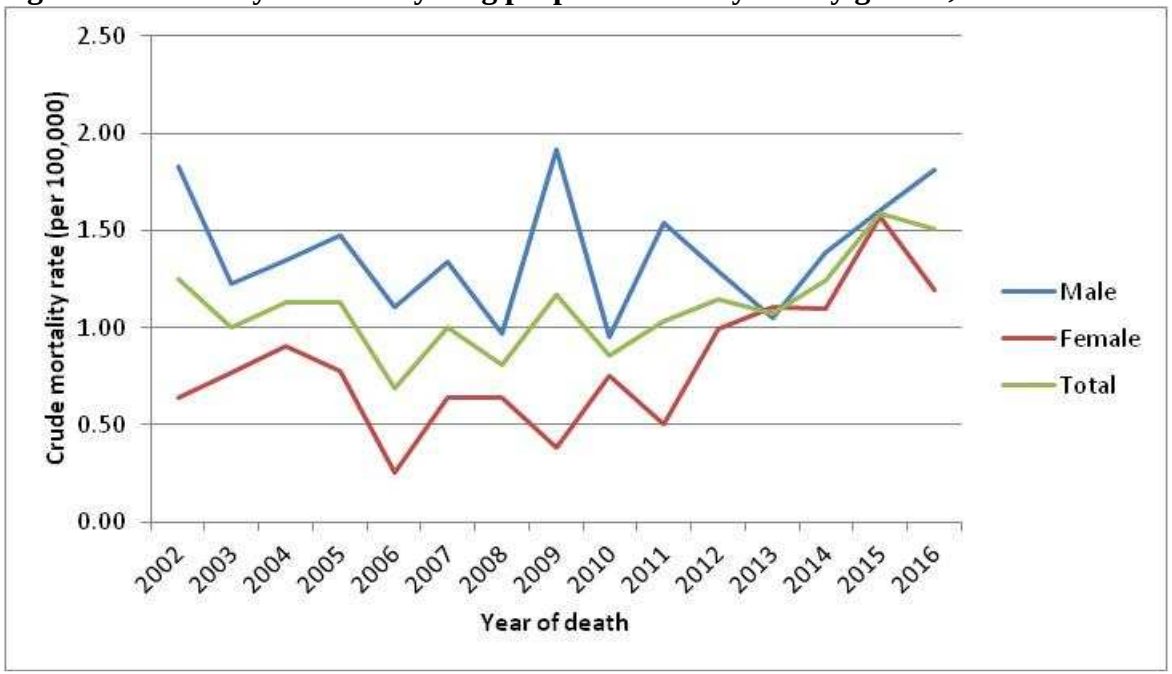

Table 3: Deaths by suicide of young people under 18 years by gender – number and rate, 2002-2016

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Female	5 (0.64)	6 (0.77)	7 (0.90)	6 (0.78)	2 (-)	5 (0.64)	5 (0.64)	3 (-)	6 (0.75)	4 (0.50)	8 (0.99)	9 (1.11)	9 (1.10)	13 (1.57)	10 (1.20)
Male	15 (1.83)	10 (1.22)	11 (1.35)	12 (1.47)	9 (1.10)	11 (1.34)	8 (0.97)	16 (1.92)	8 (0.95)	13 (1.54)	11 (1.29)	9 (1.05)	12 (1.38)	14 (1.60)	16 (1.81)
Total	20 (1.25)	16 (1.00)	18 (1.13)	18 (1.13)	11 (0.69)	16 (1.00)	13 (0.81)	19 (1.17)	14 (0.86)	17 (1.04)	19 (1.15)	18 (1.08)	21 (1.25)	27 (1.59)	26 (1.51)

Figure 2: Deaths by suicide of young people under 18 years by age, 2002-2016

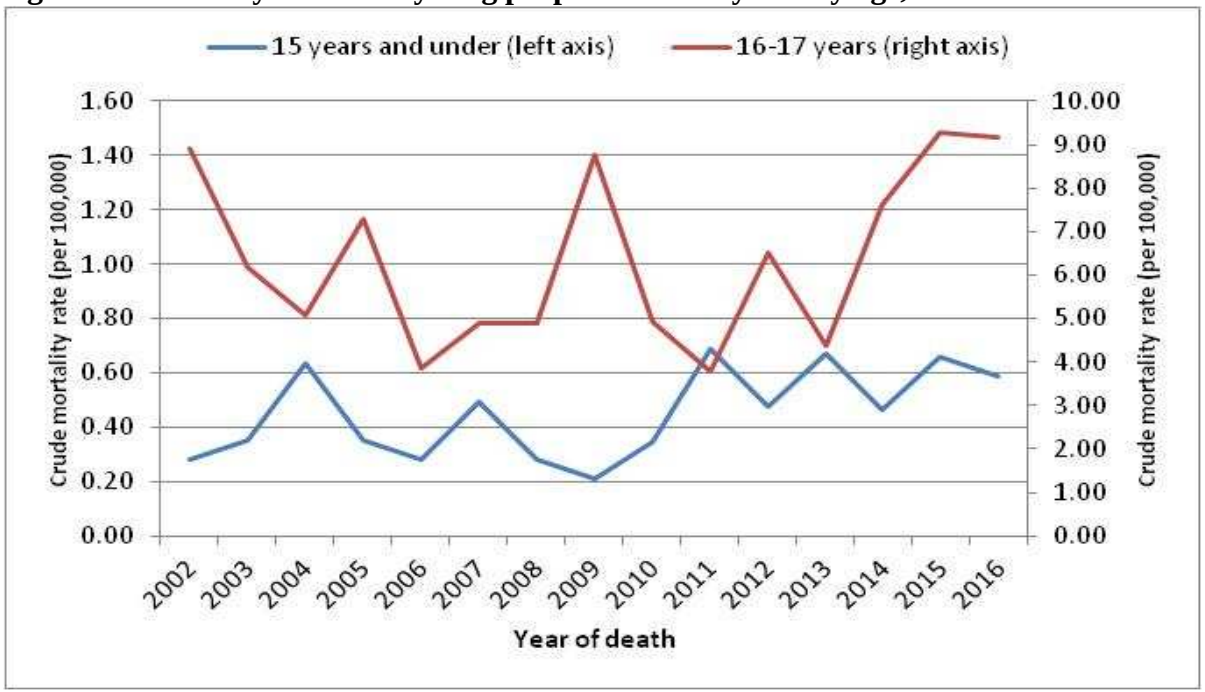

Table 4: Deaths by suicide of young people under 18 years by age – number and rate, 2002-2016

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
15 years and under	4 (0.28)	5 (0.35)	9 (0.64)	5 (0.35)	4 (0.28)	7 (0.49)	4 (0.28)	3 (0.21)	5 (0.34)	10 (0.69)	7 (0.48)	10 (0.67)	7 (0.47)	10 (0.66)	9 (0.59)
16-17 years	16 (8.92)	11 (6.17)	9 (5.08)	13 (7.30)	7 (3.86)	9 (4.88)	9 (4.88)	16 (8.75)	9 (4.92)	7 (3.80)	12 (6.52)	8 (4.36)	14 (7.64)	17 (9.28)	17 (9.17)
Total	20 (1.25)	16 (1.00)	18 (1.13)	18 (1.13)	11 (0.69)	16 (1.00)	13 (0.81)	19 (1.17)	14 (0.86)	17 (1.04)	19 (1.15)	18 (1.08)	21 (1.25)	27 (1.59)	26 (1.51)