commission for
children and young people
and child guardian

Commission for Children and Young People and Child Guardian:
Submission to the Senate Community Affairs References Committee regarding the 'Inquiry into Suicide in Australia'

The Commission is committed to identifying opportunities to inform policy formulation and prevention efforts at both a state and national level and welcomes the opportunity to provide comment in relation to the Senate's Inquiry into Suicide in Australia.

Overview of the Commission's functions

The Commission for Children and Young People and Child Guardian (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.

Under the *Commission for Children and Young People and Child Guardian Act 2000*, the Commission has a statutory obligation to maintain a register of all deaths of children and young people under the age of 18 that are registered in Queensland. The information in the register is required to be classified according to cause of death, demographic information and other relevant factors. In this capacity, the Commission has responsibility for the centralised collection and coding of mortality information for both coronial and non-coronial child deaths.

The Commission's child death review functions began on 1 August 2004. Under Part 4A (Child Deaths) 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.

The Commission has now released its fifth annual report analysing the deaths of Queensland children and young people for the period from 1 July 2008 to 30 June 2009. This report identifies trends and patterns of child mortality over the past year, with a particular focus on the circumstances and risk factors surrounding external (non-natural) causes of death, including a detailed analysis of children and young people who died by suicide. This report and the companion summary report are available on the Commission's website at www.ccypcg.qld.gov.au.

The Commission's capture and analysis of child death information and data, together with its capacity to report across all causes of deaths is a valuable evidence base that can be used by a wide range of stakeholders to identify opportunities to reduce or remove risk factors associated with preventable deaths and promote prevention messages.

The child death review work undertaken by the Commission is substantively valuable to government and the community and clearly demonstrates the importance of thoroughly and systemically reflecting upon the risks that exist in children's lives with a view to preventing them from manifesting. Child death review processes are effective in this way, over and above the work traditionally performed by statistical bodies, because they probe beyond a compilation of death certificate data and routinely involve consideration of autopsies, coronial files, child protection and police information.

Over the past five years the Commission has undertaken a significant body of work in relation to the issue of child and youth suicide in Queensland, with many of the terms of reference raised as part of this inquiry aligning with the Commission's previous findings (as published in its Child Death Annual Reports) and its current work activities in relation to suicide research and prevention through the Reducing Youth Suicide in Queensland (RYSQ) project. The preliminary findings of the RYSQ project are available in the discussion paper on the Commission's website at http://www.ccypcg.qld.gov.au/monitoring/rysq.html.

Section One of this submission provides an overview of the Commission's key findings in relation to child and youth suicide in Queensland, providing important background information and evidence (data) to inform the Inquiry.

Section Two of this submission addresses the specific terms of reference for the Senate's Inquiry into Suicide in Australia, with a particular focus on child and youth suicide in Queensland.

The Commission is committed to finding ways to reduce the number of young people who suicide and commends the Senate for advancing this very important issue.

E Fraser

Elizabeth Fraser
Commissioner for Children and Young People and Child Guardian

Summary of the Commission's comments

1. Suicide has a significant impact on vulnerable children and young people. The Commission has found that between 2004 and 2007, 42% of youth who suicided did so after the suicide, or attempted suicide, of a friend, family or community member.
2. The contagion[1] process that leads to suicide among young people requires heightened recognition and reinforces the importance of having detailed suicide prevention, intervention and postvention[2] guidelines, and the need for coordinated postvention responses to occur after the suicide or attempted suicide of an individual. The prevention, intervention and postvention context for suicide among young people is distinct from that of adults and should be managed as such.
3. The Commission has previously identified the following factors as having previously contributed to under reporting of youth suicide in Queensland: current and previous legislative barriers, incorrect assumptions around children's capacity to understand intent and issues relating to coding suicides under ICD-10.
4. Since the establishment of the Commission's child death review functions, the Commission has undertaken a number of key actions that have improved the accuracy of suicide classification and reporting in Queensland, including: the creation of a suicide classification model, writing a submission to the World Health Organisation regarding international coding practices and making several recommendations aimed at improving reporting of suicide.
5. The contemporary findings of the child death review and youth suicide research undertaken by the Commission are disseminated to a wide range of government and non-government stakeholders, experts and researchers working policy and child death prevention areas. This work is vital to these prevention efforts.
6. The Commission has identified in its Reducing Youth Suicide in Queensland (RYSQ) project preliminary findings that there are distinct differences and similarities between the suicides of Aboriginal and Torres Strait Islander young people and non-Indigenous young people, meaning tailored responses to prevention, intervention and postvention are critical.
7. The Commission has identified a number of key challenges that impact on the effectiveness of any suicide prevention initiative, including: the impact of the media on contagion, the challenge technology plays in communicating with young people, the need to capture suicide attempt data and the large population and geographic area that services must cover in Australia.

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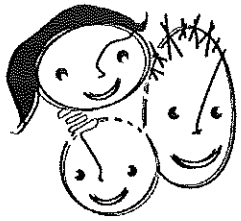
1 A prior suicide or attempted suicide influencing or causing suicidality in another is commonly referred to as contagion suicide.

2 Postvention refers to the activities and strategies undertaken after a suicide or attempted suicide to reduce associated trauma to other potentially vulnerable people. Three are two main aims – to provide bereavement support to those affected by a suicide and to prevent future suicide events.

Summary of the Commission's comments regarding the Inquiry's Terms of Reference

1. ***Term of Reference A:*** The Commission recommends the Inquiry give consideration to the issue of contagion, as either an area of focus or an extension of Term of Reference A, in recognition of the significant impact a suicide has on others and the need for coordinated postvention supports being developed nationally.
2. ***Term of Reference B:*** The Commission suggests the Inquiry consider whether other states have legislative barriers similar to Queensland that may impact on a death being classified as a suicide and, in particular, recommends that the Inquiry consider the implications of national coding practices on suicide under reporting.
3. ***Term of Reference C:*** The Commission acknowledges the essential role individual agencies play in providing services to individuals at risk of suicide; however, recommends that the Inquiry also give consideration to the important role collaborative programs play in effectively providing support to individuals at-risk individuals. For effective suicide prevention to occur, approaches must be coordinated between agencies, professionals and the community, including friends and family.
4. ***Terms of Reference D and E:*** The Commission is not placed to comment on these terms of reference.
5. ***Term of Reference F:*** The Commission recommends that suicide prevention activities considered by the Inquiry must involve and target three key areas; whole populations, specific groups at increased risk of suicide; and, at-risk individuals. The Commission supports the use of targeted programs and services for high-risk groups, noting key populations should include: young people in schools, Aboriginal and Torres Strait Islander children and young people and youth experiencing behavioural problems.
6. ***Term of Reference G:*** The Commission acknowledges the importance of current suicide research being undertaken and the importance of research being disseminated to practitioners and government. Further, the Commission considers it essential that any changes to policy and/or practices at a state and national level are guided by this evidence-based suicide prevention research.
7. ***Term of Reference H:*** The Commission considers that an essential step in ensuring future suicide prevention strategies achieve their key aims and objectives requires that the current National Suicide Prevention Strategy undergo a comprehensive and evidence-based evaluation. Evaluations are an essential part of measuring the effectiveness a strategy has had and assist in guiding the development of future national strategies.



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Submission to the

Senate Community Affairs References Committee

regarding the

Inquiry into Suicide in Australia

Date: November 09

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SECTION ONE

1.0 The Commission's key findings: Queensland youth suicide

Table 1 below provides an overview of the key findings relating to Queensland youth suicide the Commission has reported in its five Child Death Annual Reports 2004 to 2009.

Table 1: Summary of suicide deaths of children and young people in Queensland, 2004–2009

	2004–05		2005–06		2006–07		2007–08		2008–09		Total 2004–09	
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Average yearly rate
All suicide deaths												
Suicide	15	1.6	15	1.5	19	1.9	21	2.1	15	1.5	**85**	**1.7**
Gender												
Female	4	–	6	2.7	7	3.1	6	2.7	6	2.6	**29**	**2.6**
Male	11	–	9	3.9	12	5.1	15	6.3	9	3.7	**56**	**4.7**
Aboriginal and Torres Strait Islander status												
Indigenous	3	*	3	*	6	22.2	5	17.0	7	23.8	**24**	**16.7**
Non–Indigenous	12	–	12	–	13	3.0	16	3.6	8	1.8	**61**	**2.8**
Known to child protection population												
Known to the child protection system	2	*	5	7.1	4	4.6	5	5.5	11	10.8	**27**	**6.3**
Age category												
10–17 years	15	–	15	3.3	19	4.1	21	4.5	15	3.2	**85**	**3.7**
10–14 years	*6*	–	*5*	*1.8*	*8*	*2.8*	*0*	*0.0*	*1*	*	***20***	***1.4***
15–17 years	*9*	–	*10*	*6.0*	*11*	*6.4*	*21*	*12.2*	*14*	*7.8*	***65***	***7.6***
Method of death												
Hanging	13	–	13	–	17	–	18	–	9	–	**70**	**–**
Poisoning	0	–	1	–	1	–	1	–	1	–	**4**	**–**
Gunshot wound	0	–	1	–	0	–	1	–	2	–	**4**	**–**
Jumping in front of moving object	1	–	0	–	1	–	1	–	2	–	**5**	**–**
Jumping from a high place	1	–	0	–	0	–	0	–	1	–	**2**	**–**

Data source: Queensland Child Death Register (2004–09)

** Rates have not been calculated for numbers less than 4.*

– These data were not available at the time of publication, or were not reported in previously published Child Death Annual Reports.

Notes:

1. *Data presented here are those published in Child Death Annual Reports for the years 2005–06, 2006–07, 2007–08 and 2008–09.*
2. *Overall suicide rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.*
3. *All other rates are calculated per 100,000 children aged 10–17 years (in the gender/Indigenous status bracket stated) in Queensland in each year.*
4. *The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Queensland Department of Communities in the 3 years prior to their death. Rates of death are calculated per 100,000 children and young people aged 0–17 years known to the child protection system.*
5. *Rates of death for children known to the child protection system for 2005–06 differ from those published in the Child Death Annual Report for that year. Rates have been re-calculated to reflect improved denominator data made available subsequent to the publication of the 2005–06 report.*
6. *Five yearly rate averages have been calculated using the 2006–07 estimated resident population data, the mid-point of the 5 year period.*

As shown in Table 1 above:

- between 2004 and 2009, 85 children and young people aged 10–17 years have taken their own lives in Queensland – this represents an average yearly rate of 3.7 suicides each year per 100,000 youth aged 10–17 year olds in Queensland
- males are more likely to suicide than females, with an average rate of 4.7 male suicides per 100,000 compared to 2.6 females (56 male, 29 female suicides)
- Aboriginal and Torres Strait Islander children and young people suicided at a rate almost 6 times that of non-Indigenous youth, with an average yearly rate of 16.7 compared to 2.8 per 100,000
- Aboriginal and Torres Strait Islander children are significantly overrepresented in suicide figures in Queensland – Aboriginal and Torres Strait Islander young people made up 28% of all youth suicides in Queensland over the past five years yet only make up 6% of the Queensland population of children and young people aged 10–17 years
- children known to the child protection system in Queensland suicided at a greater rate compared to the general youth suicide population, with 6.3 suicides per 100,000 compared to 1.7 children and young people aged 0–17 years, and
- hanging has been the most frequently used method of suicide by children and young people in Queensland (82% of suicides, 70 deaths).

1.0.1 Interstate comparison of youth suicide statistics

Table 2 reflects the most recent interstate statistics available on youth suicide for the 2007 calendar year, as published in the Commission's *Annual Report: Deaths of children and young people, Queensland 2008–09* (www.ccypcg.qld.gov.au; refer to Chapter 10 'National child death statistics: An interstate comparison, 2007 calendar year).[3]

Table 2: Number and rate of suicides of children and young people by state, 2007

Cause of death	QLD		NSW		SA		VIC	
	Total *n*	*Rate per 100,000*	Total *n*	*Rate per 100,000*	Total *n*	*Rate per 100,000*	Total *n*	*Rate per 100,000*
Suicide	22	2.1	13	0.8	0	0.0	14	1.2

Data source: Australian and New Zealand Child Death Prevention Group (2007)

Notes: 1. *Classification of suicides may differ from state to state.*
2. *Rates are calculated per 100,000 children and young people aged 0–17 years in each state.*
3. *Total rates are calculated per 100,000 children and young people aged 0–17 years in each state.*

As shown in Table 2 above:

- the rate and number of suicides for children and young people aged 0–17 years was highest in Queensland, with 2.1 suicides occurring per 100,000 children and young people in Queensland (22 deaths), and
- Victoria had the next highest rate of youth suicide, with 1.2 suicides per 0–17 year-olds in Victoria (14 deaths).

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3 The information provided in this chapter of the Commission's Child Death Annual Report represents the first attempt to draw together the data held by member jurisdictions of the Australian and New Zealand Child Death Review and Prevention Group and make some meaningful interstate comparisons. Currently the jurisdictions with the capacity to share detailed child death data are Queensland, New South Wales, Victoria and South Australia. As other jurisdictions further develop their data collection and reporting capacity, this dataset will continue to evolve to include child death data from all Australian states and territories and New Zealand.

1.1 The Commission's Reducing Youth Suicide in Queensland (RYSQ) Project

Between 2004 and 2006, the Commission identified suicide as the leading cause of death for children aged 10 to 14 years and the second leading cause for young people aged 15 to 17 years in Queensland.[4] The repetition of the high numbers and young ages of children suiciding in Queensland reinforced the need for this issue to be further investigated. In response, the Commission commenced working on an in-depth project reviewing the suicides of Queensland children and young people – the Reducing Youth Suicide in Queensland (RYSQ) project.

The RYSQ project is a detailed review of the lives and deaths of 65 children and young people in Queensland who suicided between 1 January 2004 and 31 December 2007. The project will provide a solid and contemporary evidence base to better inform prevention efforts targeted at children and young people, with the aim of reducing youth suicide in Queensland. The project aims to achieve four key outcomes:

1. improve knowledge and understanding around children and young people who suicide in Queensland
2. identify key risk factors and warning signs specific to these children and young people
3. enhance delivery of services to at-risk children and young people, and
4. inform prevention and early intervention strategies.

The RYSQ project is reviewing records from all Queensland government agencies involved in the delivery of services to children and young people who have suicided. The Commission's review is a unique look at the lives of children and young people who have suicided – the first of its kind in Queensland – with information and records supplied including ambulance, health, child protection, police, youth justice, education and births, deaths and marriages records, public housing information and coronial files.

The first stage of this project involved the release of the *RYSQ Discussion Paper* on 31 August 2009, detailing the preliminary findings of the Commission's analysis of all available case file information for children and young people who suicided, and seeking responses from stakeholders to key discussion points relating to improving services and preventing youth suicides. A copy of the *RYSQ Discussion Paper* is available at http://www.ccypcg.qld.gov.au/pdf/monitoring/RYSQ-Discussion-Paper.pdf.

The Commission is seeking responses to the discussion paper from a range of key stakeholders from government and non-government agencies, researchers, academics and experts in the child and youth mental health fields. In particular, the Commission has engaged with health experts, including mental health workers and counsellors, education officers, child safety officers, police, Aboriginal and Torres Strait Islander people, coroners, researchers, policy makers and community based

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4 Reported in the Commission for Children and Young People and Child Guardian's *Annual Report: Deaths of children and young people, Queensland* in 2004–05 and 2005–06.

organisations. The consultation period for the *RYSQ Discussion Paper* closes on Monday 30 November 2009.

In the year ahead the Commission will bring together the responses of individuals and organisations to the *RYSQ Discussion Paper* and prepare the final report on findings to help create new pathways in suicide prevention.

1.1.1 Preliminary findings of the RYSQ project

Key preliminary findings of the RYSQ project, that will be of particular interest to the inquiry, include:

- the identification of common risk factors and circumstances among children and young people who have suicided in Queensland
- a tendency for suicide risk to increase with age
- an increased risk for males
- the number and rate of youth suicides has increased since 2004, and
- a significant over-representation of Aboriginal and Torres Strait Islander children and young people.

The RYSQ project's preliminary findings raise a number of questions for people who work with at-risk children and young people, including a number of findings that have not been identified or fully explored in previous research. This is particularly the case with respect to Aboriginal and Torres Strait Islander children and young people who have suicided. There is currently limited research identifying key vulnerabilities and specific factors impacting upon these youth.

Common risk factors and circumstances

Table 3 below provides an overview of types of common risk factors and circumstances identified among children and young people who suicided in Queensland.

Table 3: Number and proportion of common risk factors among children and young people who have suicided in Queensland, 2004–2007

Emerging risk factors and circumstances	Number of cases *n*	Proportion of cases %
Arguments and relationship breakdowns	**51**	**78%**
Argument with a significant other	*26*	
Relationship breakdown with a significant other	*24*	
Behaviour and disciplinary problems	**41**	**63%**
Suspended or excluded from school	*31*	
Contact with police or youth justice	*25*	
Communicating suicidal intent	**39**	**60%**
Suicidal behaviour	**38**	**58%**
Previous suicide attempts	*14*	
Mental health issues	**28**	**43%**
Presented to medical practitioner with mental health issues	*21*	
Mood disorders	*19*	
Schizophrenia and psychosis	*7*	
Attention-deficit and disruptive disorders	*7*	
Contagion suicide	**27**	**42%**

Imitative (friend, acquaintance, community member)	*14*	
Familial (family member)	*13*	
Childhood abuse, chronic familial conflict and violence	**26**	**40%**
Known to the Department of Communities (Child Safety Services)	*14*	
Case file current with the Department of Communities (Child Safety Services) at death	*7*	

Data Source: RYSQ Preliminary Findings Database (2004–2007)
Note: 1. Sub-categories may not sum to risk factor totals due to repeated inclusion of cases where more than one sub-category risk factor was noted.

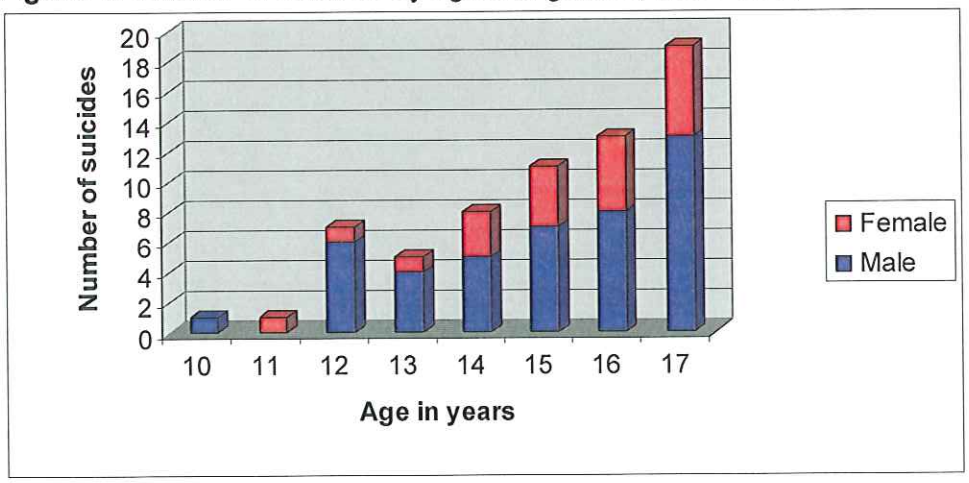
As illustrated in Table 3 above:

- 42% of youth suicides in Queensland were contagion suicides – where the child or young person took their own life after the suicide or attempted suicide of a friend, family or community member. It is clear that the occurrence of a suicide can contribute to an increased risk of suicide in other vulnerable young people, reinforcing the importance of suicide postvention
- 63% of children and young people who suicided had significant behavioural problems and disciplinary problems. This included ongoing truancy, physical and verbal abuse of others, suspension or exclusion from school, contact with police and/or youth justice. These findings challenge the popular belief that most students who suicide are predominantly introverted, withdrawn and often bullied
- 60% of children and young people who suicided had previously stated or implied their intention to suicide to a family member, friend or health professional – this highlights the importance of taking threats of suicide seriously
- 43% of children and young people who suicided had mental health problems, with the vast majority suffering from depression, followed by schizophrenia and psychosis and attention-deficit and disruptive disorders, and
- 40% of children and young people who suicided had experienced abuse or chronic family conflict or violence.

Age and gender

Figure 1 shows the number of suicides by age and gender for the 65 children and young people considered in the RYSQ project.

Figure 1: Number of suicides by age and gender, 2004–2007



Data source: RYSQ Preliminary Findings Database (2004–2007)

Table 4 shows the increased rate and number of children who suicided between 2004 and 2007.

Table 4: Number and rate of suicides in Queensland by age category, 2004–2007

Age category	Year of death registration									
	2004		2005		2006		2007		Total	
	n	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate
10–14 years	6	2.1	7	2.4	3	*	6	2.1	**22**	**1.9**
15–17 years	6	3.7	8	4.8	14	8.1	15	8.4	**43**	**6.5**
Total 10–17 years	**12**	**2.7**	**15**	**3.3**	**17**	**3.7**	**21**	**4.5**	**65**	**3.6**

Data source: RYSQ Preliminary Findings Database (2004–2007)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children and young people aged 10 to 17 years in Queensland.
2. Rates for age groups are calculated per 100,000 children and young people in each age group.
3. Population numbers are based on the number of children and young people as at June each year.
4. Rates calculated in the total column are the average yearly rate based on the number of children and young people as at June 2005.

As illustrated in Figure 1 and Table 4 above:

- Queensland children and young people suicided at a rate well above the national average. An average of 16 children and young people took their lives each year in Queensland – a rate of 3.3 young people per 100,000 – almost twice the national rate of 1.9 per 100,000[5], and
- the rate of suicide for 10 to 17 year olds in Queensland has increased since 2004, from 2.7 per 100,000 young people to 4.5 per 100,000 in 2007.

Over-representation of Aboriginal and Torres Strait Islanders

Table 5 shows the over-representation of suicide among Queensland Aboriginal and Torres Strait Islander children and young people compared to other Queensland youth.

Table 5: Number, proportion and rates (calculated over four years) of Aboriginal and Torres Strait Islander suicides compared to other youth in Queensland, 2004–2007

Age category	Queensland Aboriginal and Torres Strait Islander youth			Other Queensland youth			Total		
	n	%	Rate	*n*	%	Rate	*n*	%	Rate
10–14 years	12	67%	64.9	10	21%	3.7	22	34%	7.7
15–17 years	6	33%	65.2	37	79%	23.5	43	66%	25.8
Total 10–17 years	**18**	**28%**	**65.0**	**47**	**72%**	**11.0**	**65**	**100%**	**14.3**

Data source: RYSQ Preliminary Findings Database (2004–2007)
Notes: 1. Percentages are calculated for each column except for totals which are calculated by row.
2. Rates are calculated per 100,000 children and young people aged 10 to 17 years.
3. Rates for age groups are calculated per 100,000 children and young people in each age group.
4. Rates are calculated over four years due to small numbers. The denominator population used to calculate rates is the estimated number of Aboriginal and Torres Strait Islander or other youth as at June 2005.

[5] The national rate used for comparison is based on the Australian Institute for Health and Welfare's (AIHW) figures and has been compared to the rate calculated from the Commission's Child Death Register for Queensland. The rates compared were for the 2005–06 financial year, the most current data available from the AIHW.

Table 4 shows that:

- 28% of children and young people who suicided were Aboriginal or Torres Strait Islander, representing a rate almost 6 times that of other Queensland youth, and
- Aboriginal and Torres Strait Islander children aged 10 to 14 years suicided at more than 17 times the rate of other Queensland children who suicided.[6]

The *RYSQ Discussion Paper* also identifies a number of key differences between Aboriginal and Torres Strait Islander youth and other youth suicide in Queensland. These include:

- Aboriginal and Torres Strait Islander children and young people were more likely to threaten suicide in an 'off the cuff' fashion, with threats of suicide often their first response to a stressful situation
- Aboriginal and Torres Strait Islander youth were far less likely to have diagnosed mental health issues
- suicide notes were rare among Aboriginal and Torres Strait Islander children and young people
- Aboriginal and Torres Strait Islander youth were less likely to have made a previous suicide attempt
- Aboriginal and Torres Strait Islander children and young people were almost 3 times as likely to have experienced childhood abuse, and
- Aboriginal and Torres Strait Islander young people were more likely to be younger in age at the time they suicided compared to other Queensland youth.

These findings highlight the need for evidence-based approaches to Aboriginal and Torres Strait Islander youth suicide prevention that differ from approaches targeting other children and young people in Queensland. As in all communities, strategies aimed at preventing these deaths should not only be suicide specific but focus more holistically on building supportive families and safe and healthy communities. The incorporation of community-level cultural and traditional influences, aimed at improving the overall health and wellbeing of Queensland's Aboriginal and Torres Strait Islander population, is recognised as an essential step in preventing suicide among these children and young people.

1.2 Other Commission activities and priorities

The Commission has now released its fifth annual report analysing child deaths and, as such, the Commission's capacity to identify and report on trends, patterns and, importantly, risk factors in child death is well established. In 2008–09 the Commission welcomed the opportunity to share its suicide data and analyses to inform the development of numerous strategies, policies and procedures, including:

- participating as a member of the Queensland Injury Prevention Council (QIPC)[7] and providing evidence and input to support the work of this group

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6 Calculated using an average four-yearly rate due to small numbers.

7 The QIPC was established in 2008. The goal of the QIPC is to substantially reduce injury rates and the severity of injuries in Queensland and to demonstrate national leadership in injury prevention activities. The QIPC reports to the Director-General of Queensland Health and provides high-level strategic advice in relation to injury prevention priorities, strategies and activities.

- participating as a member of the Queensland Government Suicide Prevention Strategy (QGSPS) Steering Committee and providing input on the evaluation of the QGSPS and the development of the new state-wide suicide prevention plan
- preparing a detailed regional analysis of child deaths for the Queensland Police Service to inform the development of prevention initiatives, including a suicide postvention response strategy aimed at preventing contagion suicide
- preparing feedback for Suicide Prevention Australia in relation to its position statement on suicide bereavement and postvention, and
- providing information to the State Coroner relating to suicide trends occurring in specific geographic regions.

In addition, the Queensland Commission currently chairs and provides secretariat support to the Australian and New Zealand Child Death Review and Prevention Group, which is the Australian and New Zealand collaborative body of experts focused on developing agreed priorities for work that can be undertaken to target modifiable risk factors in preventable deaths, including suicide. All Australian states and territories have either established, or are in the process of establishing, like child death review functions. This group was established in recognition of the need to develop nationally comparable data and multi-jurisdiction prevention messages and has been recognised, endorsed and supported in the *National Framework for Protecting Australia's Children 2009–2020*.

In the year ahead the Commission will be finalising the development of its Child Death Prevention Strategy. The Commission recognises that a range of stakeholders (both government and non-government) are responsible for the development and/or implementation of various prevention strategies, programs, policies and/or initiatives. The overarching aim of the strategy will be to promote the evidence-base contained in the child death register to stakeholders (at both the state and national level) and identify opportunities for the Commission to engage with stakeholders and share its dataset and research findings, in particular those arising from its risk factor analysis, to inform ongoing prevention efforts.

SECTION TWO

2.0 The Commission's responses to the Inquiry's Terms of Reference

The Commission's feedback and comments are limited to the experiences of children and young people in Queensland (in accordance with the Commission's mandate). The Commission makes the following submission in response to the Terms of Reference for the Senate's Inquiry into Suicide in Australia.

2.1 Response to Term of Reference A

a) The personal, social and financial costs of suicide in Australia

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 is immeasurable – leaving many with unanswered questions and wondering what could have been done differently. While we may never know the exact reasons why young people take their own lives, we must try to understand as much as we can about these deaths and use this information to explore new pathways to prevent youth suicide.

While the Commission is unable to provide any detailed or specific information or figures around the cost of suicide; it is able to comment on the impact a suicide can have on vulnerable children and young people.

2.1.1 Contagion-related suicide

The Commission's *Annual Report: Deaths of children and young people, Queensland 2008–09* identified that contagion was a key factor in 9 of the 15 suicides of children and young people (60% of suicides) during the period from 1 July 2008 to 30 June 2009.

The preliminary findings of the RYSQ project also identified that 42% of children and young people who took their own life did so after the suicide, or an attempted suicide, of a friend, family or community member.

The Commission's findings are consistent with other research findings which show that people who know someone who has died by suicide are at a greater risk of suiciding or attempting suicide themselves.

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 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

- learning of the attempted or completed suicide of a respected community member, and
- reading or hearing about the death in the media.

Case study

The suicide of an older student was followed by the suicide of a younger student at the same school within a very short period of time. The younger student was reported to be extremely depressed after the death of his friend. The student communicated this and implied his suicidal intent in the weeks and days before his death. The student suicided using the same method as his friend.

The finding that a suicide or attempted suicide can provide a model for subsequent suicides by means of identification and imitation demonstrates not only the far-reaching impact suicide can have on others but the catastrophic effect it can have on vulnerable individuals, particularly children and young people.

The contagion process that leads to the suicides of vulnerable young people is something that requires heightened recognition. Some young people, especially those who may already be experiencing difficulties, may identify with the suicide victim, raising the notion of suicide as an option. It is therefore essential that any postvention response involves not only those children who were directly known to the suicide victim, but also those who may not have known the person but who may have heard about the suicide. Further, the occurrence of contagion-related deaths reinforces the importance of having detailed suicide prevention, intervention and postvention guidelines available, and the need for coordinated postvention responses to occur after the suicide or attempted suicide of an individual.

The Commission recommends the Inquiry give consideration to the issue of contagion, as a focus or extension of this term of reference, and recognise the significant impact a suicide has on others.

2.1.2 The Commission's actions to address contagion concerns in Queensland

Through the performance of its child death functions, the Commission is uniquely placed to identify and respond to issues or potential issues impacting on children and young people. Specifically, over the past five years the Commission has identified numerous cases where, on the information available, it held concerns for the ongoing safety and wellbeing of children impacted by the suicide of a friend or family member. On these occasions the Commission identified the need for immediate postvention support to be provided. In the absence of an established postvention response in Queensland, the Commission proactively contacted relevant agencies (for example, education, police, health and child safety) to alert them to the need for services to be offered to specific young people who may be at-risk of suicide, as well as advocating the need for postvention responses to occur in a coordinated and timely manner. The Commission's actions in this regard have been instrumental to raising awareness among Queensland agencies of the importance of postvention.

In 2008–09, the Queensland Police Service (QPS) asked the Commission to provide a regional analyses of suicide clusters and contagion cases which have occurred across the state since 2004. On the basis of the Commission's data and advice, the QPS established a multi-agency committee of government and non-government stakeholders[8] to further explore potential service responses. The aim of this committee is to establish a cross agency framework/process to implement a coordinated response to young people after the occurrence of a youth suicide in a community. This will involve:

- identifying vulnerable children and young people
- sharing information with appropriate departments/agencies, and
- implementing resources and postvention support for identified vulnerable youth.

The Commission recommends that the Inquiry consider the need for coordinated postvention supports to be developed; including the need to identify, respond to and monitor at-risk individuals in a timely manner after the occurrence of a suicide or suicide attempt in an effort to reduce the incidence of suicides nationally. Within a Queensland context, it is important to note that such responses will also be required to occur in locations that are very remote and not readily accessible by mainstream services.

2.2 Response to Term of Reference B

b) The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk)

The Commission's Child Death Annual Reports 2004–05 and 2005–06 both highlighted the extent of under reporting of childhood suicide to be an issue of considerable concern in Queensland. The Commission identified the following factors as contributing to the significant under reporting of child and youth suicide in Queensland, prior to the establishment of the Commission's child death functions in 2004. These include:

- current and/or previous legislative barriers
- incorrect assumptions around children's capacity to fully understand the finality and irreversibility of their actions, and
- issues relating to coding suicides.

2.2.1 Current and past legislative barriers

In Queensland, there are legislative barriers which prevent, or have previously prevented, statutory authorities from classifying a death as a suicide. For example, attempted suicide was considered an offence in Queensland until the late 1970s (which was also the case for a number of other countries and Australian states). It has also only been since 2003 in Queensland when the *Coroners Act 1958* was repealed and the prohibition on a coroner making a finding of suicide was removed.

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[8] Stakeholders currently represented on the committee include: the Commission, Queensland Police Service, Department of Communities, Department of Education and Training, Queensland Health, Queensland Catholic Education Commission and Independent Schools Queensland.

Although the term suicide, or any reference to deliberate self-harm resulting in death, is no longer prohibited by the *Coroners Act 2003 (Qld),* the revised Act does not specifically require that coroners make a finding surrounding intent. The implications of this are that some coroners remain reluctant to make a finding of suicide given the repealed Act prohibited coroners from finding anything other than the medical cause of death (for example, gunshot wound or hanging) and the current Act does not require them to do so.

Further, the *Births, Deaths and Marriages Act 2003 (Qld)* prohibits registrars from entering "the word 'suicide' or words to that effect in the register". The prohibition of this term may also impact on a coroners decision to stipulate a finding of intent and there are also clear implications for the coding of these deaths, which are discussed below.

The Commission suggests that the Inquiry considers whether other jurisdictions have similar legislative barriers that may impact upon coroners finding a death to be intentionally self-inflicted, which means the death is less likely to be classified as a suicide in official data sets.

2.2.2 Children's capacity to understand intent

The under-reporting of child suicide in particular has stemmed from the belief that young children lack the capacity to understand the finality of death and to fully comprehend the irreversibility of their actions. While uncertainty of some degree is probable in most cases of suicide ordinarily, ambiguity surrounding the intention of children and younger adolescents is particularly problematic. For a death to be considered a suicide, a significantly high standard of proof and substantial evidence are necessary to support the classification of a death as intentionally self-inflicted. For children, it has been suggested that death is a psychologically difficult concept to comprehend until a certain age of maturity and that the pattern of development for appropriate subconcepts of death differs from child to child. Consequently, how a child perceives their suicidal act and under what circumstances they take their own lives are almost always subject to debate.

In Queensland, a number of child and adolescent suicides have historically been coded as accidents. This has, in part, been attributed to the belief that children do not understand the consequences of their actions and are therefore incapable of suiciding, even when their self-inflicted injuries result in death. The unfortunate reality is that some children do know enough about suicide to attempt it. Not reporting these deaths has resulted in childhood suicide being largely overlooked as an issue requiring attention in Queensland, until the establishment of the Commission's child death functions in 2004.

2.2.3 Issues relating to coding suicides

The Commission uses the International Classification of Diseases and Related Health Problems, tenth revision (ICD-10) to code underlying and multiple causes of death. ICD-10 was developed by the World Health Organisation (WHO) and is designed to promote international comparability in the collection, processing, classifying and presentation of morbidity and mortality statistics. ICD-10 is used by

most statistical bodies in Australia, including the Australian Bureau of Statistics (ABS).

In 2005–06, the Commission noted that a number of childhood suicide deaths were being misclassified as accidents due to ICD-10 coding rules thereby resulting in the issue of childhood suicide being masked in official statistics, including the ABS dataset. For example, deaths are coded by the ABS as accidents in cases where police indicate that a death is a suspected suicide, but a clear statement of intent has not been made by the young person before their death (in the form of a suicide note or oral statement of intent) and where the coroner does not clearly specify the intent of a person in coronial findings.

The Commission sought to clarify this issue with the National Centre for Classification in Health, Australia (NCCH) and established that the current ICD-10 instruction manual does not provide any detailed information in relation to the coding of deaths to intentional self-harm versus accidental deaths, and/or what information is considered an authoritative source to aid in the coding of an intentional versus accidental death. As a result, the Commission raised the following issue with both the Mortality Reference Group and the Australian Mortality Data Interest Group forums in an attempt to clarify the opinions of national and international coders in relation to assigning intent in circumstances where there is insufficient evidence to code a death as a suicide:

> *In cases of suspected suicide (as reported by police), coroners are notably silent when it comes to stating intent on their findings for young people. (Nor is intent stated on the death certificate.) Additional police or agency documentation may indicate that there was a precipitating incident (eg. argument with parents) or a history of self-harm or depression; however, the death certificate and findings tend to read as in the following example:*
>
> > *Death certificate: 1a) Hanging*
> > *Coroners findings: 15 year old female found hanging from belt tied to ceiling beam.*
>
> *Both MMDS[9] and the index (volume 3) default to accidental for hanging unless there is any further information available from the entity legally responsible for certifying the death (in this case the coroner). I would like to ask for your opinion on how you would code this or similar situations.*

Responses to this question varied across the board, with some coders indicating that they would code this death as a suicide and others as an accident.

In an attempt to prevent the misclassification of suicides as accidents in the Queensland Child Death Register the Commission, in consultation with the NCCH, has developed and implemented a new code for use in the Queensland Child Death Register. The new 'Y20A – Hanging, strangulation and suffocation, unspecified intent' code represents cases where police indicate that the death is a suspected suicide but the deceased had not made a statement of intent before death and the coroner is silent on this issue (for example, the cause of death is assigned to

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[9] The abbreviation MMDS refers to the Mortality Medical Data System.

hanging with no behavioural descriptor).[10] The use of this additional character allows cases to be analysed as undetermined both as per the WHO definition and for the purposes of the Commission. In addition, consistency with other coding bodies, both nationally and internationally, is able to be maintained by rolling back the additional character to the original 'undetermined cause' code.

As the Commission's child death functions are research functions, legal classifications of suicide are not required to be met. Consequently, the creation of this new 'unspecified intent' code allows the Commission to identify all cases of suspected suicide (where, on the basis of police information, the death is suggested to be a suicide) and reduces the under-reporting of childhood suicide occurring in the Queensland Child Death Register (as the majority of these deaths were previously coded as accidents). The following is an example of a case which would be classified as unspecified intent (but would ordinarily be coded as an accident) prior to the development of the Y20A code.

Case study

Sally,[11] an Aboriginal 15 year old, died as a result of hanging. In the days before her death, Sally had arguments with her parents in relation to her alcohol use and non-attendance at school. The police report to the coroner indicated that this death was a suspected suicide. Coronial findings stated that the child died by "cerebral hypoxia" caused by "hanging". No statement was made by the coroner in relation to the intent of the child.

The Commission recommends that the Inquiry consider the significant implications of coding practices nationally on the under reporting of suicides in Australia.

2.2.4 *Key actions undertaken by the Commission to improve the accuracy and reporting of suicide in Queensland*

In its inaugural *Annual Report: Deaths of children and young people, Queensland 2004–05,* and its subsequent report in 2005–06, the Commission found that suicide was the leading cause of death for children aged 10 to 14 year-olds. The classification issues outlined above were considered to be the primary reason for the incidence of 10 to 14 year-olds suiciding not having previously been recorded in official statistics, and thereby only identified as an issue in Queensland with the commencement of the Commission's detailed child death review work. For example, a comparison of suicides classified by the Commission compared to the ABS in 2004 identified the proportion of suicides under reported among youth aged 10 to 17 years in Queensland was more than 40%.[12] The Commission notes that the same problem may exist in other jurisdictions.

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10 This code specifically relates to deaths as a result of 'strangulation, suffocation and hanging'. However, suspected suicides (where intent is not clear or is unstated) that occur by other means are also classified according to the new code (for example, a case of falling, jumping or pushed from a high place, unspecified intent = Y30A). The 'A' added to the end of the 'undetermined cause of death' classification can therefore be transposed across all mechanisms of undetermined death, with the classification being changed from undetermined to unspecified.

11 Sally is a pseudonym.

12 Of the cases analysed, the Commission identified 12 suicides compared to 7 reported by the ABS – representing a difference of 5 deaths.

In addition to liaising with NCCH and establishing the Y20A code, the Commission has undertaken the following key actions to improve the accuracy of suicide classification and reporting in Queensland:

- creation of the suicide classification model (see Appendix One)
- submission to the WHO regarding ICD coding (see Appendix Two), and
- made formal recommendations to the ABS, the Queensland Registry of Births, Deaths and Marriages and the Queensland Department of the Attorney-General (see Appendix Three).

2.3 Response to Term of Reference C

c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide

The role and effectiveness of agencies' service delivery to children and young people is being explored in the Commission's RYSQ project. The RYSQ project is reviewing the records of all Queensland government agencies involved in the delivery of services to children and young people who have suicided. This includes the involvement of police, emergency departments, other law enforcement including youth justice and health services provided to children and young people who suicided between 2004 and 2007. Consequently, the final RYSQ report will provide further details and information in relation to this term of reference specific to youth who have suicided in Queensland.

While the Commission is not able to comment for the purpose of this submission on individual agency roles and effectiveness, the preliminary findings of the RYSQ project, as outlined in the *RYSQ Discussion Paper,* reinforce the diversity and complexity of the challenges faced in preventing youth suicide in Queensland.

In order to reduce the number of children and young people taking their own lives, the Commission believes that individuals, communities, professional services, government and non-government organisations must work together to provide a coordinated response to suicide prevention. The preliminary findings of the RYSQ project show that many of the children and young people examined have had contact with a variety of human service agencies prior to their suicide. This includes contact with educational institutions, police, child safety, health and mental health services and the youth justice system. For effective suicide prevention to occur, the Commission notes that approaches must be coordinated between these agencies, professionals and the community.

In general, it is acknowledged that children and young people who are at a heightened risk for a number of different negative outcomes are more likely to have had ongoing contact with agencies for offence-related and behavioural problems, child protection and mental health services. The vast majority of Queensland children and young people under 18 years attend school and have access to health services. While these services all respond to populations of at-risk youth, there are various limitations on information sharing between agencies. This means a young

person who may have contact with a number of agencies can disclose different information to different people which, on the face of it, may not appear to be concerning to an individual agency. However, when collated the information in its entirety would identify a young person at high risk of suicide.

The Commission acknowledges the role individual agencies play in providing services to individuals at risk of suicide as essential; however for effective suicide prevention to occur, approaches must be coordinated between agencies, professionals and the community, including family and friends. Consequently, the Commission recommends that the Inquiry also give consideration to the important role collaborative programs play in effectively providing support to at-risk individuals. In particular, the Commission would like to draw the Inquiry's attention to a number of partnership programs between agencies interstate and overseas which aim to address fragmentation of information and knowledge between agencies. These include models such as New South Wales' *School Link* program and New Zealand's *Towards Wellbeing: Suicide Consultation and Monitoring Program* which aim to identify children and young people who may be at risk of suicide, monitor and support the youth and provide avenues for appropriate referrals.

The Commission considers these programs provide a useful starting point for considering options to assist the strengthening of early identification and intervention of at risk populations who may have contact with several agencies.

2.4 Response to Terms of Reference D and E

d) The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide

e) The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk

The Commission is not currently in a position to comment on the above mentioned terms of reference. However, notes that these terms of reference are closely aligned to the discussion points the Commission has raised in the *RYSQ Discussion Paper.* For example, the discussion paper seeks responses to questions about service delivery, improving responses to individuals at-risk of suicide and requesting information on effective prevention activities. As mentioned previously, the consultation period for the discussion paper ends on 30 November 2009. Responses to the discussion paper will be collated and analysed in 2010, with the Commission reporting on the key issues identified once the analysis of the responses has been completed. The Commission will be particularly interested in the findings of the Inquiry in relation to these terms of reference.

2.5 Response to Term of Reference F

f) The role of targeted programs and services that address the particular circumstances of high-risk groups

The Commission acknowledges that while targeted programs have an important role to play in preventing suicide, research has shown that the most effective strategies responding to suicide prevention focus on supporting whole-of-population based health approaches. The Living Is For Everyone (LIFE) national suicide prevention strategy has been developed on this premise. In line with this framework, the Commission considers that suicide prevention activities aimed at reducing suicide among children and young people should target and involve:

- the whole population of children and young people (including general mental health promotion in schools and capacity building within communities generally)
- specific communities and groups who are known to be at increased risk of suicide (including regions experiencing suicide clusters and schools where a student has suicided), and
- individual children and young people identified to be at risk of suicide (including youth showing early signs of suicide risk).

Recent research also suggests that understanding the risk factors present in those who suicide is the best way to identify populations who may be at increased risk , rather than attempting to identify at-risk individuals. This is because it is extremely difficult to determine from risk factors alone which individuals within an at-risk group are more or less likely to become suicidal. Further, while individual risk factors for suicide may be easy to identify in retrospect, the level of pervasive risk within a group must be appreciated to understand the sometimes minor incidents that often trigger a suicide.

The Commission's data has identified several key groups where the role of targeted programs and services would be of particular benefit in the Queensland context, in particular:

- young people attending school – with suggested targeted intervention to occur in the form of promoting child and youth mental health and wellbeing, training education officers to identify risk factors and early warning signs, and implementing postvention guidelines and responses after the suicide or attempted suicide of a young person in the community
- Aboriginal and Torres Strait Islander children and young people – with targeted programs incorporating the similarities and differences between the suicides of Aboriginal and Torres Strait Islander youth and other young people in Queensland identified by the Commission
- children under 15 years of age – with services and early intervention programs targeting Queensland's Aboriginal and Torres Strait Islander children in particular, and
- young people experiencing significant behavioural problems – specifically those who have been suspended or excluded from schools on multiple occasions and/or have had contact with police and the youth justice system –

targeted diversionary programs must be implemented early to ensure services are provided to this high risk group.

The Commission also notes the importance of utilising evidence-based research to identify high-risk groups when considering how and what types of targeted services and programs will address the circumstances of certain groups at increased risk of suicide.

The Commission recommends that suicide prevention activities considered by the Inquiry must involve and target three key areas; whole populations, specific groups at increased risk of suicide; and, at-risk individuals. Further, the Commission supports the use of targeted programs and services for high-risk groups, noting key populations should include: young people in schools, Aboriginal and Torres Strait Islander children and young people and youth experiencing behavioural problems.

2.6 Response to Term of Reference G

g) The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy

The Commission is unable to comment on the adequacy of general suicide research provided to practitioners, individual agencies and government. However, the Commission acknowledges the importance of current research being undertaken in the areas of suicide and suicide prevention and notes the importance of research being disseminated to practitioners and government to influence policy development and service improvement. Further, the Commission considers it essential that any changes to policy and/or practices at a state and national level are guided by this evidence-based suicide prevention research.

2.6.1 Dissemination of the Commission's suicide research

Research undertaken by the Commission in relation to child and youth suicide in Queensland is disseminated each year through the Child Death Annual Reports. These reports are provided to a wide range of government and non-government stakeholders, experts and researchers working in the areas of child death prevention, specifically including suicide prevention.

As mentioned previously, the Commission's Child Death Annual Reports contain a detailed and contemporary chapter analysing the suicides of Queensland children and young people. This chapter provides an overview of the demographics of children and young people who have taken their own lives and examines the key risk factors and circumstances surrounding these deaths. This report is provided to various stakeholders with an interest in suicide and suicide prevention, including practitioners and key policy officers within government.

Further, the Commission's *RYSQ Discussion Paper*, which contains preliminary findings relating to the suicides of children and young people during the four-year period from 2004 to 2007, has been disseminated to a wide range of stakeholders

(approximately 750 individuals and agencies) to seek feedback on key discussion points raised throughout the paper, including:

- health experts, practitioners and hospital staff
- mental health workers and counsellors
- education officers, principals, teachers and guidance officers
- child safety officers and youth workers
- law enforcement officers, police and youth justice workers
- Aboriginal and Torres Strait Islander peoples
- coroners
- researchers and policy makers, and
- community based organisations.

Specifically, the RYSQ Discussion Paper targeted individuals with knowledge of, or experiences engaging with, children and young people who are at risk of suicide, or who have suicided. In addition to the targeted distribution to stakeholders, 10,469 copies of the paper have been downloaded from the Commission's website in the 8 weeks following the release of the RYSQ Discussion Paper on 31 August 2009.[13]

The Commission has begun to analyse the feedback provided by this wide-range of stakeholders in response to the suicide data provided in the discussion paper and, in the year ahead, will be in a position to provide further information on the findings to help inform future suicide prevention directions.

2.6.2 Contribution of the Commission's research to government policy

The Commission utilises its expertise and research in the area of youth suicide to contribute to a number of key government outcomes and initiatives which influence government policy in the area of suicide prevention. In particular, as previously mentioned, the Commission is currently represented on the Queensland Government Suicide Prevention Strategy (QGSPS) Steering Committee. This QGSPS is a whole-of-population collaborative effort by key government departments which was developed in recognition that suicide is an issue that is the responsibility of the whole community. The Commission has been represented on this committee since 2006 and continues to provide advice and data to this multi-agency group which influences suicide prevention activities throughout the state.

The Commission also intends to use the information identified through analysis of agency case file records, and the feedback received to key discussion questions raised in the *RYSQ Discussion Paper*, to develop recommendations aimed at informing key directions where suicide prevention efforts should be targeted. Some of the key discussion questions the Commission has promoted address:

- collaborative responses by multiple service providers involving information sharing between agencies to help better identify and modify risk factors and to support children and young people at risk of suicide
- a coordinated postvention response after the suicide or attempted suicide of a young person

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[13] Download numbers current as at 22 October 2009.

- improved cultural connections to establish partnerships with Aboriginal and Torres Strait Islander people and to provide training to community members to support the development of community-based supports
- improvement of services and supports provided to children and young people with mental health problems, and
- referral of young people with behavioural problems to diversionary programs for early intervention.

2.7 Response to Term of Reference H

h) The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress

The Commission is not placed to comment on the effectiveness of the current National Suicide Prevention Strategy. However, there are a number of key barriers and challenges that may impact on the effectiveness of any strategy to reduce the incidence of suicide. Some of the key issues that the Commission believes requires further consideration at the national level include:

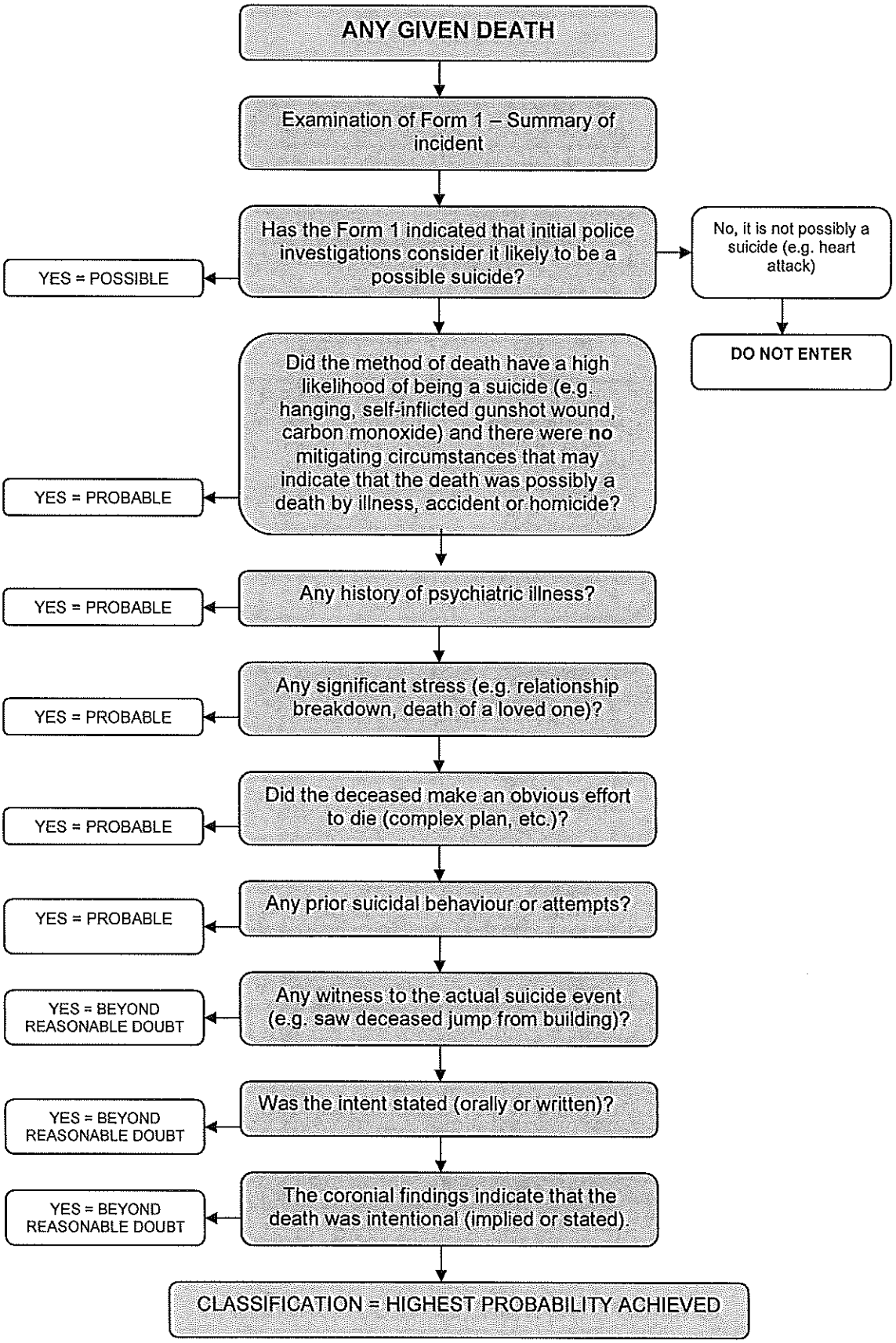
- the impact of the media on suicide contagion, and the need for heightened accountability around inappropriate media reporting
- the challenge technology plays, including managing the risk of new forms of communication for young people, in particular social networking sites
- the need to capture suicide attempt information and examine services that are effective in preventing future attempts as well as those mechanisms which fail, and
- the dispersement of the Australian population over a large geographic area, with limited services available to the majority of rural and remote areas throughout the nation.

The Commission considers that an essential step in ensuring future suicide prevention strategies achieve their key aims and objectives requires that the current National Suicide Prevention Strategy undergo a comprehensive and evidence-based evaluation. Evaluations are an essential part of measuring the effectiveness a strategy has had and assist in guiding the development of future national strategies.

APPENDICES

Appendix One

Suicide classification model


ANY GIVEN DEATH
Examination of Form 1 – Summary of incident
Has the Form 1 indicated that initial police investigations consider it likely to be a possible suicide?
YES = POSSIBLE
No, it is not possibly a suicide (e.g. heart attack)
DO NOT ENTER
Did the method of death have a high likelihood of being a suicide (e.g. hanging, self-inflicted gunshot wound, carbon monoxide) and there were no mitigating circumstances that may indicate that the death was possibly a death by illness, accident or homicide?
YES = PROBABLE
Any history of psychiatric illness?
YES = PROBABLE
Any significant stress (e.g. relationship breakdown, death of a loved one)?
YES = PROBABLE
Did the deceased make an obvious effort to die (complex plan, etc.)?
YES = PROBABLE
Any prior suicidal behaviour or attempts?
YES = PROBABLE
Any witness to the actual suicide event (e.g. saw deceased jump from building)?
YES = BEYOND REASONABLE DOUBT
Was the intent stated (orally or written)?
YES = BEYOND REASONABLE DOUBT
The coronial findings indicate that the death was intentional (implied or stated).
YES = BEYOND REASONABLE DOUBT
CLASSIFICATION = HIGHEST PROBABILITY ACHIEVED

Appendix Two

Submission to the World Health Organisation

ICD Update and Revision Platform

Inclusion of unspecified intent codes

Proposal ID : 1282 - **Proposal State :** In Moderation Layer **Proposal for Update**

Originator : *Yolandy Elizabeth Surawski* - **Last Update made by :** *Yolandy Elizabeth Surawski*

Creation Date : *21-Aug-2007 01:51 CET* - **Last Update :** *21-Aug-2007 01:52 CET*

Previously Discussed in the group(s):

Primary Code Affected : Ch20

Secondary Codes Affected : VOL2-4

Volumes Affected : 1,2,3

Proposal Type : Addition of new code

Change Reason : Need to improve clarity or reduce ambiguity in the tabular list

Detailed Description

This proposal is being submitted on behalf of the Commission for Children and Young People and Child Guardian, Queensland, Australia.

1. An 'unspecified intent' code be included in the International Classification of Diseases (ICD). An unspecified intent code is required in addition to the 'undetermined intent' codes, to more accurately classify those cases where the death appears to be a suicide; however, the coroner does not stipulate intent.

Currently the Queensland Commission for Children and Young People and Child Guardian, Australia ("the Commission") have resolved this issue for their Child Death Register by assigning an "A" code to the back of the relevant undetermined intent codes for cases which are of unspecified intent. For example, 'Y20A – Hanging, strangulation and suffocation, unspecified intent'. The code represents cases where police indicate that the death is a suspected suicide but the deceased did not leave a suicide note and the coroner is silent on the issue (for example, the cause of death is assigned to hanging with no behavioural descriptor).

2. That the 'unspecified intent' code replace 'accidental' as the default code in the index (volume 3). For example:

Hanging (unspecified intent) **new code**
- caused by other person
- - in accidental circumstances **W76**
- - stated as
- - - intentional, homicide (attempt) **X91**
- - - undetermined whether accidental or intentional **Y20**
- - - unspecified whether accidental or intentional **new code**
- homicide (attempt) **X91**
- in bed or cradle **W75**
- legal execution **Y35.5**
- self-inflicted
- - in accidental circumstances **W76**
- - stated as intentional, purposeful, suicide (attempt) **X70**
- stated as undetermined whether accidentally or purposely inflicted **Y20**
- unspecified whether accidentally or purposely inflicted **new code**
- suicide (attempt) **X70**

3. Clear guidelines be outlined in the ICD instruction manual (volume 2) in relation to the coding of self-inflicted deaths (including intentional, accidental, undetermined and unspecified code categories).

Rationale

There are several reasons for requiring the inclusion of the 'unspecified intent' codes and the provision of clear guidelines relating to coding self-inflicted deaths. These can be categorised as follows:

Accuracy

The 'unspecified intent' code range would allow for more accurate classification of cases where a coroner is 'silent' on the intent of a death. For example, in the case where an individual hangs themselves, police identify the death to be a suicide but the deceased does not leave a note and the coroner rules the cause of death to be 1a) hanging, with no behavioural descriptor relating to the deceased's intent, the ICD index (volume 3) defaults to the **W76** accidental hanging code.

The Commission has been informed by the National Centre for Classification in Health (Australia) that ICD coders are not sanctioned to form their own judgements in relation to the coding of intent. So, in circumstances where intent is not clear, the default category that coders must use is accidental (unless the death is stated to be of undetermined intent by the coroner). However, the Commission considers that coding a death to accidental is also making a statement of intent – it is making a statement of **no** intent.

The veracity of this issue is illustrated through comments made by coders from the Australian Bureau of Statistics (ABS), Australia's official statistical reporting body, that "even if suicide is suspected by the coder, for example a person has had a fight with his girlfriend and is found not long after with a noose around his neck, ... but there is no evidence of stated intention - the ABS will code [that death] to accidental".

Further, classification to accidental is not accurately representing the findings of the coroner. In circumstances where the coroner has not specified whether the intent of the deceased was intentional, accidental or undetermined, this should be so classified and not defaulted to a presumed accident.

Legislative barriers

It should be recognised that in a number of jurisdictions there are legislative barriers which prevent, or have previously prevented, legal authorities from classifying a death as a suicide. For example, attempting suicide was considered an offence in Queensland until the late 1970s (which was also the case for a number of other countries and Australian states). It has also only been as recent as 2003 in Queensland that the *Coroners Act 1958* was repealed, and the prohibition of a coroner making a finding of suicide, removed. Even now while use of the term suicide, or any reference to deliberate self-harm resulting in death, is not prohibited by the *Coroners Act 2003*, the revised Act does not specifically require that coroners reach a verdict surrounding intent. The implications of this are that some coroners may be reluctant to make a finding of suicide given the repealed Act prohibited the coroners from finding anything other than the medical cause of death (for example, gunshot wound or hanging) and the current Act does not require them to do so.

In addition, the Queensland State Coroner has previously informed the Commission that if a coroner considers a death to be accidental or undetermined, then this will be expressly stated in the coroner's findings (for example, 'accidental hanging'). In cases where the finding simply states the cause of death as 'hanging' (and the police indicate the death is a suspected suicide), the absence of the term accidental or undetermined should be taken to imply that the death was intentional.

This information provided by the Queensland State Coroners is that silence of a coroner implies that the intent was intentional, **not** accidental. This directly conflicts with the default indexing to accidental in the ICD index (volume 3).

Furthermore, in Queensland, the *Births, Deaths and Marriages Act 2003* prohibits registrars from entering "the word 'suicide' or words to that effect in the register". The prohibition of this term may also impact on a coroners decision to stipulate a finding of intent.

The Commission considers it likely that other jurisdictions may have similar legislative barriers which impact upon coroners finding a death to be intentionally self-inflicted. This has implications on the way these deaths are coded. Specifically, if coroners are discouraged, through current or prior legislative restrictions, from making a finding of suicide than it is less likely that they will make a statement of intent. Further, it has been documented that coroners may also avoid stipulation of intent to avoid embarrassment and guilt in family members, or due to the influence of religious values and/or cultural attitudes. Nevertheless, in circumstances where a coroner is silent on intent for any of these reasons, coders classify the cause of death to the default category of accidental – which frequently is not the finding of the coroner – the intent of the deceased person is 'unspecified'.

Coding consistency

To gain some clarity around suicide coding generally, the Commission placed a query with both the Mortality Reference Group and the Australian Mortality Data Interest Group forums in an attempt to clarify the opinions of national and international coders in relation to assigning intent in circumstances where there is insufficient evidence to code the death as a suicide. Responses varied considerably with some coders indicating that they would code these deaths to a suicide and others would code to an accident (see attached scripts).

The Commission identified that the way many suicide deaths are being coded both nationally and internationally differs significantly, even when provided with the same information. For example, responses from some coders indicated that if a coroner is silent on intent, information provided in the police report was considered an authoritative document and may be used to code a self-inflicted death as intentional. Conversely, other coders did not consider that the information provided in the police report alone was authoritative enough to classify a death as intentionally self-inflicted.

The current ICD-10 instruction manual (volume 2) does not provide any detailed information in relation to the coding of deaths to intentional self-harm versus accidental deaths, and/or what information is considered an authoritative source to aid in the coding of an intentional versus accidental death. For example, is it enough for the police to note that the death is a suspected suicide, and for the coroner to find the death to be a 'hanging' for a coder to classify the death as intentional? As a result, coders are required to use discretion when coding self-inflicted deaths. This results not only in inconsistency nationally and internationally, but also can vary between different organisations in the same jurisdictions.

It is therefore clear that some further guidance is required in the ICD instruction manual (volume 2) to help with the classification of self-inflicted deaths.

Impact of under-recording suicides

As a result of the above mentioned issues, the Commission has identified that a significant number of suicide deaths are being classified to accidental categories, resulting in the under recording of suicide and an overrepresentation of the number of accidental deaths recorded in official statistics. This has a significant impact on research and resource allocation, as well as awareness of the suicide phenomenon in general.

The Commission has identified that this is a problem, in particular, for children and young people who suicide. Since January 2004, the Commission has identified that suicide is the leading cause of death for children in Queensland aged 10 to 14 years, and the second leading cause for 15 to 17 year-olds. However, official statistics do not report most of these deaths and have classified many to accidental causes. This has

resulted in neglect of the issue of childhood suicide because the deaths do not appear to be occurring. Further, there is a lack of research examining the issue of childhood suicide in Australia, a lack of awareness among policy makers and the population as a whole that childhood suicide is an issue of concern and there has been a paucity of resources assigned to childhood suicide to develop prevention and early intervention strategies to reduce the number of suicides occurring among children as a result of this under reporting.

On analysis of this situation, one may ask what is to be gained by reporting suspected suicides as accidents? While we don't want to be unknowingly over representing the numbers of suicides, in cases where police have recorded the death is a suspected suicide and the coroner does not disagree with this statement than it can be seen to be of no advantage to report this death as an accident. Particularly when the method of suicide is such that it is almost certainly intentionally self-inflicted and there is a low likelihood that the death was, in fact, an accident (such is the case in hangings) as opposed to more ambiguous methods such as single vehicle car accidents and poisonings.

As stated in the ICD instruction manual (volume 2), "[t]he purpose of the underlying cause definition is an attempt to identify potentially preventable causes of death and to help understand where a sequence of events leading to death could have been interrupted or a cure could have been effected and thus the death prevented'. The Commission would argue that allocating a suicide to an accidental category, because the coroner did not specify intent, is not achieving this purpose as resources for the prevention and intervention of suicide are only allocated when official statistics show that there is cause for concern. Conversely, use of the unspecified intent code would allow for these deaths to be more accurately reflected in official data, therefore contributing to an increased awareness of the occurrence and status of these deaths.

Supporting Publication Web Links
Annual report deaths of children and young people Queensland 200506 refer to chapter 10 suicide
Annual report deaths of children and young people Queensland 200405 refer to chapter 7 suicide

Supporting Publications (Upoaded Files)
Query placed by the Commission on the Mortality Reference Group Forum in February 2006
Suicide coding issues discussed at the Mortality Reference Group meeting in Washington in May 2006 pgs 84 to 86

Comments

Appendix Three

Previous recommendations to address the accuracy of suicide reporting

In the *Annual Report: Deaths of children and young people, Queensland 2005–06* the Commission made the following recommendations to the Australian Bureau of Statistics and the Registry of Births, Deaths and Marriages in relation to improving the way information on childhood suicide is collected, classified and recorded in Queensland.

Recommendation One
The Registry of Births Deaths and Marriages review the *Births Deaths and marriages Registration Act 2003* with a view to amending restrictions on entering the word 'suicide' or words to that effect in the register.

Reason: While amendments to the Coroners Act have removed restrictions on use of the word 'suicide' or references to self harming, amendments to the Births Deaths and Marriages Registration Act have not. The Commission considers that this contributes to the stigmatisation around and under reporting of suicide, particularly childhood suicide.

Status of recommendation: The Attorney-General is considering this issue and the Commission is waiting to be advised of the outcome.

Recommendation Two
The Australian Bureau of Statistics work with training bodies, mortality coders, Australian child death review teams and coronial system representatives to develop a method of coding intention self-harm that more accurately reflects the cause of death in the absence of a clear statement of intent from a coroner.

Reason: Suicides have traditionally been under reported, partly as a result of the reluctance of coroners to provide clear statements as to whether the injuries leading to death were intentionally self-inflicted. A national approach to the coding of intentional self-harm in such instances is imperative to ensure child suicides are accurately reported.

Status of recommendation: This recommendation has been implemented. In 2006 the Australian Bureau of Statistics convened a Suicide Coding Working Group to assist in improving the quality of national suicide data. Significant changes have now been made to improve suicide reporting nationally, including:

- no longer automatically coding suicides to accidental when coroners fail to stipulate intent
- considering police identification that a death is a suspected suicide and giving greater weight to the presence of risk factors
- developing guidelines to ensure consistent reporting, and
- revising causes of death in future publications where a death is reported without coronial findings.

These changes will vastly improve the accuracy of suicide reporting nationally.

Recommendation Three
The Australian Bureau of Statistics publically report on suicides of children and young people under 15 years of age.

Reason: The Australian Bureau of Statistics does not report on suicides for children under 15 years of age. The Commission has identified this as a contributing factor to the under-appreciation of childhood suicide.

Status of recommendation: This recommendation has been partially implemented. The Australian Bureau of Statistics publication *Suicides Australia* published in March 2007 contained aggregate information on the suicides of children under 15 years during the period 1995–2005. An additional information paper regarding the quality of external cause of death data was published in April 2007 to explain concerns regarding small number when reporting suicides of children. The Australian Bureau of Statistics does not report on deaths of children aged under 15 years as a separate age category but includes an explanatory note in its publications outlining the low number of child suicides which occur in Australia.