Suicide & risk-taking deaths

of children & young people

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OF CHILDREN
& YOUNG PEOPLE

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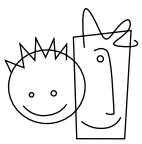

nsw commission for
children & young people

NSW HEALTH
Working as a Team

A collaborative research project undertaken by the
NSW Commission for Children and Young People, the
NSW Child Death Review Team and the Centre for Mental Health.

Published by:
NSW Commission for Children and Young People
Level 2, 407 Elizabeth Street
Surry Hills NSW 2010
Telephone: +61 (2) 9286 7276
Facsimile: +61 (2) 9286 7267
Email: kids@kids.nsw.gov.au
Website: www.kids.nsw.gov.au

NSW Commission for Children and Young People
Cataloguing-in-Publication data
New South Wales. Commission for Children and Young People.
Suicide and risk-taking deaths of children and young people: report.

ISBN 0 7347 7113 4

1. Children – New South Wales – Mortality.
2. Children – New South Wales – Suicidal Behavior.

I. Sankey, Melissa. II. Lawrence, Ruth.
III. Title.

362.28083 (DDC 21)

Suggested citation: *Suicide and risk-taking deaths of children and young people.* Report written by Dr Melissa Sankey, NSW Commission for Children and Young People and study conception and design by Dr Ruth Lawrence, NSW Commission for Children and Young People.
Sydney: NSW Commission for Children and Young People, NSW Child Death Review Team and the NSW Centre for Mental Health, 2003.

Convenor's foreword

In 1998 the NSW Government asked the Child Death Review Team to conduct research into the suicide deaths of children and young people. This report examines the deaths of 187 children and young people aged 12 to 17 years who died from suicide and risk-taking in the period January 1996 to December 2000 in New South Wales.

On behalf of the Child Death Review Team I would like to extend my sympathy to the bereaved families and friends of these children and young people. I would also like to extend my sympathy to those professionals who provided care for and knew these children and young people.

The findings suggest avenues for suicide and risk-taking prevention and intervention and have implications for service provision. Most importantly, the findings highlight that the prevention of further suicide and risk-taking deaths among children and young people is the responsibility of the whole community. Prevention needs to be multi-faceted, addressing all the important areas in children and young people's lives.

I would like to thank my colleagues on the Child Death Review Team for the knowledge and skill they brought to the Team's deliberations regarding this report. The Team hopes that this report is informative and that the important findings it contains will be used to strengthen the *We Can all Make a Difference: NSW Suicide Prevention Strategy*.

Gillian Calvert

Gillian Calvert
Convenor, Child Death Review Team
Commissioner for Children and Young People

January 2003

Acknowledgements

This study was made possible by the generosity and commitment of many individuals. The NSW Child Death Review Team, the Centre for Mental Health and the NSW Commission for Children and Young People would like to acknowledge the contributions of the following persons:

Ms Jennifer Chipps of the Centre for Mental Health, Dr Michael Fairley of the NSW Child Death Review Team, Dr Ruth Lawrence and Dr Melissa Sankey of the NSW Commission for Children and Young People, and two young people, Mr Jonathan Nicholas and Ms Nancy Maksimovic for their project oversight and guidance as members of the project steering committee.

Dr Michael Dudley, CEO, Suicide Australia, for his invaluable comments on an earlier draft of this report.

The government agencies who facilitated access to the records of the children and young people.

The Catholic Education Commission who facilitated access to the educational records of those children and young people who attended Catholic schools.

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Child Death Review Team members

Gillian Calvert
(June 1999 onwards)
Convenor.
NSW Commissioner for Children and Young People.

Dr Judy Cashmore
(April 1996 onwards)
Deputy Convenor.
Honorary Research Associate, Social Policy Research Centre, University of New South Wales.

Dr Ian Cameron
(December 1999 onwards)
Chief Executive Officer, NSW Rural Doctors Network.

Dr Michael Fairley
(December 1998 onwards)
Head of the Department of Child and Adolescent Mental Health at Prince of Wales Hospital and Sydney Children's Hospital.

Dr Jonathan Gillis
(August 2001 onwards)
Senior Staff Specialist in Intensive Care. Chairman, Division of Critical Care and Diagnostic Services, The Children's Hospital at Westmead.

Anne Maree Gleeson
(September 2001 onwards)
NSW Department of Community Services representative.
Area Director, Hunter Department of Community Services.

Pam Greer
(May 1999 onwards)
Aboriginal representative.
Community worker, trainer and consultant.

Dr Ferry Grunseit
(April 1996 onwards)
Consultant Paediatrician. Former Chair of the NSW Child Protection Council and NSW Child Advocate.

Commander John Heslop
(April 1996 onwards)
NSW Police representative.
Manager, Child Protection Enforcement Agency, NSW Police.

Associate Professor John Hilton
(April 1996 to April 2001)
Associate Professor, Department of Pathology, University of Sydney. Clinical Director, Department of Forensic Medicine, Central Sydney Area Health Service.

Associate Professor Judith Irwin
(December 1999 onwards)
Chair of the Department of Social Work, Social Policy and Sociology at the University of Sydney.

Melva Kennedy
(December 1999 to October 2002)
Aboriginal representative.
Aboriginal Liaison Officer, St Vincent's Hospital Sydney.

Helen Kerr-Roubicek
(April 1996 onwards)
NSW Department of Education and Training representative.
Manager of Student Welfare, NSW Department of Education and Training.

Kathrina Lo
(October 2000 to July 2002)
Attorney-General's Department representative.
Manager, Legislation and Policy Division, NSW Attorney General's Department.

Peter Mathews
(February 2002 onwards)
Office of the State Coroner representative.
Manager, Coronial Services NSW and Executive Officer to the State Coroner, Coroner's Court, Glebe.

Dr Andrew McDonald
(August 2001 onwards)
Area advisor in paediatrics for South West Sydney Area Health Service and Consultant Paediatrician, Macarthur Health Service.

Dr Elisabeth Murphy
(December 1999 onwards)
NSW Health representative.
Clinical Consultant, Primary Health and Community Care Branch, Policy Division NSW Health Department.

Graham O'Rourke
(April 1996 to December 2001)
Office of the State Coroner representative.
Formerly Manager, Coronial Services NSW and Executive Officer to the State Coroner, Coroner's Court, Glebe.

Carol Peltola
(April 2000 to September 2001)
Department of Community Services representative.
Formerly Executive Director of Child and Family Services, NSW Department of Community Services.

Alice Silva
(August 2001 onwards)
Aboriginal representative.
Mobile Aboriginal Casework Specialist (SAAP) and Families First CPO Orana Far West Region.

Toni Single
(April 1996 onwards)
Senior Clinical Psychologist, Child Protection Team, John Hunter Children's Hospital, Newcastle.

Executive summary

Research purpose

The aim of the research project was to study the population of all deaths of children and young people under 18 years in New South Wales (NSW) by suicide or risk-taking over a five-year period (January 1996 to December 2000).

The study consisted of a case file review of records from government and non-government departments, including NSW Coroner, Health, Police, Community Services, Juvenile Justice, Education and Training, as well as education records for young people who attended Catholic schools.

Overview of child suicide and risk-taking deaths

Over the five-year period, 187 children and young people (aged 12-17 years) died from suicide and risk-taking, out of 814 deaths of children and young people (aged 12-17 years) from all causes in NSW (23% of deaths of 12-17 year olds were attributed to suicide or risk-taking).

The following factors were shown to be associated with this population of suicide and risk-taking deaths:

Gender

Males are over-represented in deaths from all causes. This is also true for suicide and risk-taking deaths. The majority (71.1%) of suicide and risk-taking deaths were of males.

Age

Almost three-quarters (72.7%) of the children and young people were aged 16 or 17 years at the time of death.

Indigenous status

Aboriginal children and young people are over-represented in deaths from all causes. Similarly, Aboriginal children and young people were over-represented in suicide and risk-taking deaths (7.5% of the population of this study) compared with their numbers in the population (2.8% of the NSW population).

Living arrangements

Well under half (38.5%) of the children and young people who died were living in intact biological families at the time of their deaths. This figure is substantially lower than the NSW population figure. In 1997, 69.6% of all children and young people aged 12-17 years in NSW lived with both biological parents (ABS, 1999).

Education

Just under half (47.1%) of the children and young people had left school before completing Year 12. This figure is substantially lower than the NSW population age participation rates in education. In 2001, the age participation rates for full-time school

students were 93.0% for 15 year olds, 82.4% for 16 year olds and 62.2% for 17 year olds (ABS, 2001). Children and young people who experienced risk-taking deaths were far less likely to be attending school (33.3% of the population of risk-taking deaths were attending school) than those who died from suicide (69.4% of the population of suicide deaths were attending school).

Drug use

Over one-third (35.3%) of the children and young people had engaged in frequent drug use (at least once/week), with cannabis, alcohol and heroin being the substances most commonly used. Children and young people who died by risk-taking were more likely to have engaged in frequent drug use than those who died suicide deaths (56.1% vs 39.4% of frequent drug users).

Offending behaviour

Two-fifths of the children and young people had been in trouble with the police for engagement in criminal activity, although more risk-takers (55.3%) were known to the police for their offending behaviour than those who died by suicide (38.2%).

Prior suicidal behaviour

Eighty-two (43.9%) children and young people had exhibited prior suicidal behaviour, in the form of ideation, attempts and deliberate self-harm. Those who died by suicide were more likely to have exhibited prior suicidal behaviour than those who died by risk-taking (58.6% of suicide cases compared with 22.7% of risk-taking cases).

Stressful life events

Almost three-quarters (72.7%) of the population of this study had experienced at least one adverse life event in the year prior to their deaths. The most common adverse life events experienced by those who died by suicide were interpersonal conflicts. Those who died by risk-taking were more likely to have experienced legal problems, such as charges and court appearances for criminal activity.

Precipitating incident to death

Most of the precipitating incidents to the suicide deaths involved a relationship breakdown or an apparently trivial argument with a significant person in their lives (62.2%). Alcohol or other drug intoxication was the precipitating incident most frequently recorded in the risk-taking cases (72.4%).

Method of death

Hanging was the most frequently used method of suicide death for both males and females. Drug overdose was the most common method of risk-taking deaths for both males and females, of which the majority were heroin overdoses.

Clusters of child suicide and risk-taking deaths

The children and young people in this study could be classified into three distinct clusters on the basis of their life histories and precipitating incidents:

1) Enduring difficulties

The deaths of 124 (66.3%) children and young people occurred in the context of significant enduring or chronic difficulties. These included mental health problems, family dysfunction, school-related difficulties, or any combination of these. Twenty-eight of the 124 children and young people experienced more than one enduring difficulty.

Thirty-two children and young people in this cluster had been diagnosed with mental health problems, the most common of which were behavioural disorders, followed by depression. A further 22 children and young people were clearly suffering from extreme emotional distress, although they had not received a mental health diagnosis. Seventy children and young people in this cluster experienced chronic family dysfunction, including physical abuse, neglect, emotional abuse, sexual abuse, unhelpful parenting and ongoing conflict and arguments. Thirty-eight of the children and young people in this cluster experienced significant school-related problems, including stress associated with Higher School Certificate[1] study, learning difficulties, problems in peer relationships, and behavioural and disciplinary problems.

2) Pivotal life events

Twenty-six (13.9%) of the 187 children and young people formed this cluster, all but two of whom died by suicide. No child or young person in this cluster suffered enduring difficulties. Rather, they experienced an isolated incident prior to their deaths, which they all perceived as pivotal or life-changing. Their suicides appear to have been either impulsive responses to this major life event or to have occurred in an acutely depressed state due to their experience of the pivotal event. The most commonly experienced pivotal life events were interpersonal issues, typically a relationship breakdown, a death of a significant person, or an argument with an important person in their lives. The other significant life events that were precipitants to this cluster of deaths were associated with a major illness or accident, sexual assault, unemployment and legal problems.

3) Adolescent experimentation

Twenty-eight (15%) of the 187 children and young people formed this cluster, all but one of whom died by risk-taking. These children and young people died while engaging in risk-taking behaviours that are common during adolescence, notably substance use and dangerous driving. Their substance use typically occurred in a social or group context: they had consumed alcohol or ingested illicit substances with friends, either at a pub, party or at home and had died while in a substance-affected state. All but two of the fatalities in this cluster were of males, indicating that fatal risk-taking is predominantly a male phenomenon.

Contact with human service agencies

In this study, 41.7% of the children and young people had no record of human service provision. Of those who had been the recipients of services, those accessed included the Department of Community Services (26.2%), school counsellor services (21.4%), the Department of Juvenile Justice (20.9%), mental health services (20.9%), hospital Emergency Departments for alcohol and other drug-related incidents or suicidal behaviour (13.4%), refuge services (10.2%) and drug and alcohol services (9.1%).

The legislative and policy contexts in which the deaths of this population of children and young people occurred have changed. Some sections of the *Children and Young Persons (Care and Protection) Act 1998* have been proclaimed, significantly, the ability of children

[1] The Higher School Certificate (HSC) is a locally, nationally and internationally recognised qualification for students who successfully complete secondary education in NSW. The HSC examination is the final examination undertaken by Year 12 secondary school students in NSW.

and young people to request assistance (s20), the reporting of homelessness of children and young people (s120 and s121) and the definition of risk of harm (s23). In addition, the *NSW Interagency Guidelines for Child Protection Intervention* have been revised. These have brought various changes to the operation of the service system, policies and procedures and should have a significant effect on child protection practice and service provision.

Prevention of suicide and risk-taking deaths among children and young people

The study findings suggest avenues for the prevention of further suicide and risk-taking deaths of children and young people. The NSW Government introduced the *We Can All Make A Difference: NSW Suicide Prevention Strategy* in 1999, which was after the majority of deaths in this study occurred. Some of the findings from this study are already adequately recognised within the *NSW Suicide Prevention Strategy*. Other study findings are recognised to some extent within the Strategy. The remainder of the study findings are not currently recognised within the Strategy.

The following study findings are already adequately recognised within the *NSW Suicide Prevention Strategy:*

- Aboriginal children and young people were over-represented in suicide and risk-taking deaths compared with their numbers in the population.
- Family dysfunction was a factor for more than one-third of the children and young people.
- Many children and young people were unable to manage stressful situations.
- For several children and young people there was an underestimation of suicide risk by health professionals.
- Several children and young people who presented to hospital with suicidal behaviour or having overdosed on drugs were discharged without sufficient observation or assessment or joint management plans in place.
- Several suicide deaths were associated with copycat or imitative factors.
- For just under half of the children and young people, the only information was that contained in the coronial file.

The following study findings are currently recognised to some extent within the *NSW Suicide Prevention Strategy:*

- Many children and young people did not seek assistance for their difficulties.
- Several children and young people experienced significant problems in peer relationships.
- Just under half of the children and young people had no record of contact with human service agencies.

The following study findings are not currently recognised within the *NSW Suicide Prevention Strategy:*

- The majority of suicide and risk-taking deaths were of males.
- Narrow male stereotypes created difficulties for several males.
- Many young people informed a friend or family member of their intention to commit suicide.
- Some children and young people were unable to cope with the stress of the Higher School Certificate.
- Several children and young people experienced significant learning and behavioural problems.

- Many children and young people died while engaging in typical adolescent risk-taking behaviours.
- Several children and young people were victims of extreme child abuse and neglect.
- The suicide deaths of several children and young people occurred during a period of non-compliance with medication.
- Several young people died by overdosing on friends' or family members' takeaway methadone, or by illegally obtaining quantities of methadone.

Some of these study findings are currently recognised within other NSW strategies. For example, NSW Health is addressing the issue of takeaway methadone. A range of drug education, road safety and crime prevention programs target the issue of risk-taking among children and young people. It would, however, be useful for these strategies to be linked to the *NSW Suicide Prevention Strategy*, to increase the impact of the effort.

The current Child Death Review Team legislation restricts consultation of the findings with anyone outside the Team until the report has been tabled in Parliament. Consequently, the Team has chosen to present the findings and then to allow a period of 12 months in which the *NSW Suicide Prevention Strategy* is reviewed and updated to reflect the study findings.

Recommendation

That over the next 12 months the NSW Government reviews and updates the *We Can All Make A Difference: NSW Suicide Prevention Strategy* to reflect the findings from this study.

Chapter one

Suicide and risk-taking: An introduction

1.1 Introduction to the study

A great deal of child and youth oriented research has focused on adolescence as a time of both experimentation (Turner, Irwin, Tschann, & Millstein, 1993) and risk-taking (Eccles, Midgely, Wigfield, Buchanan, Reuman, Flanagan, & MacIver, 1993). For some of the young people who are confronting the physiological, social and cognitive changes that occur during this period, positive developmental outcomes are not guaranteed (Baumrind, 1991). It is therefore not surprising that researchers have been concerned to identify those factors that negatively affect the physical and psychosocial health and well-being of these young people. This study sought to identify and explore those factors that were associated with the suicide and risk-taking deaths of children and young people[2].

Few studies have focused on the suicide deaths of children and young adolescents, despite an abundance of studies of youth suicide (aged 15-24 years). This relates partly to the fact that child and young adolescent suicides are a rare phenomenon and partly to the great discomfort that many people feel when considering that children can desire to end their lives (Wagner, 1997). Yet suicide deaths among children and young adolescents do occur and need to be examined and understood.

The overall purpose of this study was to examine the suicide and risk-taking deaths of children and young people under 18 years in NSW that occurred during the period 1996-2000. This chapter first presents definitions of the terms 'suicide' and 'risk-taking'. It then discusses suicide and risk-taking behaviours in terms of their level and extent, the theoretical frameworks used to understand these behaviours, and various methodologies that have been employed in their study.

1.2 Defining suicide and risk-taking

Suicide

The term 'suicide' is used to refer to any self-inflicted injury resulting in death where it is established by a coronial inquiry that the death resulted from a deliberate act by the deceased person with the intention of taking his or her own life (ABS, 2000; Centre for Mental Health, 2000).

Each Australian jurisdiction has its own coronial Act and procedures. The result is that processes for deciding whether a death is due to suicide differ among the States and Territories. In NSW, the standard of proof required to classify a death as suicide is a

[2] The definitions of 'child' and 'young person' are taken from the *Children and Young Persons (Care and Protection) Act 1998*. Under the Act a child is defined as a person who is under the age of 16 years and a young person is 16 years or above but is under the age of 18 years.

high standard of probability' (Cantor, Neulinger, Roth & Spinks, 2000). This is a higher standard than the 'balance of probabilities' standard of proof required for civil cases, but a lower standard than the 'beyond reasonable doubt' standard of proof required for criminal cases.

There is a general tendency worldwide towards not reaching a finding of suicide (Hawton & van Heeringen, 2000). One factor that may influence this is the application of a high standard of probability for classifying a death as suicide. In the absence of any strong evidence (for example, a suicide note) some suicides could be classified as accidental or undetermined. Other factors that may influence a suicide finding include a wish to avoid upset to families; national, religious and cultural values and attitudes; and lack of knowledge of the heterogeneity of suicidal behaviours (ABS, 2000; Hawton & van Heeringen, 2000).

Other factors relate specifically to the classification of child deaths as suicide. It has been found that some Coroners are reluctant to classify child deaths as suicide due to the belief that children are incapable of fully understanding the concept of death and its irreversibility (Beautrais, 2001). Yet research has shown that most five to seven year olds and almost all older children know that suicide will result in death, and understand that death is permanent and final (Mishara, 1999).

The factors that influence suicide findings also affect official suicide statistics. These statistics may underestimate suicides, particularly with equivocal deaths such as drug overdoses, single-vehicle crashes and suicides of children (Madge & Harvey, 1999).

Risk-taking

The term 'risk-taking' can been used to refer to both positive or socially approved behaviours and negative or deviant behaviours. Examples of positive or socially approved behaviours include sports-related risk behaviours such as rock-climbing, water-skiing, scuba diving and white water rafting (Gonzalez, Field, Gonzalez, Lasko, and Bendell, 1994). Examples of negative or deviant behaviours include substance abuse, various driving behaviours such as speeding and unlicensed driving, unprotected sexual intercourse, criminal activity and suicidal behaviours (McKie et al., 1993; Graber & Brooks-Gunn, 1995; Hewitt, Elliott & Shanahan, 1995; Piccone & Oldenburg, 1998).

Risk-taking behaviours have also been classified in other ways. For instance, the United States Centers for Disease Control and Prevention (2000) differentiates between risk behaviours that contribute to unintentional injuries, such as lack of seat belt use, injurious physical activity and driving after drinking alcohol, and risk behaviours that contribute to intentional injuries, such as carrying a weapon and suicide ideation and attempts.

Risk-taking is a term that is often used in relation to adolescent behaviour. Some researchers have claimed that experimentation with negative or deviant risk behaviours is essential for normal adolescent development (Baumrind, 1987; Irwin & Vaughan, 1988). Erikson (1950; 1968), for example, conceptualised adolescence as a 'psychosocial moratorium', in which experimentation and risk-taking was necessary to achieve independence. While research has shown that some engagement in risk-taking behaviour can have positive effects (Shedler & Block, 1990), most researchers would agree that involvement in chronic risk-taking places young people at very high risk of negative physical and psychosocial outcomes (Moore & Parsons, 2000).

For the purposes of this study, 'risk-taking' was defined as 'any behaviour engaged in by a child or young person where there was a high probability of death as an outcome'. This definition was adopted because the population in this study was deceased.

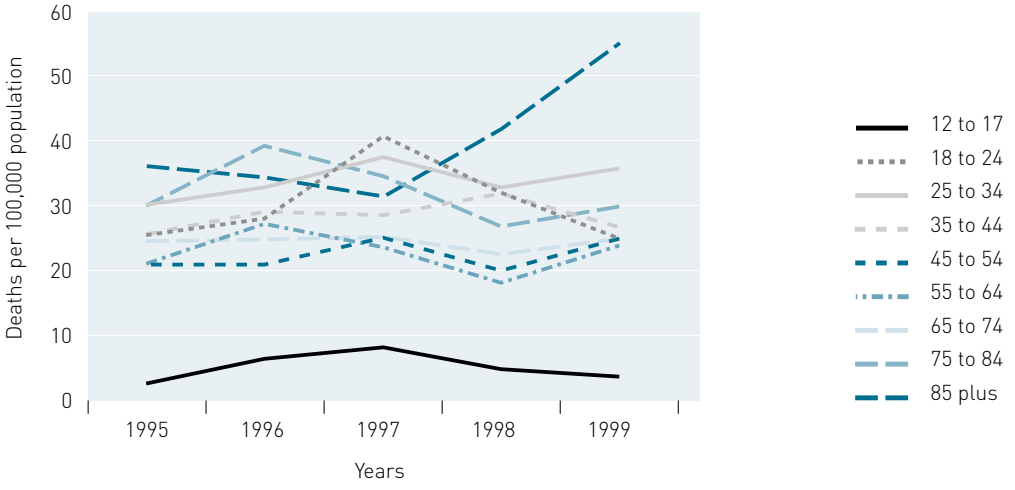
The next sections of this chapter discuss the level and extent of suicide in the general population, the level and extent of adolescent risk-taking, and the various theories that have attempted to account for engagement in such behaviour.

1.3 Suicide in the general population: The size of the problem

Death by suicide is an infrequent event. In 1999 in Australia, only 1.9% of all deaths were attributed to suicide (ABS, 2001a). Figures 1.1 and 1.2 present the suicide death rates by age group and gender in NSW for the years 1995-1999. These figures show that male suicides are far more frequent than female suicides. With respect to both males and females, suicide rates have consistently been lowest in the 12-17 year age group. The one exception occurred in 1999, when the suicide rate for female 12-17 year olds was approximately the same as the rates for the female 55-64, 65-74, 75-84 and 85+ age groups. Males aged 85 years and over have had the highest suicide rates in three out of the five years; moreover, the rates for this group have been increasing steadily since 1997[3]. The rates for 12-17 year old males showed little or no change between 1995 and 1999. In contrast, the rates for 12-17 year old females appear to have changed markedly from year to year, although this should be interpreted with caution, as the rates are based on a very small number of cases, such that even a few extra deaths in one year can double the observed suicide rate.

Figure 1.1

Male suicide death rates by age group in NSW (1995-1999)



These data were prepared by the Centre for Mental Health, NSW Health Department (2001).

[3] These data show that in NSW males aged over 85 years have the highest suicide rates. Nationally, however, males aged between 25 and 34 years have the highest rates, closely followed by males aged over 85 years (ABS, 2000).

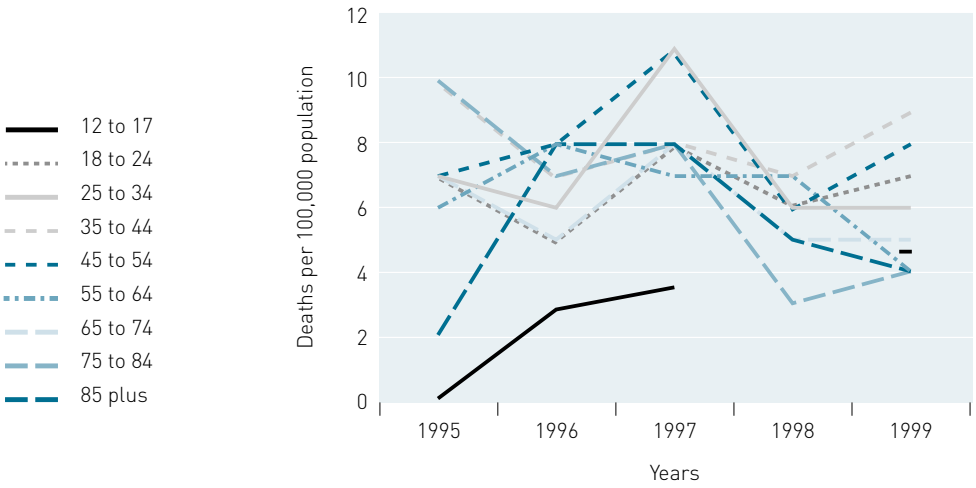


Figure 1.2

Female suicide death rates by age group in NSW (1995-1999)

These data were prepared by the Centre for Mental Health, NSW Health Department (2001).

In 1995, no 12-17 year old females died by suicide. In 1998 less than four females in the 12-17 year age group died by suicide, making the calculation of a rate unreliable.

Interstate comparisons

Within Australia, suicide rates differ among the States and Territories. Figure 1.3 presents the suicide rates for each State and Territory for the years 1995 to 1999. Suicide rates for the Northern Territory, followed by Queensland, have consistently been the highest, with the exception of 1999. From 1998 to 1999 there was a marked increase in the rates for Tasmania and the ACT, while the Northern Territory and Queensland rates decreased. However, care needs to be exercised in interpreting this finding, as data based on a single year can be unrepresentative of suicide trends over a longer period (ABS, 2000).

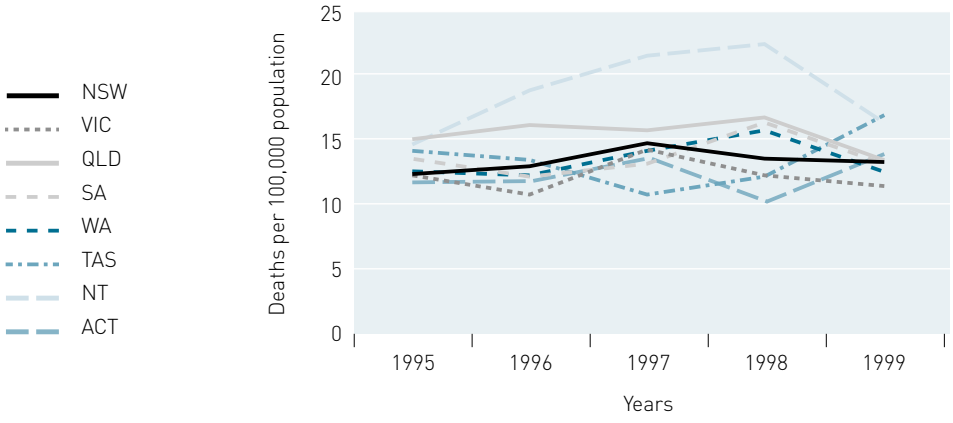


Figure 1.3

Suicide death rates by State and Territory (1995-1999)

Source: ABS (2001a)

International comparisons

Suicide rates also vary widely across countries. In the Western world, over time, high suicide rates have been observed in Western Europe and Scandinavia. For example, the suicide rate for males in Austria in 1994 was 33.0 per 100,000, while for males in Finland the rate was 43.6 per 100,000. In comparison, Southern Europe has had low suicide rates (Cantor, 2000); the suicide rate for males in Greece in 1994 was 5.5 per 100,000. In Asia and the Far East suicide rates differ considerably among countries. In 1994, Sri Lanka and China recorded the highest rates, being 43.4 and 25.8 per 100,000, respectively. The lowest rate was recorded in Bahrain, being 1.4 per 100,000 for the male population (Cheng & Lee, 2000). Differences in suicide death rates throughout the world may be partly explained by differing cultural values and practices in collecting and interpreting suicide death data.

In comparison to the rest of the world, Australia's overall suicide rate is average. In 1994, the country's overall male suicide rate was 18.7 per 100,000 (ranked 28th out of 51 countries) and its female rate was 4.5 per 100,000 (ranked 31st ; WHO, 1996; cited in Cantor et al., 2000). However, with respect to youth suicide (15-24 years), Australia has one of the higher rates. In 1994, Australia's male youth suicide rate was 23.7 per 100,000 (ranked 13th out of 51 countries; WHO, 1996; cited in Cantor et al., 2000).

Populations with high prevalence of suicidal behaviour

Both international and Australian data show that specific populations have higher suicide rates than exist in the general population. In Australia, there is evidence to suggest that Aboriginal young people are over-represented in suicide rates. A Queensland study found that the suicide rate for 15-24 year old male Aboriginals was 112.5 per 100,000, while the Queensland population suicide rate for this age group was 30.9 (Baume, Cantor & McTaggart, 1997; cited in Cantor et al., 2000). Similarly, young people in custody, young people with serious physical illness or disability, and homeless young people have a higher incidence of suicidal behaviour compared with the general population (see Centre for Mental Health, 2000).

A growing body of research evidence documents that same-sex attracted young people exhibit higher levels of suicidal behaviour than other young people. For instance, Nicholas and Howard (1998) found that gay-identified youth were 3.8 times more likely to report having made a suicide attempt than their heterosexual peers.

Several countries have examined the extent to which suicide rates are higher in rural compared with urban regions. In Australia, suicide rates for males aged 15-24 years are higher for those in rural and remote areas compared with those in urban areas, with these rates being almost twice as high in remote areas compared with capital cities (see Beautrais, 2000).

Method of suicide

Figures 1.4 and 1.5 present the method of suicide deaths as a proportion of total suicide deaths for Australian males and females for the years 1995 to 1999. As shown, hanging has consistently been the most common method of death for males throughout the years 1995 to 1999. For females, while the use of poisoning by drugs decreased over the years, hanging has been the most common method of death since 1997. While poisoning by drugs is now the second most commonly used means for females, it is the least frequently used method by males.

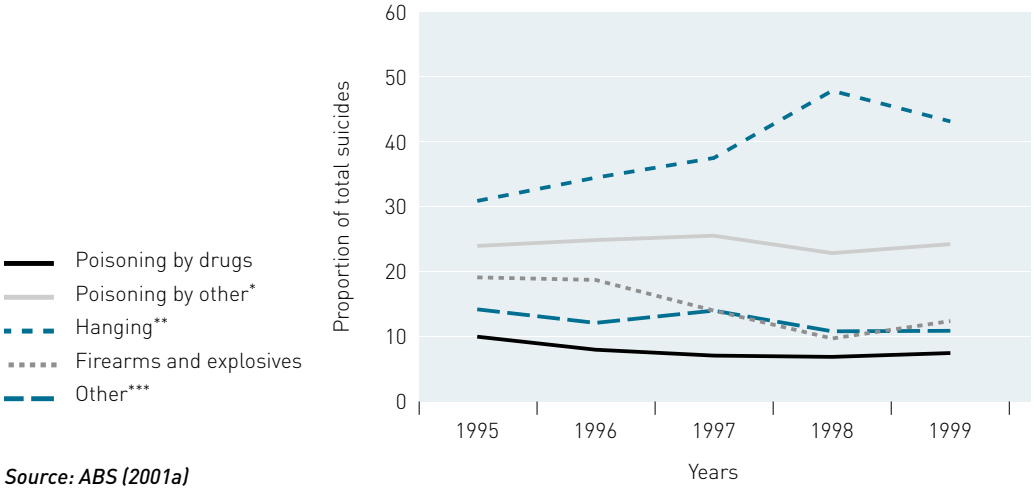


Figure 1.4

Male suicides by method, proportion of total suicides

Source: ABS (2001a)

**** Includes other solids and liquids and gases and vapours.***

***** Includes strangulation and suffocation.***

****** Includes drowning, cutting/piercing instruments, jumping from high places, and other unspecified means.***

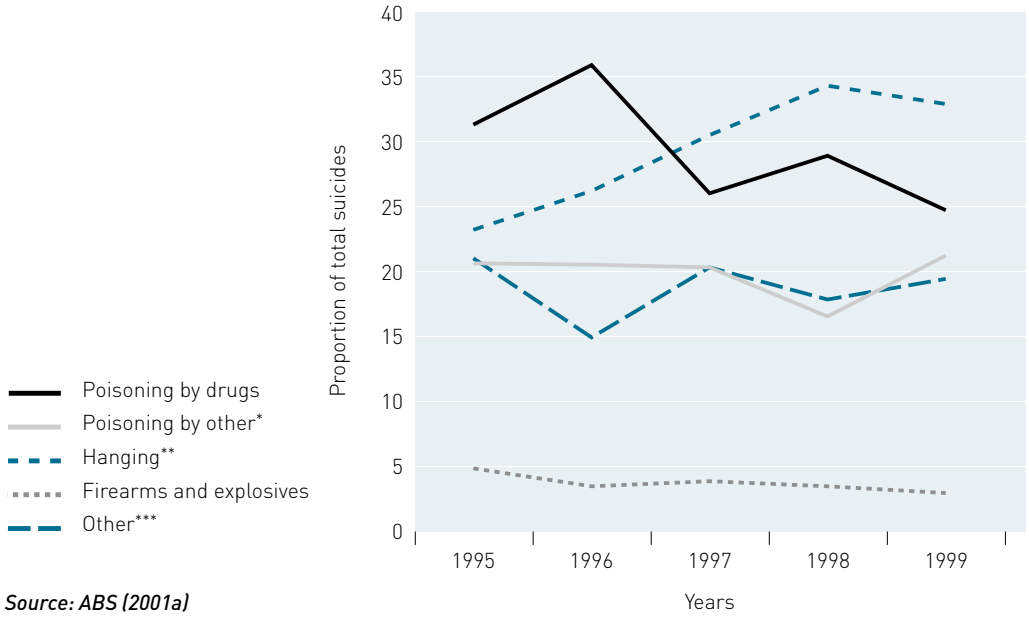


Figure 1.5

Female suicides by method, proportion of total suicides

Source: ABS (2001a)

**** Includes other solids and liquids and gases and vapours.***

***** Includes strangulation and suffocation.***

****** Includes drowning, cutting/piercing instruments, jumping from high places, and other unspecified means.***

Suicide deaths versus attempts 1.4

The term 'attempted suicide' is used to refer to a self-inflicted, non-accidental injury that does not result in death (Centre for Mental Health, 2000). Research evidence shows that people who attempt suicide are at high risk for future fatal and non-fatal suicidal behaviour (Kerkhof, 2000).

Despite this finding, the connection between attempted suicide and suicide death is not entirely clear. Two main views exist. On the one hand, it has been argued that these

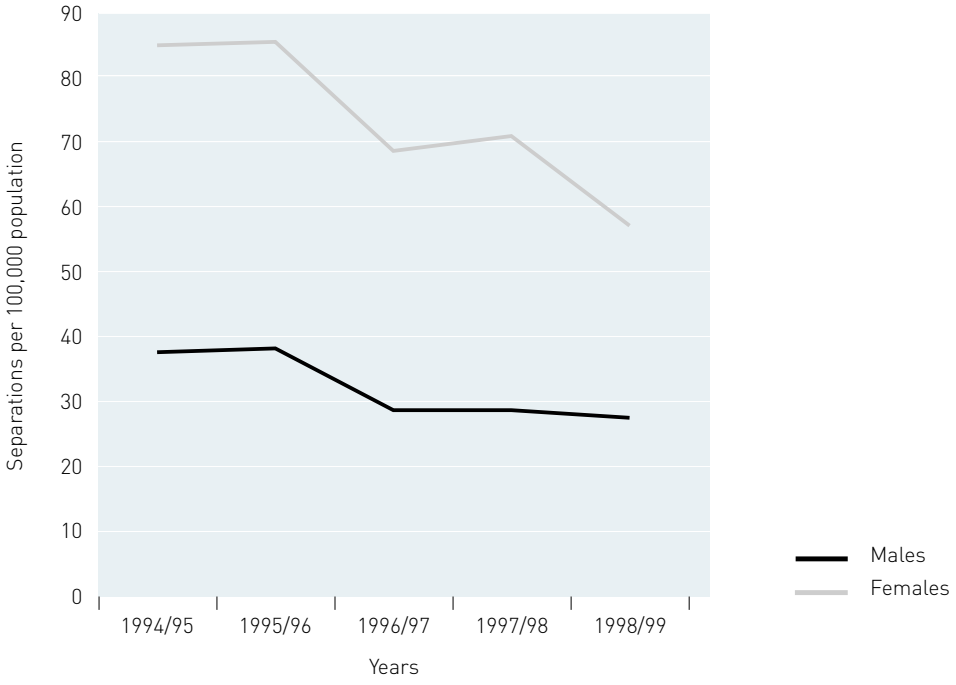
behaviours form a continuum of self-harming behaviours of increasing severity, starting from suicidal thoughts or ideation and leading to suicide plans and attempts, which may result eventually in suicide death (van Heeringen, Hawton & Williams, 2000). Alternatively, it has been argued that suicide attempts are epidemiologically distinct from suicide deaths (see Williams, 1997). While the patterns and trends of suicide and of attempted suicide (for example, differences in age and sex distributions) would suggest that they constitute two different phenomena, the co-variance of attempted suicide and suicide rates, and the increased risk of suicide death following a suicide attempt, provide strong arguments for the continuum of suicidal behaviours (van Heeringen et al., 2000).

Whatever the nature of the relationship, it is clear that suicide attempts occur with far greater frequency than suicide deaths. For every suicide death, between 30 and 40 people may attempt suicide (Centre for Mental Health, 2000). These figures may still underestimate the extent of attempted suicide. Rates for suicide attempts are derived from hospital admission data and many people who attempt suicide do not present to hospital. For instance, when there is no need for hospital admission, those who attempt suicide may be treated by general practitioners, or may not even come to the attention of a medical professional (Kerkhof, 2000). Another reason relates to the fact that there are no widely accepted definitions or reporting procedures for suicide attempts (Centre for Mental Health, 2000).

Figure 1.6 presents data for suicide attempts of 12-17 year old males and females in NSW for the years 1995 to 1999, as standardised hospital separation rates[4]. These data were analysed by financial year, beginning on July 1 of a given year through to June 30 of the following year.

Figure 1.6

Hospital separation rates for suicide attempts for 12-17 year olds in NSW (1995-1999)



[4] The term 'hospital separation' refers to the end of an episode as a hospital inpatient (for example, by discharge, transfer or death).

As Figure 1.6 shows, in contrast to suicide deaths, attempted suicides occur far more frequently in females than males. This may be attributed to the finding that males are more likely to use more violent and more lethal methods than females, resulting in immediate death (Hassan & Tan, 1989). Figure 1.6 also shows that hospital separation rates have declined overall for both males and females over the years, although this decline has been more pronounced in females.

Suicide is typically viewed as a male problem. Yet data for attempted suicides show that females outnumber males. It has therefore been suggested that when the figures for fatal and non-fatal suicidal behaviour are examined together, the gender differences become modest (Cantor et al., 2000). Thus, suicidal behaviour is a problem for both males and females.

In summary:

- Males have higher suicide death rates than females across all age groups. Females, however, consistently outnumber males in suicide attempts.
- Males older than 85 years have the highest suicide rates of any age group in NSW. Females aged 12-17 years have the lowest rates.
- Suicide rates differ among the States and Territories and across the world. Australia's overall suicide rate is average in comparison to the rest of the world.
- In Australia, hanging has been the most common means of suicide death for both males and females since 1997.

Adolescent risk-taking: The size of the problem 1.5

Risk-taking in adolescence is often viewed as a 'normal part of growing up' (Baumrind, 1987) and researchers have noted that healthy risk-taking behaviours can positively impact upon the developing adolescent (Abbott-Chapman & Denholm, 2001). While some degree of risk-taking is therefore important for adolescent identity formation and consolidation and the push toward autonomy, the taking of certain risks can have grave and lasting consequences. Alcohol and other drug use, and reckless driving, are two risk-taking behaviours commonly associated with adolescents, both of which can have serious ramifications (Hewitt et al., 1995).

Alcohol and other drug use

Surveys consistently reveal that more adolescent males and females have tried alcohol than any other drug type (Hewitt et al., 1995). For example, in a 1996 survey of Australian secondary students' use of over-the-counter and illicit substances, alcohol was the drug most frequently used. About 30% of 13 year olds and about 70% of 16 year olds had used alcohol in the previous month. Cannabis was the most commonly used illicit substance, with 36% of all secondary students aged between 12 and 17 years reporting the use of cannabis at some time in their life. Over half of 16 and 17 year olds surveyed had tried cannabis, and around 20% of students overall had used cannabis in the month prior to the survey. In contrast, less than 2% of 12-17 year olds reported having used opiates or cocaine in the month prior to the survey (Letcher & White, 1999).

Similar levels of alcohol and other drug use among adolescents have been reported overseas. In the United States for example, a 1999 national school-based survey, the Youth Risk Behavior Surveillance System (YRBSS) found that 50% of students reported having had at least one alcoholic drink in the month preceding the survey. Around 27%

of students had used cannabis, 4% had used cocaine and 2.4% had used heroin in the month prior to the survey (Centers for Disease Control and Prevention, 2000).

While adolescent substance use is a problem for both males and females, evidence suggests that males typically start drinking alcohol at an earlier age than females and are more likely than females to drink heavily and to experience alcohol-related problems (Spooner, Mattick & Howard, 1996).

Both Australian and US surveys have revealed that alcohol and other drug use has become more of a problem in recent years. In a 1998 survey of 15-17 year olds in three Australian states, 78% of adolescents reported that 'more' people their age were drinking too much alcohol compared with 12 months ago (Shanahan & Hewitt, 1999). Similarly, results from the YRBSS Survey show that the frequencies of adolescent cannabis, cocaine and heroin use have all increased since the first survey was conducted in 1990 (Centers for Disease Control and Prevention, 2000).

There are many negative consequences of alcohol and other drug use. Substance use and abuse can lead to a wide range of problems, including physical health, legal, economic, social, family and psychological problems (Spooner et al., 1996). The most extreme consequence of substance use is, of course, death. In 1997, substance-related deaths accounted for 11% of all deaths of 12-24 year olds in Australia (Moon, Meyer & Grau, 1999). This is not reflective of all substance-related deaths, as deaths of young people by alcohol-related causes are underestimated in these data due to the non-inclusion of motor transport accidents that are alcohol-related. In 1996, 28% of male and 8% of female driver/rider motor vehicle accidental deaths among young people aged 16-19 years had a blood alcohol concentration greater than or equal to 0.10g/100mL. Also in 1996, 69% of male and 50% of female pedestrian accidental deaths among young people aged 16-19 years had a blood alcohol concentration of greater than or equal to 0.10g/100mL (Moon et al., 1999). Overall, data show that alcohol is the leading cause of road traffic accidents.

Reckless driving

The majority of the literature on accidental injury among young people has focused on motor transport accidents. The road fatality rate among young people, in particular among young males, has been of great concern, with researchers concentrating on risk-taking behaviours such as speeding, alcohol consumption and driving, failure to wear seat belts, and on the influences of age and experience on young driver risk (Moller, 1995).

Deaths due to motor transport accidents are twice as high in the 15-24 years age group than in any other age group. In 1998, young people in NSW aged 17-25 years represented 16% of all licensed drivers and riders, yet accounted for 30% of all drivers or motorcyclists killed or seriously injured (Richardson, 2000; Williamson, 2000).

Young males are significantly over-represented in road accidents compared with young females. In Australia in 1998, in the 17-25 year age group almost four times as many male drivers were killed compared with female drivers (Federal Office of Road Safety, 1999). Young driver accidents are more likely to involve excessive speed, loss of control or running off the road, alcohol and other drugs, and non-wearing of seat belts (Hombsch, 1999).

Reckless driving among young people is not limited to Australia. Results from the YRBSS Survey (1999) showed that 33.1% of adolescents surveyed had ridden with a driver who had been drinking alcohol in the month prior to the survey, and 13.1% had driven a vehicle themselves after consuming alcohol (Centers for Disease Control and Prevention, 2000).

Closer to home, in New Zealand in 1997 alcohol and speed were the major contributing factors for young drivers involved in fatal crashes. Young drivers aged between 15 and 24 years were about twice as likely to have speed and alcohol as factors in fatal crashes than drivers over the age of 25 years (New Zealand Land Transport Safety Authority, 1999).

Drivers pose the highest fatality risk among road-user categories. In Australia in 1990, 36.7% of 15-19 year olds who died on the road were drivers of motor vehicles. The category of road users next most at-risk was passengers, with 30.7% of 15-19 year olds who died on the road being passengers in motor vehicles (see Hewitt et al., 1995).

In summary:

- Some engagement in risk-taking behaviour is commonly seen as a normal and necessary part of being an adolescent.
- Substance use and reckless driving are two risk-taking behaviours that are widespread among adolescents. Engagement in such behaviour can have serious harmful consequences, including death.

The next section of this chapter details the various theories that have attempted to explain engagement in suicidal behaviour in the general population, and suicide and risk-taking behaviour among adolescents.

Explaining suicide: Cultural aspects 1.6

Cultural factors are important in any attempt to explain suicidal behaviour. Attitudes to suicide differ among countries and cultures, and have changed considerably over time. Throughout history suicide has taken on different meanings and values; for example, it has been or is an unforgivable sin, a psychotic act, a human right or a ritual obligation (Boldt, 1988). In most Western countries, suicide attempts were decriminalised only in the 1960s and 70s and many religions continue to act as inhibitors to suicide. In contrast, some aspects of modern youth culture, such as heavy metal music, may portray suicide in positive terms (Cantor, 2000).

Suicide rates in certain countries can in part be understood by culture-related issues. In Japan, for example, suicide by disembowelment with his own sword (or *hara-kiri*) was traditionally seen as an honourable means for a defeated Samurai warrior to redeem himself or to prevent capture. The procedure ended with the closest friend of the person beheading him with a sword (Maris, Berman & Silverman, 2000).

There have also been and continue to be political suicides in some countries. Examples include the suicide bombings currently occurring in the Middle East and the Japanese kamikaze pilot suicide missions in World War II. It must be noted, however, that individuals who kill themselves in fulfilment of their mission are not primarily suicidal. Rather, they may be willing to sacrifice their lives for a cause or to advance an ideology, or to martyr themselves in service to a charismatic leader against a perceived enemy (American Association of Suicidology, 2002).

1.7 Explaining suicide: Biological aspects

There is increasing evidence that suicidal behaviour may in part be explained by biological and genetic factors. This evidence suggests that at least part of the genetically determined risk for suicidal behaviour is mediated by the serotonergic system. Specifically, several studies have shown low or below average levels of the neurotransmitter serotonin and/or its metabolite (5-HIAA) in the cerebrospinal fluid of individuals who attempt suicide, compared with levels in non-suicidal control subjects (see Beautrais, 2000). In addition, studies of post-mortem brain tissue have reported anatomical changes in the prefrontal cortices of individuals who have died by suicide consistent with reduced serotonin function (Beautrais, 2000; Traskman-Bendz & Mann, 2000).

Little is currently known, however, about the ways in which the serotonergic system and suicidal behaviour are linked. The explanations that have been proposed centre on findings that low serotonin levels are linked to poor impulse control, behavioural disinhibition and aggression. Such impairment may increase suicide risk (Beautrais, 2000; Traskman-Bendz & Mann, 2000).

1.8 Explaining suicide: Psychiatric aspects

Suicidal behaviours can occur in association with many psychiatric disorders, the most common association being with mood disorders (Apter & Freudenstein, 2000). Evidence to support these claims typically derives from psychological autopsy studies that examine the prevalence of psychiatric disorders among those who have died by suicide. More than half of clinically depressed individuals have suicidal thoughts. The risk of suicidal behaviour fluctuates during the course of depressive illnesses, with the highest risk typically occurring just after discharge from hospital treatment (Lonnqvist, 2000).

Substance abuse disorder is the second most frequent psychiatric precursor to suicide in the general population (Murphy, 2000) and is also an important risk factor for adolescent suicide (Shaffer, Gould, Fisher, Trautman, Moreau, Kleinman, & Flory, 1996). Substance abuse together with depression increases suicide risk even further in both young people and adults (Murphy, 2000).

Schizophrenia is another mental disorder that places individuals at-risk for suicide. It is estimated that 10% of all schizophrenic patients suicide and that the risk of suicide in the schizophrenic population is 40 times higher than in the general population (De Hert & Peuskens, 2000).

Many people who exhibit suicidal behaviour have multiple or co-morbid mental disorders (Lonnqvist, 2000), and there is evidence to suggest that the risk of suicidal behaviour increases with increasing numbers of psychiatric disorders (Beautrais, 2000).

While there is no doubt that mental disorder is a risk factor for suicide, most individuals with a mental disorder will not commit suicide. Moreover, not all individuals who commit suicide meet the criteria for a mental disorder. Thus psychiatric disorders alone are unable to fully explain suicidal behaviour.

1.9 Explaining suicide: Psychological aspects

It has been suggested that certain psychological mechanisms or personality factors are

the characteristics that distinguish suicidal from non-suicidal individuals (van Heeringen et al., 2000). Impulsivity, cognitive style and hopelessness are among factors that have been implicated.

Impulsivity describes the extent to which an individual is prone to hasty, rash or reckless behaviour (Beautrais, 2000). Most of the research on suicide and impulsivity has focused on adolescents. Those studies have found that the majority of adolescent suicides are unplanned, impulsive acts (Hoberman & Garfinkel, 1988; Shaffer, Gould, Fisher, & Trautman, 1988). Further evidence for an association between impulsivity and suicide comes from neurobiological studies. As mentioned in Section 1.7, those studies have shown that impulsivity is biologically mediated by the serotonergic system, which has also been associated with suicidal behaviour.

Researchers have also used cognitive style variables, such as dichotomous thinking, in an attempt to account for suicidal behaviour. Dichotomous thinking refers to the tendency to think in extreme, all-or-nothing terms (Williams & Pollock, 2000); for example, 'If I don't pass my exams, then life isn't worth living'. Research has shown that suicidal individuals are more rigid and extreme in their thinking than non-suicidal individuals, such that when faced with a negative situation they may believe that there is no escape from that situation (Neuringer, 1976; cited in Williams & Pollock, 2000).

Similarly, the available evidence supports an association between the personality variable hopelessness and suicidal behaviour. Hopelessness refers to the extent to which an individual feels defeated or that there is little chance of escape from an unbearable situation (Williams & Pollock, 2000) and thus turns to suicide in the belief that nothing will change in the future. Williams and Pollock (2000) further claim that hopelessness is one of the main factors mediating the relationship between depression and suicide.

Explaining suicide: Sociological aspects 1.10

Durkheim in his seminal study *Suicide* (1897) proposed a high suicide rate as an index of ineffective social bonds. Durkheim saw social bonds as relating an individual to society by attaching him or her to socially given purposes and ideals, and regulating his or her individual desires and aspirations.

On this basis, Durkheim described four conditions that weaken social bonding and thus increase the likelihood of committing suicide. The first is egoism, which arises when the bonds attaching an individual to society are too weak. The second is altruism, which arises when the individual is too strongly integrated into society; that is, when he or she is not autonomous. The third and fourth conditions do not depend on how individuals are attached to society, but on how society regulates them. Anomie refers to the condition where the bonds regulating society are too weak. Fatalism arises when the bonds regulating society are too strong; that is, when society holds the individual in too firm a grip (Lukes, 1973; Bill-Brahe, 2000).

In sum then, Durkheim's theory of suicide, proposed that when the social context fails to provide individuals with adequate sources of attachment and/or regulation, at the appropriate level of intensity, their psychological health is impaired and vulnerability to suicide is increased (Lukes, 1973).

Other sociologists have sought to account for suicidal behaviour from different

theoretical frameworks, with cultural explanations and economic approaches as two examples. The view that suicide can be explained in terms of cultural factors has been described in Section 1.6. Economic approaches view suicide from the perspective of a costs/benefits problem. If the perceived costs of continuing one's life outweigh the benefits of ending it, the probability of suicide increases (Stack, 1982).

1.11 Explaining suicide: Imitative and contagious effects

Suicide contagion is said to occur when exposure to suicidal acts appears to trigger copycat suicidal acts. The 'suicide contagion hypothesis' states that for individuals who are already vulnerable to suicide, exposure to acts of suicide is a risk factor (Marsden, 2001).

Semantic priming has been thought to play a role in suicide contagion. Priming refers to the idea that the interpretation of situations can be involuntarily patterned by recent and frequently experienced events. In other words, when a concept becomes the focus of attention, that concept and related concepts in an individual's memory are easier to retrieve; the mind is primed with those concepts and will use them to interpret situations (Fiske & Taylor, 1991; cited in Marsden, 2001). Thus, exposure to acts of suicide has a short-term impact on the extent to which a predisposed individual may exhibit suicidal behaviour.

Imitation is one method by which contagion may occur (Beautrais, 2000). In its most basic form, behaviourism holds that all behaviour is learned. Bandura's (1977) social learning theory states that modelling and imitation are particularly important ways in which behaviour is learnt. According to the theory, some suicides may be explained as an imitation of the behaviour of others. Examples of suicide by imitation include suicides that occur following the widespread exposure of a suicide through the mass media, and suicides that occur around the anniversary of a similar event within the family or peer group of the persons involved (Hazell, 1998).

Research evidence indicates that imitation effects of suicidal behaviour depend on several factors, including the characteristics of the model (for example, age, gender, race and social status) and the extent to which the behaviour of the model is positively reinforced (Schmidtke & Schaller, 2000).

1.12 Explaining suicide: An integrative approach

From the findings outlined in the previous sections, it is clear that suicidal behaviour is not attributable to one single cause. Rather, an adequate account requires an integrated complex of causal factors within which situational and individual factors may exert variable influence on a case-by-case basis. In other words, an understanding of the emergence of suicidal behaviour requires a theoretical framework that includes cultural, biological, psychiatric, psychological, sociological and environmental aspects.

While it is evident that multiple factors interact to influence the occurrence of suicidal behaviour, the extent to which these influences are specific to suicidal behaviour remains unclear. For example, while it is believed that serotonin levels may affect suicidal behaviour, research has also pointed to the role of serotonin in eating and anxiety disorders (van Heeringen et al., 2000). Thus the lack of specificity of those factors associated with suicide makes it extremely difficult to isolate the causes of suicide at the individual level.

Suicide and risk-taking in children and young people: A developmental perspective 1.13

It has already been established that the risk factors for suicide are numerous and complex and that adequate accounts of engagement in such behaviour require the multiplicity of risk factors to be taken into account. However, the theories explained previously neglect a crucial requirement for any comprehensive explanation of suicide among children and young people: they pay no attention to adolescent development.

Early pioneering research concerning adolescence commonly assumed that the difficulties and turmoil associated with adolescence as a time of 'storm and stress' represented normal adolescent development (Peterson, 1988). That view is generally no longer accepted, with research evidence now indicating that most adolescents do not experience excessive difficulties during this developmental period (Heaven, 1994). Research attention has turned to the factors that promote or impede successful development, most notably family influences, peer relationships and school experiences (Heaven, 1994), since it is generally believed that their interplay significantly influences the developing adolescent (Coleman & Hendry, 1990).

Among the many influences on the healthy functioning of the family and its individual members, parenting style, and in particular the nature of communication between parents and adolescents, has been implicated as a critical factor in shaping the successful transition from adolescence to adulthood (Noller & Patton, 1990). A high degree of parent-adolescent conflict, for example, has been shown to have a negative impact on adolescent development (Peterson, 1988), with possible outcomes including engagement in delinquent behaviour (Wasserman, Miller, Pinner & Jaramillo, 1996), substance abuse (Shek, 1997) and suicide (Brent, Perper, Moritz, Baugher, Roth, Balach & Schweers, 1993).

Peer relationships also have a significant influence on adolescent development (Heaven, 1994), which is perhaps not surprising, since adolescence is characterised by an increasing amount of time spent with peers at the same time as that spent with family decreases (Larson & Richards, 1991). Acceptance by peers is of crucial importance to the adolescent. This is supported by findings that adolescents who participate in peer activities report themselves to be less lonely, shy or socially anxious than their less sociable counterparts (Coleman & Hendry, 1990), and that adolescents who have experienced problems in peer relationships, such as bullying, are more likely to exhibit suicidal ideation (Rigby & Slee, 1999).

Peer relationships are particularly important within the schooling context, although school experiences have a far broader influence on adolescent development (Heaven, 1994). Adolescence coincides with the transfer from primary to high school[5]. That move has the potential to negatively affect emotional adjustment, since many students find the large, impersonal and departmentalised aspects of secondary schooling alienating and unsupportive (Poole, 1990; Azar, 1996). In addition to the school transition, however, the school climate is of great significance to adolescent development (Santrock, 1987). A great deal of research evidence has linked unhappiness about the school environment with poor motivation and alienation and, in more extreme cases, with antisocial behaviour and suicide (Poole, 1990).

[5] In NSW, children are already 12 years of age or are turning 12 years of age when they enter high school.

Taken together, in contrast to the early view that adolescence is inevitably a difficult period, researchers have begun to focus on the way various aspects of the adolescent experience can protect or predispose during this period of human development. This research study focused on those aspects that predispose the adolescent to suicide and risk-taking.

The role of puberty

It has long been hypothesised that the experience of pubertal development shapes and interacts with other transitions in ways that impact adolescent mental health (Brooks-Gunn, Graber & Paikoff, 1994; cited in Graber, Lewinsohn, Seely & Brooks-Gunn, 1997). Indeed, several studies have shown that mental health problems and suicidal behaviour become increasingly common after the onset of puberty (e.g. Hawton, Fagg & Simkin, 1996; Verberne, 2001).

The timing of the onset of puberty has been thought to be the most important factor in determining the extent to which pubertal development is associated with poor mental health outcomes (Graber et al., 1997). Girls' and boys' progression through puberty is different, with girls generally maturing earlier than boys. Early maturing girls and late maturing boys (relative to their peers) are hypothesised to be at greater risk for adjustment problems than other groups, given that they are the two most 'off-time' groups (Brooks-Gunn & Reiter, 1990). Early maturing girls begin puberty before any other children and so it is posited that they are at-risk for mental health and other problems because they are less well prepared for the physical, psychological and social changes that accompany pubertal development. Late maturing boys begin puberty after all other adolescents have passed these events and may experience psychosocial problems or feelings of inferiority due to their less mature appearance (see Graber et al., 1997).

Consistent with this hypothesis, research has shown that early maturing girls are more likely than other girls to exhibit depression, eating disorders and delinquent behaviour as well as general behaviour problems (see Graber et al., 1997). Furthermore, early maturing girls may engage in behaviours such as smoking, drinking and sexual intercourse at an earlier age (Brooks-Gunn & Reiter, 1990).

The average age at onset of puberty shows a secular trend over the past century toward earlier occurrence (Brooks-Gunn & Reiter, 1990), although this trend appears to have slowed or ceased over the last 30 years (Viner, 2002). Lee, Kulin and Guo (2001) argue that the data suggest that puberty is beginning earlier than previously thought, although only for pubertal breast development in females. Specifically the data show that the median age of onset has declined to 9.6 years. Prior reports indicated the mean age of onset was 10.5 to 11.3 years. Lee et al. (2001) further claim that although data suggest that puberty is beginning earlier and such beliefs are becoming widespread, it is not being completed earlier nor is menarche occurring earlier. Rather, puberty among those with early onset may be progressing at a slower pace, or the initial appearance of breast growth may not signal the real onset of puberty.

Taken together, regardless of whether the age of onset of puberty has lowered, the primary issue of concern relates to 'off-timers', that is, early maturing girls and late maturing boys. Data show that these boys and girls are at greater risk for a range of mental health problems (Graber et al., 1997).

The next section of this chapter details the various methodologies that have been employed in the study of suicidal behaviour.

Research methodologies 1.14

Three major research methodologies are commonly used to investigate suicidal behaviour; psychological autopsies, longitudinal studies and case control designs.

Psychological autopsies

Psychological autopsy studies are an example of descriptive research. Descriptive research aims to 'describe social systems, relations or social events, providing background information about the issue in question as well as stimulating explanations' (Sarantakos, 1998, p.6). This type of research attempts to provide an accurate picture of a particular situation or phenomenon without trying to establish cause-and-effect relationships. Descriptive research usually takes the form of observational research (observing people in their everyday environments), survey research (questionnaires, interviews), case studies (in-depth analysis of a single case) or archival research (examination of public or private records and letters).

In suicide research the most common descriptive studies use the psychological autopsy method. The primary goal is to reconstruct the sequence of events and factors that led to the suicides (Beautrais, 2000). This information is gathered by interviewing the relatives, friends and other associates of the people who have committed suicide about the individual's mental state, psychiatric and physical diagnosis, contact with health professionals, and communication of suicidal ideas and plans. For example, Brent, Baugher, Bridge, Chen, and Chiappetta (1999) interviewed the parents, siblings and friends of the 140 adolescent suicide victims in their study about the circumstances of the suicide, stressors, psychopathology, family history, and access to methods.

The main advantage of descriptive research in general is that it can provide a great deal of detailed, descriptive information. Thus the strength of the psychological autopsy method is that it may provide a detailed account of the circumstances that led to the suicide. Descriptive research is, however, limited in that there is no comparison group, and cause-and-effect relationships cannot be established. In addition, psychological autopsy studies are retrospective, which means that informants may be biased in their recall of events.

Longitudinal studies

Longitudinal studies involve choosing a group of participants and measuring them repeatedly at selected intervals to note changes that occur over time in specified characteristics. In suicide research, longitudinal studies measure risk factors prospectively before the onset of suicidal behaviours. A cohort is studied over a period of time, with assessments of exposure to risk factors being made at regular intervals and the cohort being assessed for the onset of suicidal behaviours (Beautrais, 2000). For example, Fergusson, Woodward and Horwood (2000) investigated the development of suicidal ideation and suicide attempts using a longitudinal design. Participants belonged to a New Zealand birth cohort that had been studied at regular intervals from birth to age 21 years as part of the Christchurch Health and Development Study.

By measuring risk factors prior to the development of suicidal behaviour, it is possible

to assess the extent to which prior exposure to a risk factor leads to a consequent increase in suicidal behaviour. The major limitation of such studies is that suicides are usually rare in a cohort. The low prevalence of suicide deaths means that suicidal ideation and attempts are often studied. In addition, longitudinal studies are time consuming and costly (Beautrais, 2000). For these reasons, relatively few studies have used longitudinal designs in studying suicide.

Case control designs

Case control studies improve on the psychological autopsy method by including a comparison group of those not exhibiting suicidal behaviours. A sample of individuals exhibiting suicidal behaviours is compared with a sample of those not exhibiting suicidal behaviours on a series of risk factors (Beautrais, 2000). For instance, Cheng, Chen, Chen and Jenkins (2000) examined the individual and combined effects of psychosocial and psychiatric risk factors for suicide using a case control design. Subjects were 117 suicide victims and 226 living individuals. The individuals in the comparison group were randomly selected from the census records.

The major limitation of this design is its vulnerability to recall bias, as information about risk factors is collected retrospectively after the suicidal behaviour has developed (Beautrais, 2000).

The three methodologies outlined above all rest on the assumption that suicide is the result of some series of events common to all individuals. It is possible, however, that the underlying causes leading to suicidal and risk-taking behaviour are different for different individuals or for different types of individuals. Specifically, young people engage in drug use for different reasons and it is most likely they take their lives for different reasons.

This study sought to extend existing knowledge regarding suicide and risk-taking among children and young people by examining the extent to which there is diversity in the backgrounds and experiences of children and young people who die in these ways.

Chapter two

Methodology

Aim of study 2.1

The aim of the research project was to study the population of all deaths of children and young people in NSW by suicide or risk-taking over a five-year period (January 1996 to December 2000), with a view to addressing the following questions:

1) What are the factors associated with and the circumstances surrounding suicide and risk-taking deaths of children and young people?
2) To what extent did these individuals have contact with human service agencies?
3) What can be done to prevent further deaths of children and young people from suicide and risk-taking?

Age range of cases 2.2

The upper age limit of 17 years and 11 months is set through Child Death Review Team (CDRT; the Team) legislation (*Children and Young Persons (Care and Protection) Act 1998*). It was decided to set the lower age limit at 12 years and no cases of suicide under 12 years of age were identified.

Identification of cases 2.3

The CDRT has maintained a register of all deaths of children 0-17 years of age in NSW since 1 January 1996. This is known as the Child Death Register. Deaths are classified according to the cause of death, demographic criteria and other factors, with a view to understanding the causes of death and preventing further fatalities. The basis of the Child Death Register is death registration data from the NSW Registry of Births, Deaths and Marriages. These data include date of birth, date of death, date of registration of the death, cause of death noted on the death certificate, age of the child, last known residence, parents' names, place and country of birth, Aboriginal and Torres Strait Islander status, and gender.

For each coronial case, additional information is available, including:

- A Police Report of Death to Coroner (P79A), which includes a narrative of the circumstances under which the death took place;
- A Final Post-Mortem Report, including autopsy, pathology and toxicology findings; and
- A Coronial Report (or Dispensation of Inquest).

This study included deaths that were registered during the period January 1996 to December 2000. As there is a routine time lapse in the availability of documentation from coronial cases, only cases for which the Final Post Mortem Report was received by the end of June 2001 were included in the study. This resulted in one young person who died in the chosen time period being omitted from the study.

The Child Death Register was searched from January 1996 to December 2000. This process involved reading the coronial documentation for every case. All suicide cases were selected. A case was included as risk-taking if it was deemed to be an accidental death and if it met one of the following criteria:

- Drug overdose[6];
- Car driver fatality in which the child or young person was driving and was unlicensed, or speeding, or affected by alcohol or other drugs;
- Other motor transport fatality (child or young person as passenger in car, pedestrian, motorcycle rider or bicycle rider) in which the child or young person was affected by alcohol or other drugs;
- Train fatality in which the child or young person was affected by alcohol or other drugs and stood, sat or lay on the train tracks;
- Fall in which the child or young person was affected by alcohol or other drugs;
- Drowning in which the child or young person was affected by alcohol or other drugs; or
- 'Accidental' hanging.

This resulted in 187 cases being selected for inclusion in the study.

2.4 Coding of cause of death

The World Health Organisation has promoted an international classification system for coding mortality data, the International Classification of Disease or ICD (World Health Organisation, 1992). One of the Team's paediatricians coded the cause of death for each of the 187 cases, using ICD-10 coding, the most recent version of this coding.

ICD coding is a classification system that includes codes for deaths from external causes of injury and poisoning. A framework for grouping the external causes of death has been suggested by the United States National Center for Injury Prevention and Control and the United States National Center for Health Statistics (Centers for Disease Control and Prevention, 1997). The framework is a matrix that specifies mechanism of death by intent of injury (for example, suffocation = mechanism, suicide = intent). The cases in this study were coded according to this framework.

2.5 Identification of suicide and risk-taking groups

Three groups of cases were created using the intent codings: intentional deaths (suicide), accidental deaths (risk-taking cases), and deaths for which there was insufficient information available to determine intent (undetermined intent).

As stated, one of the Team's paediatricians coded the cause of death for each of the 187 cases. Differences between the Coroner's and the Team member's determination of the intent of injury were noted for 14 of the 187 cases. These are summarised in Table 2.1.[7] As previously mentioned, coronial legislation does not include any uniform criteria for the recording of suicides (ABS, 2000). Thus, in the absence of any strong evidence (for example, a suicide note), some suicides could be recorded as accidental or

[6] Includes recreational and prescription drugs.

[7] Another Team member independently reviewed the 14 cases for which there were differences in the determination of the intent of injury coding between the Coroner and the Team. There was 100% agreement between the two Team members in their coding.

undetermined. Coroners may also avoid using the term to spare families from the stigma and shame that can often be associated with suicide (Tatz, 1999). Differences between the Coroner's and Team member's determination of the intent of injury may also partly be explained by the fact that the Team sometimes obtains more information than does the Coroner.

Table 2.1

Intent of injury determined by Coroner and by Team member

Number of cases	Cause of death determined by Coroner	Cause of death determined by Team member
6	Accidental	Undetermined intent
4	Accidental	Intentional
2	Undetermined intent	Intentional
1	Undetermined intent	Accidental
1	Intentional	Undetermined intent

Research methods 2.6

This study employed a descriptive archival research design. The study consisted of a case file review of government and other official records and used a combination of narrative (Lieblich, Tuval-Mashaiach & Zilber, 1998) and documentary (Sarantankos, 1998) research methods. First, narratives or case histories were developed for each child and young person by a review of the documents or records obtained. Each case history was organised around five areas:

1) Precipitating incident to death.
2) Life history of child or young person (including individual, family and broader social circumstances).
3) Child or young person's perspective on his or her own well-being.
4) Contact with health, welfare or other professional agencies.
5) Issues for prevention/intervention.

In addition, a data collection tool was developed to record quantitative information. The tool was based on a review of the suicide and risk-taking literature and consisted of variables clustered around the following domains: demographics, family characteristics and childhood experiences, education and employment related experiences, individual circumstances, environmental factors (for example, stressful life events, imitative and contagious factors), circumstances of the death and prior agency involvement (see Appendix 1).

Data sources 2.7

The study consisted of a case file review of records made available to the CDRT. The *Children (Care and Protection) Act 1987* imposes a duty on all government departments, statutory bodies or local authorities to provide the Team with 'full and unrestricted access' to records that the Team reasonably requires for the purpose of exercising its functions.

Different human service agencies serve different roles for children and young people and have different procedures for recording information. This means that the extent of

information documented on file will differ among agencies. As this study was restricted to information on file, for some cases there was a lack of information regarding human service provision. In addition, there may have been an over reliance on the more comprehensive records for some cases.

Once the group of 187 cases was identified, the following records were sought:

Coroner's records

A Police Report of Death to Coroner was obtained for all but one case and a Final Post-Mortem Report was obtained for all but two cases. For one of those cases, the body of the young person was never located. An autopsy was not conducted for the second case as the parents of the young person objected on religious grounds. Complete coronial files were also requested for all of the children and young people in the study and were received for 87% of cases. A complete coronial file contains the Brief of Evidence prepared by investigating police for the Coroner. In cases in which an inquest is held, the inquest transcript and Coroner's findings are also included. In almost all suicide cases in which the child or young person had left a suicide note, the note was also contained on the coronial file. The amount of information available from the coronial files varied, although all cases included a detailed account of the circumstances of the deaths. Information about the lives of the deceased, for example, their family and school circumstances, was recorded less consistently.

Medical records

With the help of the NSW Area Health Services, medical records, where available, were obtained for the deceased children and young people. These included birth records, hospital emergency records and mental health records. At least one type of medical record was obtained for 74% of cases.

Police records

Police records are held on the Computerised Operational Policing System (COPS) and include Apprehended Violence Orders for children and young people and their parents, as both victims and perpetrators, and childrens', young persons' and their parents' criminal histories. One hundred and eighty four of the 187 children and young people had a COPS record of their death. Of those, 76 (40.6%) had a COPS record indicating engagement in offending behaviour.

Department of Community Services' records

For each of the deceased children and young people information was sought from the Department of Community Services to determine whether they or a sibling had been a client of the Department of Community Services. Forty-nine (26.2%) children and young people had been clients of the Department of Community Services and records were obtained for all except one case, whose records could not be located.

Education and school counsellor records

Education and school counsellor records were sought from the NSW Department of Education and Training for the children and young people in the study who attended government schools. Fifteen per cent of the deceased children and young people attended non-government schools. Some education and welfare records were obtained for this group with the assistance of the NSW Catholic Education Commission. In total,

education and/or school counsellor records were obtained for 29.4% of the children and young people in the study[8].

Juvenile Justice records

NSW Department of Juvenile Justice records were obtained for 36 of the 39 children and young people in the study who had been clients of the Juvenile Justice Department.

The amount of information obtained for each case varied from minimal to substantial. In addition, as with all records there are omissions of information and the possibility of error. Several data sources were, however, available for most cases and so the probability of reliable and valid data was increased.

Data analyses 2.8

Data analyses were both quantitative and qualitative in nature. Data collected using the data collection tool were entered into the statistical package SPSS (SPSS, 1999). Due to the nature of the available information, descriptive statistics were the most appropriate to create an overall profile of the cases and to distinguish between groups (for example, suicide and risk-taking).

Incidence rates and trends were also calculated. This report used crude death rates, which showed how many deaths there were per 100,000 children in each age and gender group in the population. Consistent with the Australian Bureau of Statistics and the Australian National Injury Surveillance Unit, rates were not calculated on less than four cases, as such calculations are unreliable.

Case histories were entered into NVivo (Fraser, 2000), a software package for qualitative data analysis, and a content analysis was performed. This involved three stages. First, categories or themes were developed by reading the narratives and defining the content categories that emerged. Additional categories were developed from a literature review of the factors associated with suicide and risk-taking. Second, each narrative was 'coded', which involved assigning relevant sections of the narrative to each category or theme. Finally, the themes or categories that emerged were analysed using a variety of techniques such as clustering, counting, comparing and contrasting, factoring and noting relations between variables (Miles & Huberman, 1994).

During the analysis of human service agency involvement, the NSW Health policy guidelines developed for the management of patients with possible suicidal behaviour were employed (Centre for Mental Health, 1998). In addition, during the analysis of the child protection cases, the interagency child protection practice framework as specified in the *NSW Interagency Guidelines for Child Protection Intervention (2000)* was used. Analyses were conducted with regard to the specific stages in child protection work: recognition and reporting, assessment and investigation, protective intervention, ongoing care and support, and closure.

[8] There are two possible explanations for the proportionately low yield of education and school counsellor records. First, school counsellors are required to open a file only if a significant intervention is put in place for a child or young person. Second, there is no provision under the *Children (Care and Protection) Act 1987* for the CDRT to require records from non-government agencies and, as already stated, 15% of the children and young people in this study attended non-government schools.

A major focus of this study was to determine whether the constellation of factors associated with suicide and risk-taking deaths is the same for all children and young people or whether there are subsets, each having a common background or experience, for which certain factors are most important. Thus, analyses were also performed to investigate the extent to which the factors associated with suicide and risk-taking differed between individuals. A typological analysis was conducted whereby all case histories were compared and contrasted and the children and young people grouped according to common characteristics.

2.9 Methodological limitations and cautions

The accuracy of the information in this report is reliant on the accuracy and completeness of the administrative data that form its basis. The quality and extent of information contained in the records was highly variable, particularly with respect to the children and young people's family and social circumstances, mental health, behavioural and personality characteristics. For example, coronial files typically contained detailed information about the death and the precipitating circumstances, while information about life circumstances was recorded less consistently.

Approximately 42% of the children and young people had no record of contact with human service agencies. The information received for them is therefore restricted to that contained in the coronial file and thus for many in this group, no details at all were available regarding the general circumstances of their lives.

It is also important to clarify from the outset what conclusions can and cannot be drawn from the study findings. This study can describe the population of children and young people who died by suicide and risk-taking over the specific time period. It can also describe the extent to which there are clusters of individuals who died by suicide and risk-taking, having a common background and set of experiences. No conclusions can be drawn from the study findings about cause-and-effect relationships. In other words, this study cannot provide information about the causes of the suicide and risk-taking deaths. This is because the study is retrospective, that is, it attempts to describe the life histories of children and young people after their deaths have occurred. It does not include a comparison group of children and young people who have not died by suicide or risk-taking.

Chapter three

Suicide and risk-taking deaths: Profile of children and young people

This chapter presents the overall profile of the population of 187 suicide and risk-taking deaths. The deaths of the children and young people are first detailed, followed by a description of the demographic background, the circumstances of death, the psychosocial and mental health characteristics of the children and young people, and an overview of whether there had been prior human service agency involvement with the deceased and their families.

Deaths of children and young people from suicide and risk-taking 3.1

It is estimated that in 2000, there were 528,107 children and young people aged 12-17 years in NSW. Over the five-year period January 1996 to December 2000, 814 children and young people aged 12-17 years died in NSW from all causes (natural and external). Within this group, 187 died as a result of suicide or risk-taking, making up 23% of deaths (aged 12-17 years) from all causes in NSW in the five-year period (see Figure 3.1). Suicide deaths alone accounted for 13.6% of deaths (aged 12-17 years) from all causes. Risk-taking deaths alone accounted for 8.1% of deaths (aged 12-17 years) from all causes. Figure 3.1 also shows that it was not possible to determine the intent to die in 1.2% of deaths.

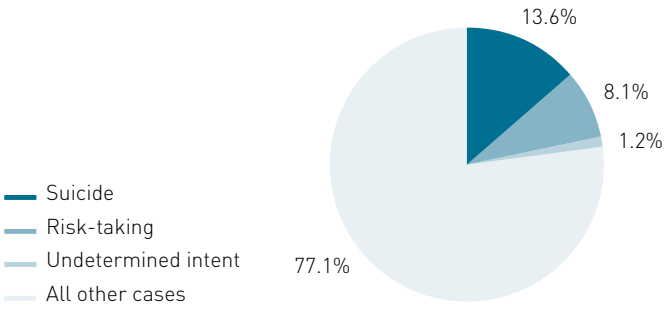


Figure 3.1

Causes of deaths of 12-17 year olds in NSW (1996-2000)

By definition, suicide deaths are intentional and risk-taking deaths are accidental. Table 3.1 shows that suicide accounted for over half (59.4%) of the deaths of the children and young people in the study. It is also important to note that over one-third (35.3%) of the deaths were risk-taking deaths, indicating that considerable numbers of children and young people died while engaging in risky behaviours, such as substance use and dangerous driving. This is an important finding, given the widely held view that engagement in risk-taking behaviour is a necessary and normal part of adolescence.

Table 3.1 also shows that gender is a significant factor; 133 (71.1%) of the 187 deaths were of males.

Table 3.1

Intent of injury by gender: Deaths of 12-17 year olds (1996-2000)

Intent of injury	Females		Males		Total	
	n	% deaths	n	% deaths	n	% deaths
Intentional (by suicide)	37	68.5	74	55.6	111	59.4
Accidental (by risk-taking)	15	27.8	51	38.3	66	35.3
Undetermined intent	2	3.7	8	6.1	10	5.3
Total	**54**	**28.9***	**133**	**71.1***	**187**	**100.0**

****Percentage of total deaths***

Suicide and risk-taking death rates

Figure 3.2 presents the combined suicide and risk-taking crude death rates for the years 1996-2000. This is the rate of deaths for 12-17 year olds per 100,000 12-17 year olds in the population. Across all years, there was a higher rate of deaths from suicide and risk-taking for males than for females. In 1997 there was a sharp increase in the rate of male deaths, but this rate has declined steadily since then. With regard to females, the rate of deaths from suicide and risk-taking remained relatively stable across the five-year period, with the exception of 1999, when there was a marked increase in the rate of female deaths.

Figure 3.2

Death rates of 12-17 year olds: Suicide and risk-taking deaths combined

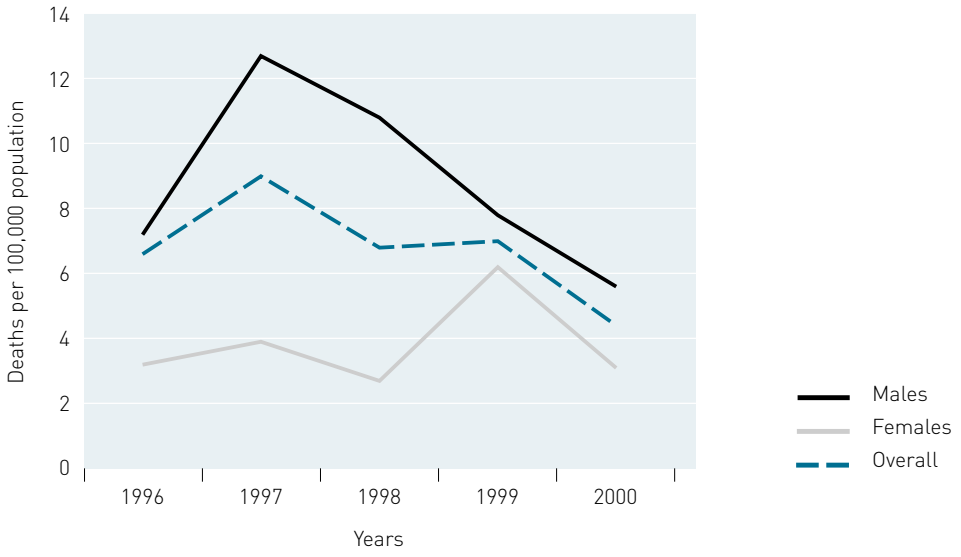


Figure 3.3 presents the rates for suicide and risk-taking deaths separately for the years 1996 to 2000 for 12-17 year olds per 100,000. For suicide deaths, there was a higher rate of males than females in all years except 1999. However, the rates for both males and females declined sharply in 1998. From 1999 to 2000, the suicide rate for females declined, although the rate for males increased slightly. Given the small number of females who died by risk-taking, rates for risk-taking deaths have been presented only for males and females combined. With the exception of 1998, the overall risk-taking death rates were lower than the overall suicide death rates across all years. It is interesting to note that in 1998 there was an increase in overall risk-taking death rates and a sharp decrease in overall suicide death rates. While suicide deaths may well have

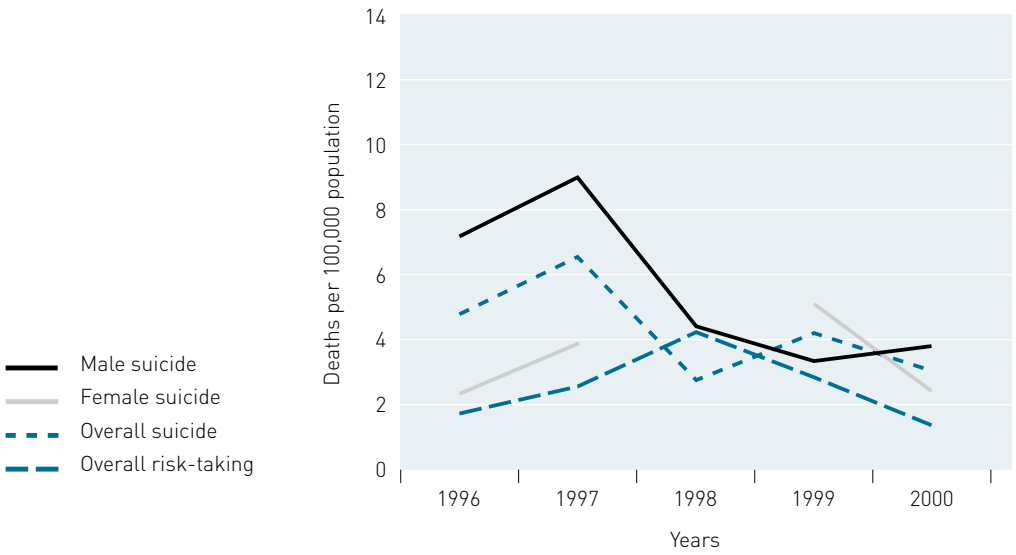


Figure 3.3

Death rates of 12-17 year olds: Suicide and risk-taking deaths separately

Rates for females for 1998 cannot be computed because less than four females died by suicide in that period. Rates are therefore unreliable.

dropped in that year and risk-taking deaths may have risen, another possible explanation is that this is a consequence of the more uncertain suicide deaths being coded as accidental deaths.

The following sections present an overall profile of the children and young people who died from suicide and risk-taking over the five-year period.

Demographics 3.2

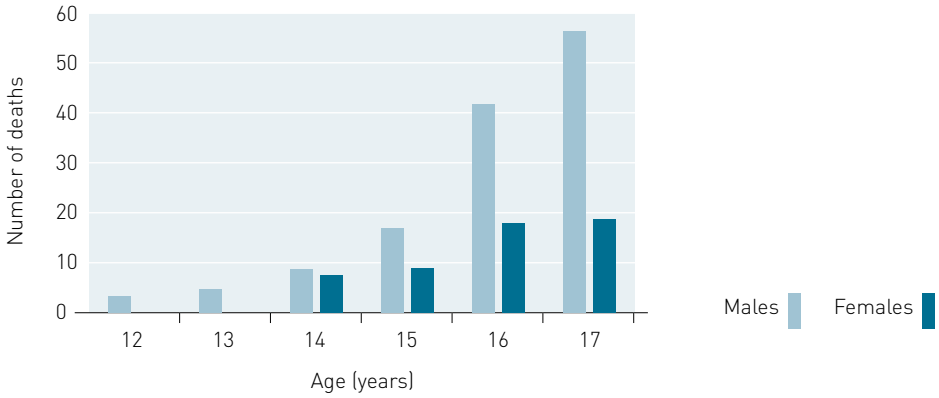
Age and gender

The age and gender distribution of the children and young people who died from suicide and risk-taking is shown in Figure 3.4. The number of deaths from these causes increased with increasing age for both males and females. Deaths among 12 and 13 year olds were extremely infrequent, making up just 4.3% of the population of deaths from suicide and risk-taking. In contrast, 16 and 17 year olds made up 72.7% of the population of deaths from suicide and risk-taking. No females younger than 14 years of age died from suicide or risk-taking in the five-year period. Overall, most suicide and risk-taking deaths were of males. For every death of a female there were more than twice as many deaths of males (the ratio of males to females was 2.5:1).

These findings are consistent with national and overseas data that suicide is not clearly noticeable until the age of 15 to 16 years and that deaths from suicide and risk-taking are most predominant in middle to late adolescent males (Hoberman & Garfinkel, 1988; Cantor et al., 2000). It is, however, important to reiterate that child suicide statistics are most likely under-recorded because of beliefs that children are incapable of understanding the irreversible nature of death. Thus, the low numbers of suicide deaths of children and early adolescents may partly reflect the different data collection practices for children, already noted in Section 1.2 of this report.

Figure 3.4

Children and young people's age and gender



Cultural and linguistic diversity[9]

In 1996, approximately 15% of 12-17 year olds in NSW were born overseas (ABS, 1998). Table 3.2 presents the countries of birth for the overall population of children and young people in the study, with 27 (14.4%) having been born overseas. Seven children and young people spoke a language other than English in the home.

Table 3.2

Children and young people's country of birth

Country of birth	n
Australia	160
South-East Asia	9
New Zealand	5
United States, Canada and United Kingdom	5
Europe (excluding United Kingdom)	3
North-East Asia	2
Other	3
Total	**187**

Indigenous children and young people

Several sources were used to identify Aboriginal and Torres Strait Islander children and young people. These included the Registry of Births, Deaths and Marriages, the Police Report of Death to the Coroner, Department of Community Services' records, Medical records, and Department of Juvenile Justice records. Fourteen children and young people (7.5% of the population of deaths) were identified as Aboriginal by at least two of those sources, nine of the 14 by three or more different sources. No Torres Strait Islander children were identified.

In 1996, Aboriginal children aged 12-17 years comprised approximately 2.8% of all children aged 12-17 years in NSW (ABS, 1998). Aboriginal children and young people

[9] This section has been written in compliance with the Standards for Statistics on Cultural and Language Diversity (ABS, 1999). The Standards are based on four core variables: Country of birth, main language other than English spoken at home, proficiency in spoken English, and Indigenous status.

were therefore over-represented in suicide and risk-taking deaths (7.5%) compared with their numbers in the population ($\chi^2 = 15.1$, $p<.001$). This is consistent with recent research evidence that points to over-representation of young Indigenous suicides (see Cantor et al., 2000).

Place of residence

In NSW, the suicide rates for young people, notably young males, living in rural areas have consistently been higher than for young males living in urban areas. This trend has been evident from 1984/85 onwards (Centre for Mental Health, 2000).

The place of residence of the children and young people at the time of death was coded according to the seven-category rural, remote and metropolitan areas classification (Arundell, 1991). In contrast to existing literature, Table 3.3 shows that children and young people living in rural and remote areas were not over-represented in suicide and risk-taking deaths, compared with their numbers in the population ($\chi^2 = 2.7$, not statistically significant).

Table 3.3

Place of residence at time of death

	Children and young people in the study who lived in each area		12-17 year olds in NSW living in each area*
	n	%	%
Capital city	99	52.9	59.1
Other metropolitan	16	8.6	13.1
Large rural centre	9	4.8	5.5
Small rural centre	17	9.1	8.1
Other rural	27	14.4	13.4
Other remote	5	2.7	0.8
Other**	14	7.5	
Total	**187**	**100.0**	**100.0**

** Source: ABS (1998)*

***Other means the children and young people either had no fixed place of abode or lived outside of NSW.*

In summary:

- Age is a significant factor in suicide and risk-taking deaths of children and young people. The majority of deaths were of 16-17 year olds (72.7%).
- Gender is also a significant factor. The majority of suicide and risk-taking deaths were of males (71.1%).
- Aboriginal children and young people were over-represented in suicide and risk-taking deaths, compared with their numbers in the population.

Circumstances of the death 3.3

Precipitating incident

Precipitating incidents to the deaths could be identified in 97 out of the 187 cases (51.9%). For the suicide cases, most precipitating incidents involved a relationship break-up or an apparently trivial argument with a significant person (family member, girlfriend/boyfriend, friend; 62.2%). A further 12 children and young people had blood

alcohol levels between 0.100g/100mL and 0.396g/100mL recorded in the toxicology report, and so the immediate precipitant was identified as intoxication. In a further 10 suicide cases, the immediate precipitant was identified as being Higher School Certificate-related stress. For 50 suicide cases the immediate precipitant was not recorded on any documentation. The remaining suicides either occurred in the context of chronic mental health problems or there was information to suggest that the child or young person had been planning his or her suicide for some time and that there was no single precipitant leading to the death.

For the majority of risk-taking cases (72.4%), the precipitating incident to the death was recorded as being alcohol or other drug intoxication. All of the risk-taking cases for which no immediate precipitant could be identified were accidental drug overdoses.

Method of death

Table 3.4 presents the methods used in the suicide and risk-taking deaths by gender. Hanging was the most frequently used means of suicide death in both males and females. Other frequently used means of suicide by males were jumping from heights and firearms. These three means were the cause of death in 86.5% of male suicide deaths. In contrast, in females, poisoning was the next most frequently used means after hanging. These two means caused 78% of all suicide deaths in females. Table 3.4 also shows that accidental poisoning (drug toxicity and overdose) was the most common cause of risk-taking deaths for both males and females; 64% of those (25 out of 39 deaths) were heroin overdoses.

Place of incident

Table 3.5 presents the place of incidence of the deaths from suicide and risk-taking. Almost two-thirds of suicides (64.0%) and just under one half of risk-taking deaths (48.5%) occurred at either the child's or young person's place of residence or at another place of residence. One-third of risk-taking deaths took place on roadways.

Suicide notes

Just over one-third of children and young people who suicided left suicide notes, many of which included a reason for the suicide. Explanations for the suicide included beliefs that suicide was the only way to escape pain; that suicide was their pathway to happiness; that they were failures and deserving of death; as well as general feelings of betrayal, rejection, alienation and inadequacy. Comments included the following:

> 'Sorry for being such a disappointment, I guess I'm not the child you wanted me to be.'
>
> 'I love everyone in my life ... I wish they felt the same way about me.'
>
> 'I feel so alone in this world. Who do I really have? No one.'
>
> 'My parents, friends, nurses and relatives believe that I am happy and doing well when really I am extremely hopeless.'
>
> 'I don't think I'll ever be truly happy, I've been more of a source of sorrow than joy and if I lived I should just continue to hurt you.'
>
> 'My birth was the biggest mistake.'

Just over half (52.6%) of the children and young people who left suicide notes

Table 3.4

Methods used in suicide and risk-taking deaths by gender

Method**	Females		Males		Total	
	n	%*	n	%*	n	%*
SUICIDE						
Hanging	24	64.9	41	55.4	65	58.6
Jumping from a high place	2	5.4	12	16.2	14	12.6
Firearms	2	5.4	11	14.9	13	11.7
Poisoning	5	13.5	2	2.7	7	6.3
Motor vehicle exhaust gas	1	2.7	3	4.0	4	3.6
Jumping or lying before moving object	2	5.4	4	5.4	6	5.4
Crashing of motor vehicle	0	0.0	1	1.4	1	0.9
Drowning and submersion	1	2.7	0	0.0	1	0.9
Total number of suicide deaths	**37**		**74**		**111**	
RISK-TAKING						
Poisoning	11	73.3	28	54.9	39	59.1
Motor transport:						
Car driver in transport accident	3	20.0	7	13.7	10	15.2
Pedestrian in transport accident	0	0.0	9	17.6	9	13.6
Motor cycle rider in transport accident	0	0.0	4	7.8	4	6.1
Pedal cyclist in transport accident	1	6.7	0	0.0	1	1.5
Car passenger in transport accident	0	0.0	1	2.0	1	1.5
Occupant of railway train injured by fall from train	0	0.0	1	2.0	1	1.5
Drowning and submersion	0	0.0	1	2.0	1	1.5
Total number of risk-taking deaths	**15**		**51**		**66**	
UNDETERMINED INTENT						
Poisoning	1	50.0	3	37.5	4	40.0
Hanging	1	50.0	1	12.5	2	20.0
Pedestrian in transport accident	0	0.0	1	12.5	1	10.0
Falling or jumping from high place	0	0.0	1	12.5	1	10.0
Lying or running before or into moving object	0	0.0	1	12.5	1	10.0
Insulin-dependent diabetes mellitus	0	0.0	1	12.5	1	10.0
Total number of undetermined intent	**2**		**8**		**10**	

** Percentage of total deaths within each intent of injury category.*

*** Deaths were classified according to ICD-10 external cause codes. The complete list of ICD categories is provided in Appendix 2.*

Table 3.5

Place of incidence of deaths

Place of incident	Suicide		Risk-taking		Undetermined		Total	
	n	%	n	%	n	%	n	%
Child's residence	65	58.6	15	22.7	4	40.0	84	44.9
Other residence	6	5.4	17	25.8	2	20.0	25	13.4
Park or bushland	14	12.6	1	1.5	0	0.0	15	8.0
Cliff face or bridge	16	14.4	0	0.0	1	10.0	17	9.1
Railway tracks	5	4.5	5	7.6	2	20.0	12	6.4
Roadway	4	3.6	22	33.3	0	0.0	26	13.9
Other	1	0.9	6	9.1	1	10.0	8	4.3
Total	**111**		**66**		**10**		**187**	**100.0**

apologised to their families and friends for their suicide, exactly half expressed love for their families and friends in their notes, and over one-third (35.9%) both apologised and expressed love for their families and friends.

Coronial investigations

Post-mortem examinations and toxicological investigations were conducted in all but one case where the body of the young person was never found. Alcohol was noted in the toxicology report of almost one-quarter (24.3%) of suicide cases and in 30% of risk-taking cases. Blood alcohol levels recorded for the suicide cases ranged from 0.014g/100mL to 0.396g/100mL with a mean of 0.116g/100mL. For the risk-taking cases, blood alcohol levels ranged from 0.021g/100mL to 0.263g/100mL with a mean of 0.136g/100mL. Drugs other than alcohol were noted in 28.9% of suicide cases and 71.2% of risk-taking cases.

Coronial inquests were held into the deaths of 28 (15%) of the 187 children and young people. Over half of those (57.1%) were held for deaths from risk-taking.

Suicide contagion, imitation and media influences

Suicide contagion is defined as the process by which a prior suicide facilitates the occurrence of subsequent suicides. Imitation is one method by which contagion may occur (Beautrais, 2000). Research shows that younger people are more suggestible and thus more prone to imitate their peers than older persons (Schmidtke & Schaller, 2000).

There is evidence to suggest that 17 (15.3%; 11 males and 6 females) of the suicide deaths in this study were associated with copycat or imitative factors. In the five-year period, the suicides of seven children and young people occurred within three weeks of a suicide by either a close friend or other young person known to them. A further two suicides in this study occurred within several months of the suicide of a friend or other young person, and an additional two suicides occurred in the year following the similar suicide death of another known child or young person. Another young person committed suicide within a week of the anniversary of her father's suicide. One young person entered into a suicide pact with a family member, and there is evidence to suggest that another young person may have entered into a suicide pact with a group of young people (subsequent to his death, a friend of his was rescued during an attempted suicide).

There is also a growing body of evidence to suggest that media publicity about suicide, both fictional and news-related, can trigger suicidal behaviour among individuals already vulnerable to suicide (see Beautrais, 2000 for a review). Among the subjects of this study, three children and young people had watched movies that portrayed suicidal behaviour in the days prior to their suicide deaths. In two of those cases, the young people committed suicide in the same manner as depicted in the movies they had watched. For another suicide, a CD that contained songs of a suicidal nature was located in the young person's room. Another young person showed his mother a picture of a celebrity who had committed suicide and began speaking about death. This occurred in the week prior to his suicide.

Taken together, these findings provide substantial evidence for an imitative or copycat effect for some suicide deaths among children and young people.

In summary:

- Most of the precipitating incidents to the suicide deaths involved a relationship break-up or a trivial argument with a significant person. In contrast, alcohol or other drug intoxication was the precipitating incident most frequently recorded in the risk-taking deaths.
- Hanging was the most frequently used method of suicide for both males and females, while poisoning was the most common means of death for males and females who died by risk-taking. The majority of those were accidental heroin overdoses.
- Seventeen (15.3%) suicide deaths were most likely a result of imitative or copycat effects. Of those, 13 followed within a short time period of another suicide of a child or young person and four coincided with media exposure to suicide issues (movies and music with themes of suicide).

Family circumstances 3.4

Of the population of children and young people, 72 (38.5%) were living at home with both biological parents. A further 39 (20.9%) were living with one biological parent only; 25 (13.4%) were living in step-parent or blended families; 18 (9.6%) were living with relatives or friends; one was living with adoptive parents; four (2.1%) were living in residential care; 27 (14.4%) were living independently (12 of those children and young people had no fixed place of abode); and no information about living arrangements was recorded for one young person.

The living arrangements for the population of children and young people who died from suicide and risk-taking were somewhat different to the living arrangements for the overall population of children and young people aged 12-17 years in NSW. In 1997, 69.6% of all children and young people aged 12-17 years in NSW lived with both biological parents; by contrast, 38.5% of the children and young people in the present study lived in intact families. In 1997, 9.2% of 12-17 year olds in NSW lived in step and blended families, compared with 13.4% in the present study. In 1997, approximately 20% of 12-17 year olds in NSW lived with one biological parent in one-parent families. Consistent with this figure, approximately 20% of the children and young people in the present research study also lived in one-parent families with a biological parent. Also consistent with the present study findings, the overwhelming majority of 12-17 year olds in NSW living in one-parent families live with their biological mother (Data extracted from ABS, 1999).

Two-thirds of children and young people in the present study who had no fixed place of abode at their time of death were risk-taking cases. Of course, figures regarding young people's living arrangements do not indicate the quality of family life within those arrangements. The qualitative aspects of the family circumstances of the children and young people in this study, and differences between the suicide and risk-taking groups, are reviewed in detail in later sections of the report.

School and employment circumstances 3.5

Just over half (52.9%) of the population of children and young people in the present study were enrolled in some form of education (typically school, TAFE or university) at the time of their deaths. This figure is substantially lower than the NSW population age participation rates in education. In 2001, the age participation rates for full-time school

students were 93.0% for 15 year olds, 82.4% for 16 year olds and 62.2% for 17 year olds (ABS, 2001b).

Of those children and young people who had left school early, file records show that at least 11 had left school prior to reaching the legal school leaving age of 15 years. For 35 (18.7%) of the children and young people who had left school early, there was insufficient information on file to determine at what age they had left.

Children and young people who died by risk-taking were far less likely to be enrolled in some form of education than those who died from suicide (33.3% of the population of risk-taking deaths compared with 69.4% of the population of suicide deaths). In fact, the odds of a child not participating in some form of education were four times higher for children who died by risk-taking than those who died by suicide (OR = 4.3, CI, 2.2, 8.3). Fifteen per cent of children and young people who died by risk-taking and 10% of those who died by suicide were in some form of employment at the time of their death. Over one-third (37.9%) of those who died by risk-taking and 13.5% of those who died by suicide were unemployed at the time of their deaths. Significantly more children and young people who died by risk-taking were unemployed than those who died by suicide ($\chi^2 = 15.2$, $p<.0001$).

3.6 Mental health problems

Of the overall population of children and young people in the study, 32 (17.1%) had been diagnosed with mental health problems[10]. The figure of 17.1% is, however, slightly higher than population estimates of mental health problems among children and young people. Findings from the National Survey of Mental Health and Well-being suggest that 14% of children and adolescents in Australia have mental health problems (Sawyer et al., 2000).

Thirty-nine (20.9%) children and young people in the present study had received some form of mental health treatment (either medication or counselling by a mental health professional or school counsellor). Those with diagnosed mental health problems (32 cases) had received their diagnoses from psychiatrists or other specialist doctors. The most common diagnoses were behavioural disorders (13), followed by depression (9). Other diagnoses included schizophrenia and other psychotic disorders, anxiety disorders and personality disorders. Children and young people who died by risk-taking were slightly more likely than those who died by suicide to have been diagnosed with mental health problems (18.2% of risk-taking cases versus 15.3% of suicide cases).

3.7 Drug use

Information suggesting frequent drug use (at least once/week) was noted on the records of 66 (35.3%) children and young people. The records of a further 29 (15.5%) suggested infrequent drug use (less than once/week). Records indicated that cannabis was the most frequently used drug among the population in this study, followed by alcohol and then heroin. Amphetamines, cocaine and methadone were used by very few.

[10] This figure is likely to be an underestimate as many children and young people in this study had not been assessed by a mental health professional. This may in part be due to poor community understanding, recognition and response to mental health issues. See Chapter 4, Table 4.1 (page 44) for details.

The level of drug use among this population of children and young people was mostly consistent with findings from previous surveys of alcohol and other drug use among children and young people in NSW. The only exception to this was with respect to heroin use. File records showed that 34 (18.2%) out of the 187 children and young people in this study were users of heroin. In contrast, the 1996 survey of Australian secondary students' use of over-the-counter and illicit substances showed that only four per cent had ever used opiates such as heroin or morphine, and less than two per cent reported having used opiates in the month prior to the survey (Letcher & White, 1999).

Seventeen (9.1%) children and young people had received treatment for substance use. Frequent drug use was more prevalent among those who died of risk-taking than those who died of suicide (56.1% vs 39.4% of frequent drug users). Those who died by risk-taking were also more likely to have received treatment for substance use than those who died by suicide ($\chi^2 = 12.8$, $p<.0001$). Seventy per cent of those who had received treatment for substance use were risk-taking cases.

Offending behaviour 3.8

Seventy-six (40.6%) children and young people had come to the attention of police as a result of their offending behaviour and 53 (28.3%) of those had been charged and/or convicted for their offending behaviour. In comparison, NSW Criminal Court Statistics show that 13,583 12-17 year olds appeared before Children's Courts in 1998/1999 (NSW Bureau of Crime Statistics and Research, 2000), comprising only 2.6% of 12-17 year olds in NSW. Thus, this population of children and young people are over-represented in juvenile crime statistics more than 10-fold.

More children and young people who died by risk-taking were known to the police for offending behaviour than among those who died by suicide (55.3% vs 38.2% of those known to police, $\chi^2 = 24.2$, $p<.0001$). The most common offences for which children and young people in this study were apprehended by police were theft, break and enter, assault, property damage, illicit drug offences, motor vehicle theft and stolen goods in custody. These made up 83.1% of all offences that were committed by the study population. The mean number of charges for the overall study population was 5.0. Children and young people who died by risk-taking had a higher mean number of charges (Mean = 6.3) than those who died by suicide (Mean = 1.4; $t = 2.9$, $p<.01$).

Previous suicidal behaviour 3.9

Eighty-two (43.9%) children and young people had exhibited prior suicidal behaviour, in the form of ideation, attempts, or deliberate self-harm. Records indicated that 74 (39.6%) had expressed suicidal thoughts prior to their death, most often to a friend, girlfriend or boyfriend. To a lesser extent they had expressed thoughts of suicide to a family member, mental health or other professional, or had written about their suicidal thoughts in their diary or journal. The majority (79.7%) of those whose records indicated prior suicidal thoughts died from suicide rather than from risk-taking.

Of the 38 (20.0%) children and young people whose records indicated that they had made at least one prior suicide attempt, most (78.9%) later died from suicide rather than from risk-taking.

Records show that 23 (12.3%) children and young people had engaged in prior

deliberate self-harm, almost always in the form of cutting or mutilating various body parts. Again, the majority (82.6%) died later from suicide rather than from risk-taking.

3.10 Stressful life events and circumstances

Almost three-quarters (72.7%) of the study population of children and young people had experienced at least one adverse life event in the year prior to their death. More than three-quarters (78.4%) of those who died by suicide and 63.6% of those who died by risk-taking had experienced either legal or school disciplinary problems, interpersonal problems including losses due to bereavement, relationship breakdowns and/or arguments with partners, family or friends. The most common adverse life event experienced by those children and young people who died by suicide was interpersonal conflict relating to relationship breakdowns and arguments. In contrast, legal problems, such as being apprehended by police for criminal activity, charges, and juvenile court appearances, were the most prevalent stressful life events experienced by those who died by risk-taking. Records also indicated that many of the children and young people had been exposed to multiple stressful life events. The mean number of stressful events experienced by the overall study population was 2.3 (SD = 1.1, Range: 1-5). This is consistent with research findings that show a higher total number of stressful life events among young people who die by suicide (see Beautrais, 2000 for a review). There were no significant differences in the number of stressful life events experienced by the suicide and risk-taking groups.

3.11 Human service agency involvement

Of the study population of children and young people, 78 (41.7%) had no record of contact with human service agencies. Of those who had prior contact, there were clear differences between the suicide and risk-taking groups in terms of the agencies with which they had contact[11].

Hospital Emergency Departments

Approximately 60% (112) of the 187 children and young people had presented to hospital Emergency Departments on at least one occasion during their lives. The overwhelming majority of those presentations were for general illness or accidents. However, 25 (13.4%) children and young people had attended hospital Emergency Departments for alcohol and other drug-related incidents or due to suicidal behaviour. There were no significant differences between the suicide and risk-taking groups with respect to the extent of contact with hospital Emergency Departments.

Department of Community Services

Just over one-quarter (26.2%) of the children and young people who died had been clients of the Department of Community Services at some stage during their lives. Of

[11] The legislative and policy contexts in which the deaths of this population of children and young people occurred have changed. Some sections of the *Children and Young Persons (Care and Protection) Act 1998* have been proclaimed, significantly, the ability of children and young people to request assistance (s20), the reporting of homelessness of children and young people (s120 and s121) and the definition of risk of harm (s23). In addition, the *NSW Interagency Guidelines for Child Protection Intervention* have been revised. These have brought various changes to the operation of the service system, policies and procedures and should have a significant effect on child protection practice and service provision.

those, one-third had active Department of Community Services' involvement at the time of their deaths. Department of Community Services' involvement was much more common for children and young people who died from risk-taking than for those who died from suicide. Thirty-two (48.5%) out of the 66 children and young people who died from risk-taking had been clients of the Department of Community Services. In contrast, 17 (15.3%) of those who died from suicide had experienced Department of Community Services' involvement. Less than half (21; 42.9%) of those who had been clients of the Department of Community Services had experienced ongoing, intensive involvement for either their entire lives or at least for several years prior to their deaths. The other half had either experienced very brief Department of Community Services' involvement or had been the subjects of one-off notifications.

School counsellor services

Of the 40 (21.4%) children and young people who had a school counsellor file, over half died by suicide. The extent of involvement was not able to be determined from most records.

Department of Juvenile Justice

Thirty-nine (20.9%) children and young people had been clients of the Department of Juvenile Justice. Of those, 28 (71.8%) died by risk-taking. The extent of involvement with the Department of Juvenile Justice varied from very brief to intensive supervision over several years.

Mental health services

Of the 39 (20.9%) children and young people who had been seen by mental health professionals, 25 (64.1%) died by suicide. For the majority of those cases, however, mental health involvement was very brief, usually consisting of just a few visits.

Refuge services

Of the 19 (10.2%) children and young people who had accessed refuge accommodation, 13 (68.4%) died by risk-taking. Typically, their use of refuges was intermittent, being accessed briefly whenever a living arrangement had broken down.

Drug and alcohol services

Seventeen (9.1%) children and young people had received treatment for drug and alcohol problems. The majority of these died by risk-taking. Treatments included detoxification programs, methadone and naltrexone.

Profile of children and young people dying from suicide and risk-taking 3.12

From the findings presented thus far, the majority of children and young people who died from suicide and risk-taking in NSW between 1996 and 2000 were male, aged 16 to 17 years, and born in Australia. There were, however, considerable differences between the profiles that emerged for the suicide and risk-taking groups separately.

For those who died by suicide, the precipitating incident to the death was typically an apparently trivial argument with a significant person and the mechanism of death was typically by hanging. The majority of these children and young people were enrolled in some form of education. The most typical adverse life events experienced by this group involved interpersonal conflicts, such as arguments and relationship breakdowns.

In contrast, for those who died by risk-taking, the precipitating incident to the death was usually alcohol or other drug intoxication and the most common mechanism of death was poisoning. This group of children and young people were typically not involved in any type of education and over one-third were unemployed at the time of their deaths. They were significantly more likely to have received treatment for substance use and to have come to the attention of police for involvement in criminal behaviour. Not surprisingly, therefore, the most common adverse life events experienced by this group were legal problems (for example, charges for criminal activity).

With regard to available human service agencies, the children and young people who accessed mental health and school counselling services were typically those who died by suicide. In contrast, those who died by risk-taking were more likely to have been clients of the Department of Community Services and the Department of Juvenile Justice.

In summary, the overall profile of risk that emerged for children and young people who died from suicide was quite different to the profile of risk that describes those who died from risk-taking. However, a primary focus of this study was to investigate the extent to which different clusters or types exist within each of the two groups (suicide and risk-taking).

3.13 Suicide and risk-taking typology

In order to determine whether suicide and risk-taking types do exist, each case review was examined in-depth in order to understand the child or young persons' life history and circumstances leading to the death. Case reviews were then compared and contrasted with each other and the children and young people were clustered according to common characteristics and experiences.

There are, of course, many ways to classify deaths. In this study, the classifications have primarily been based on the life histories of the children and young people, grouping them according to common backgrounds and experiences. In cases where little or no information was obtained regarding the life history of the child or young person, the precipitating factors that led to the death were also used as a means of grouping. Three overriding clusters emerged. These are presented in Table 3.6

Table 3.6

Suicide and risk-taking clusters

Cluster	Males	Females	Total	
			n	%
Enduring difficulties*	**84**	**40**	**124**	**69.7**
Mental health problems	(35)	(19)	(54)	(30.3)
Family dysfunction	(49)	(21)	(70)	(39.3)
School-related difficulties	(28)	(10)	(38)	(21.3)
Pivotal life events	**15**	**11**	**26**	**14.6**
Adolescent risk-taking	**26**	**2**	**28**	**15.7**
TOTAL	**125**	**53**	**178****	**100.0**

** The sum of the mental health, family dysfunction and school-related difficulties subgroups does not equal the total number of cases in the enduring difficulties cluster (n=124), as 28 children and young people in the enduring difficulties cluster experienced more than one type of enduring difficulty.*

*** The total number does not equal the total number of children and young people in the study (n=187) as nine children and young people could not be placed in a cluster due to lack of recorded information.*

1) Children and young people with enduring difficulties

This was overwhelmingly the largest cluster, comprising 124 of the 187 children and young people. The deaths of these children and young people occurred in the context of significant enduring difficulties or problems. The members of this cluster could be further categorised into three subgroups, on the basis of the specific enduring difficulties that were experienced – mental health problems, family dysfunction and school-related difficulties. Twenty-eight of the 124 suffered more than one ongoing difficulty or problem and were therefore placed in more than one subgroup. For that reason, the sum of the cases for the three subgroups does not total 124. Of those 28 children and young people, 11 experienced all three enduring difficulties, 12 suffered both mental health problems and family dysfunction, and five experienced both school-related difficulties and mental health problems.

A: Mental health problems

Thirty-two of the 124 children and young people had been diagnosed with mental health problems, the most common of which were behavioural disorders, followed by depression. Behavioural disorders were more common among those who died by risk-taking, while depression and psychotic disorders were more prevalent among those who died by suicide.

A further 22 children and young people, all but two of whom died by suicide, were included in this subgroup because file records showed evidence of extreme sadness and distressed emotional state. It is widely acknowledged that many children and young people with mental health problems never receive professional help (Sawyer et al., 2000). Thus, it is possible that some of these children and young people might have been suffering from an undiagnosed depression at the time of their death.

B: Family dysfunction

This subgroup comprised 70 of the 124 children and young people who experienced enduring difficulties. Members of this group had experienced a range of family problems, including chronic physical abuse and neglect, emotional abuse, sexual abuse, unhelpful parenting, and ongoing conflict and arguments. They died from both risk-taking and suicide.

C: School-related difficulties

Thirty-eight children and young people who died by either suicide or risk-taking formed this subgroup. For those who died by suicide, their life histories revealed a range of significant school-related problems. These included learning difficulties, Higher School Certificate stress, problems in peer relationships, and a minority experienced behavioural and disciplinary problems. For those who died by risk-taking, however, school-related difficulties were of a different form. Typically, these children and young people experienced problems at school, usually learning and disciplinary problems, which led to either dropping out of school or a suspension/expulsion process. Once they were out of the school system they typically associated with peers who were in a similar situation, which then led to drug use, criminal behaviour and legal problems. These children and young people eventually died from accidental drug overdoses.

2) Children and young people who experienced a pivotal life event

The 26 children and young people who formed this cluster, all but two of whom died by suicide, could be distinguished from those in the first cluster in that none appeared to have suffered enduring or chronic difficulties. Rather, they all experienced an isolated major event or incident which they perceived as life-changing, and information on file suggests that this event triggered their suicides. Events experienced included interpersonal problems, physical illness or accidents, sexual assault, unemployment and legal problems. These suicides would thus seem to have been either impulsive responses to a pivotal life event or to have occurred in an acutely depressed state reactive to a major life event.

3) Children and young people who died while engaging in typical adolescent risk-taking behaviours

Twenty-eight children and young people formed this group, 27 of whom died by risk-taking. For one young person it was not possible to determine their intent to die. Twenty-six of the 28 were male. Unlike those in the first cluster, members of this group did not experience any enduring family, school or individual difficulties that could be identified from available records. Also, unlike those children and young people who made up the pivotal life events cluster, they had not experienced any major, life-changing adverse events. Rather, their deaths occurred in a typical adolescent risk-taking context – that is, they all died while engaging in risk-taking behaviours, notably drug and alcohol use or dangerous driving. Their deaths can be largely attributed to adolescent alcohol and other drug experimentation, most of which took place while socialising with friends.

Nine cases could not be placed into a cluster as little or no information was obtained about either their life histories or the precipitating incident to their death. These cases were therefore excluded from further analyses. Seven of the nine cases were suicides and two were deaths for which intent was unable to be determined.

The following four chapters explore in detail each of the suicide and risk-taking clusters.

Chapter four

Children and young people with enduring difficulties: Overall profile

One hundred and twenty-four children and young people (84 males and 40 females), whose deaths occurred in the context of significant enduring difficulties, formed this cluster, making up 66.3% of the study population of deaths from suicide and risk-taking. These children and young people could be further classified into three subgroups, on the basis of the specific enduring problems that were experienced: mental health problems or severely distressed emotional state, family dysfunction and school-related difficulties. Twenty-eight suffered more than one of these ongoing problems and were therefore placed in more than one subgroup.

Of the 124 children and young people, 80 died by suicide (72.1% of all suicide cases), 38 died from risk-taking deaths (55.9% of all risk-taking cases), and intent was unable to be determined for six cases.

This chapter provides an overall profile of these 124 children and young people and then details the nature of the problems experienced by this group. The circumstances of the deaths, and contact with human service agencies, are detailed in the following chapter.

Enduring difficulties cluster: Overall profile 4.1

Age and sex

Eighty-four of the 124 children and young people were male and 40 were female. The age and gender distribution of this cluster is presented in Figure 4.1. As with the overall population of suicide and risk-taking deaths, the number of deaths in this cluster increased with increasing age. Approximately 70% of the children and young people were aged 16 and 17 years at the time of death; more than three-quarters (67.7%) of this group were male.

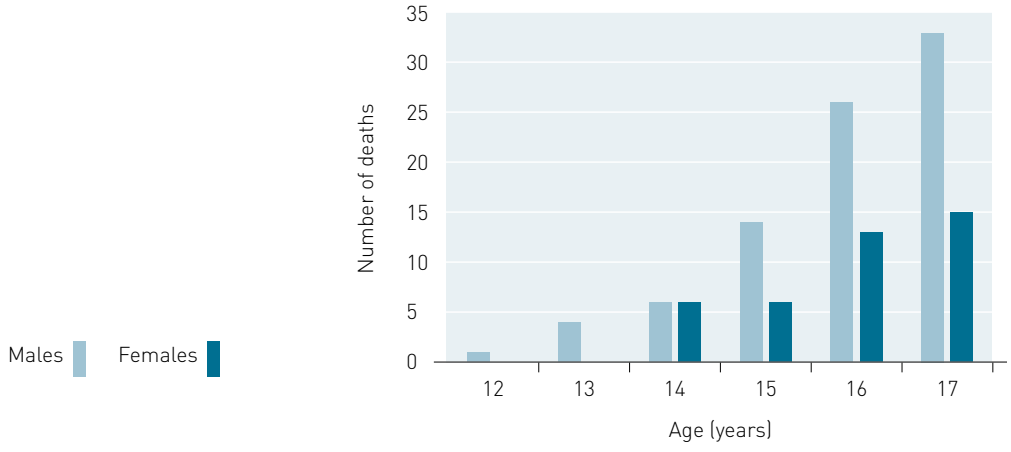


Figure 4.1

Enduring difficulties cluster: Age and gender distribution

Cultural and linguistic diversity

Eighteen (14.5%) of the children and young people in this cluster were born overseas (11 males and seven females). Their mean age of arrival in Australia was 6.5 years. Five spoke a language other than English in their family home.

Indigenous children and young people
Nine (7.3%) children and young people in this cluster were Aboriginal. Seven were male and two were female.

Family circumstances

Less than one-third (38; 30.6%) of the children and young people in this group were living with both biological parents at the time of their deaths. However, those from the mental health problems and school-related difficulties subgroups were far more likely to be living with both biological parents (50% and 55.2%, respectively) than were those from the family dysfunction subgroup (13.2%).

There were five wards of the state in this study; all were grouped in the enduring difficulties cluster, indicating that their deaths occurred in the context of ongoing problems.

Twenty-three children and young people were living with one biological parent only (17 of the 23 with their biological mothers), and 21 were living in step-parent or blended families. Ten children and young people were living with other relatives, six were living with friends' families (one of them was a ward of the state), and one young person was living with his adoptive parents (and had been there since five weeks of age). Seven young people, all of whom were from the family dysfunction subgroup, were living independently; a further 11 had no fixed place of abode. Of those who had no fixed place of abode, all were from the family dysfunction subgroup and two of these were wards of the state.

Three males were living in de facto relationships, one of them with his 39 year old partner (who had formerly been his school teacher). Two young people who were wards of the state were living in supported accommodation with youth workers. Two young people were in an institutional residence when they died. One had been living in the mental health ward of a hospital and was on weekend release when she died, and one young person had been detained in a Juvenile Justice facility and had absconded at the time of his death.

The quality of family lives experienced by these children and young people is detailed later in this chapter.

Familial psychopathology

Fifteen (12.1%) children and young people came from families with a history of either mental health problems or suicidal behaviour. In 12 of those cases, the mother or father had exhibited suicidal behaviour. One young person's father committed suicide when the young person was 12 years of age; in a further eight cases, one or other parent had attempted suicide (one young male had found his father attempting to commit suicide by gassing himself in his car). In the other three cases, one of the parents had communicated to their children their desire to take their own lives. The father of one young female, for example, had phoned her on several occasions to say goodbye.

The mother or father of four young people had been diagnosed with depression and a further two young people had siblings with schizophrenia, one of whom was so severely affected that she had been institutionalised for eight years.

Education and employment

Just less than one-half (60; 48.4%) of the children and young people were enrolled in school. Eight were attending TAFE, one had completed high school and was attending university, and one had just finished Year 12 at the time of his death.

Of the 54 children and young people who were not enrolled in some form of education, one left school just a few days prior to her death. She had been fully present at school for just six days of an entire term and a meeting had been held with the school principal, the young person and her family at which all agreed that it would be best if she left the school. A further seven children and young people were employed; three were working as labourers, one was an assistant baker, one was an apprentice carpenter, one was a personal trainer and one was working in a café. A further 36 children and young people were unemployed at the time of their death.

Of the remaining 10 children and young people, one was in psychiatric care, one was receiving the Youth Training Allowance, one was a ward of the state and receiving financial support from the Department of Community Services and one was gaining an income by engaging in sex work; for the other six there was insufficient information to determine their income support.

Specific aspects of this cluster's school-related experiences are detailed later in this chapter.

Drug use

Drug use was recorded on the files of 67 (54%) children and young people with enduring difficulties; approximately 84% engaged in frequent drug use (at least once a week). Cannabis was the drug most commonly used by this group of children and young people, followed by heroin and then alcohol. All of the frequent users of heroin died from accidental overdoses of heroin. Fourteen of these young people had received treatment for drug addiction.

It is important to note that drug use was associated with the mental health diagnoses of five children and young people in the mental health problems subgroup. Two had been diagnosed with drug-induced psychosis, one following regular cannabis use and the other following an isolated incident of LSD use. Another had developed generalised anxiety disorder with associated panic attacks, supposedly following the ingestion of an ecstasy tablet. The suicides of a further two young people appear to have largely been a result of associated drug problems. One was addicted to heroin, her suicide note indicating her belief that she was unable to escape the addiction. Another young person had a history of cannabis abuse, smoking about 10 joints a day. He had allegedly given up 'cold turkey' about two months prior to his death and become clinically depressed as a result.

Offending behaviour

File records show that 59 (47.6%) children and young people with enduring difficulties had come to the attention of police as a result of their offending behaviour. Engagement

in criminal behaviour was far more common among those in the family dysfunction subgroup than among those in the mental health problems and school-related difficulties subgroups.

The types of offences committed by this cluster of children and young people ranged from theft-related, to drug-related to serious offences against the person (such as armed robbery and assault). Sentences received by this group included fines, community service orders, supervision and recognisance orders, and nine children and young people had received control orders, that is, they had been detained in a Juvenile Justice facility for a period of time.

Prior suicidal behaviour

Twenty-five (20.2%) children and young people in this cluster had attempted suicide on at least one occasion prior to their deaths and 20 (16.1%) had engaged in self-mutilation, primarily in the form of cutting various body parts. Nine had both attempted suicide and engaged in self-mutilation.

A further 25 (20.2%) children and young people had expressed suicidal thoughts, either to other people or in letters, but had not made any prior attempt. In most of those cases, file records show that the person who had been informed of the young person's suicidal intent did not attempt to intervene. For instance, the parent of one young person found a suicide note in her room just two days prior to her suicide. In her statement to the police after her daughter's suicide, she indicated that she had not arranged for professional help, or even confronted the young person about the note, despite being concerned for her daughter's well-being after finding it.

Fifteen children and young people who had exhibited prior suicidal behaviour later died from risk-taking. This highlights the overlap between suicide and risk-taking, suggesting that the two are not entirely distinct phenomena.

In summary:

- One hundred and twenty-four children and young people (84 males and 40 females) formed this cluster based on the common experience of enduring difficulties – specifically, mental health problems, family dysfunction and school-related problems.
- Less than one-third (30.6%) were living with both biological parents at the time of their deaths. The children and young people from the family dysfunction subgroup were the least likely to be living with both biological parents.
- Less than half (48.4%) were enrolled in school.
- More than half (54.0%) engaged in alcohol and other drug use.
- Just under half (47.6%) had come to the attention of police for their offending behaviour.
- More than half (56.5%) had exhibited prior suicidal behaviour. Fifteen of those children and young people later died from risk-taking.

As already described, the children and young people who experienced enduring difficulties could be further grouped on the basis of the type of difficulties that were experienced. The following sections explore in detail the nature of the enduring difficulties that were experienced by this cluster.

Enduring difficulties: Mental health problems and severe emotional distress 4.2

Fifty-four out of the 124 children and young people formed this subgroup. Of those, 32 (24 males and 8 females) had been diagnosed with mental health problems. Seventeen out of the 32 died by suicide, 12 died from risk-taking, while intent was unable to be determined for the other three young people.

A further 22 children and young people (11 males and 11 females), 20 of whom died by suicide, were placed in this subgroup because their suicide notes and other documentation portrayed feelings of extreme hopelessness and a distressed emotional state, suggesting that they might have been suffering from an undiagnosed depression at the time of their deaths. Williams and Pollock (2000) suggest that the defining characteristic of hopelessness is the belief that nothing will change for the better in the future. These authors also acknowledge the body of research evidence that documents hopelessness as one of the main factors mediating the relationship between depression and suicidal behaviour.

Mental health problems

Table 4.1 lists the mental health diagnoses for the 32 children and young people who had received psychiatric diagnoses. The most common mental health diagnosis was some type of behavioural disorder (Attention Deficit Hyperactivity Disorder, Conduct Disorder or Oppositional Defiant Disorder), followed by depression. Three young people had suffered from co-morbid constellations. All diagnoses were made by a psychiatrist or another medical specialist (for example, a neurologist).

Table 4.1 also shows that more males (24) than females (8) had been diagnosed with a mental health problem. These findings are consistent with existing literature that among those with mental health problems, males are more likely than females to commit suicide (see Apter & Freudenstein, 2000).

Table 4.1

Children and young people's mental health diagnoses

Mental health diagnosis	Males	Females	Total
Attention Deficit Hyperactivity Disorder	9	0	**9**
Conduct Disorder	3	0	**3**
Oppositional Defiant Disorder*	0	1	**1**
Depressive Disorder	6	3	**9**
Schizophrenia	2	0	**2**
Drug-Induced Psychosis	1	1	**2**
Dissociative Disorder	0	1	**1**
Antisocial Personality Disorder	0	1	**1**
Generalised Anxiety Disorder	1	0	**1**
Co-morbid Constellations**	2	1	**3**
Total	**24**	**8**	**32**

** The diagnosis of Oppositional Defiant Disorder was a provisional diagnosis.*

*** One young male was diagnosed with a combination of depression, Obsessive Compulsive Disorder and schizophreniform psychosis. Another young male had a combination of Antisocial Personality Disorder, cannabis abuse and schizophreniform psychosis. One female was diagnosed with depression and borderline and antisocial personality traits.*

Those who died by suicide were more likely to have been diagnosed with depression and Psychotic Disorder, while the children and young people who died by risk-taking were more likely to have been diagnosed with behavioural disorders. Although the numbers are small, the results are consistent with previous research findings that depression consistently emerges as the diagnosis most frequently associated with suicidal behaviours (Apter & Freudenstein, 2000; Beautrais, 2000).

Eighteen of the 32 children and young people who had received mental health diagnoses also experienced enduring family dysfunction or school-related difficulties. Perhaps not surprisingly, almost all of the young people who had behavioural disorders experienced significant school-related difficulties. In addition, those with psychotic disorders who were still attending school had experienced various difficulties in the months leading up to their deaths. For instance, one young person who was suffering from a drug-induced psychosis was suspended from school for shouting and swearing in class. He told the principal that he had been hearing voices in his head and had been shouting to get them to stop. Thus, the majority of young people who were attending school were having difficulties coping in the education system, and this could largely be attributed to their psychiatric condition.

Distressed emotional state

For the 22 children and young people who had not received a mental health diagnosis, their suicide notes and other documentation showed clear evidence of extreme sadness, hopelessness and depressed mental state. The case of 16 year old Ally is illustrative:

> **Ally[12], 16 years old**
> Ally's father died when she was two years old. Her mother remarried and Ally appeared to have a close relationship with her stepfather. Her parents said that for the two years prior to her suicide, Ally had been suffering periods of 'depression', which they had attributed to hormonal changes and 'just being a teenager', and for that reason they had never taken her to a mental health professional. After her death, however, Ally's stepfather said that upon reflection he could see that Ally had poor self-esteem and possibly the beginnings of an eating disorder. She had lost a lot of weight and was eating erratically. Ally's suicide note indicated feelings of hopelessness and possible depression: '... No guy has ever liked me. No guy ever will. I'm so ugly and fat' ... 'Why am I such a loser?' ... 'I'm so annoyed that I've let myself fall into this big hole of depression and I keep on digging down deeper and deeper ...'

There is research evidence documenting a relationship between eating disorders and depression, and that girls with eating disorders are at increased risk for suicide[13] (Apter et al., 1995; Apter & Freudenstein, 2000; Herzog et al., 2000).

[12] Pseudonyms have been employed throughout the study to protect the privacy of individuals and their families.

[13] During the reporting period (1996-2000) there were two females who died from complications due to anorexia nervosa. They were not included in this study as their deaths did not meet the criteria for accidental death.

Excerpts from other suicide notes of children and young people who had not seen a mental health professional indicated similar feelings of hopelessness and depression:

> 'I don't think I'll ever truly be happy ... If I'm to come back don't let me be human ... no creature suffers as the human does.'

> '... for years my life has been a mess and there was nothing I or anybody else could do about it ... I'm not smart enough to get anywhere and not talented enough to get anywhere that I wanted...'

> ' ... there is nothing that you or anybody could do ... I think there is just something within me that stops me from being happy... '

Of the 22 children and young people who were experiencing extreme emotional distress, 10 expressed severe emotional distress over their family situations or school-related difficulties. For instance, one young male was clearly distraught over his parents separating and feared that he would be caught between them. Another young male indicated to his doctor his distress over his family situation. He said that he did not get on with his stepfather and this created family conflict. He also indicated that he had lost his appetite, was unable to sleep and was experiencing constant stomach pains and nausea.

File records indicate that one young male was suffering severe emotional distress as a result of extreme bullying and tormenting by his school peers, which he had endured for most of his life. Excerpts from a letter that he wrote indicate his extreme distress and feelings of worthlessness as a result: ... 'because I grew up being bullied, I have come to believe that you can basically let these people walk all over you' ... 'now you might understand why I don't like talking about myself, I'm not too proud of what's happened to me or what I've been through...'

In summary:

- Behavioural disorders and depression were the most common mental health diagnoses.
- More males than females had been diagnosed with mental health problems.
- Diagnoses of depression were more commonly associated with suicide deaths, whereas diagnoses of behavioural disorders were more frequently associated with those who died from risk-taking.
- Twenty-two children and young people had not been diagnosed with a psychiatric disorder, although they were clearly suffering from a mood state that was causing obvious distress to them.

Enduring difficulties: Family dysfunction 4.3

Of the 70 children and young people in this subgroup, 37 suffered long-term child abuse and/or neglect. Their experiences included physical and sexual assaults by family members, emotional abuse in the form of severe verbal abuse, scapegoating and withholding expressions of love and affection, and neglect, including failing to receive adequate food, supervision and other basic needs.

While the other 33 children and young people in this subgroup did not experience child abuse or neglect as generally defined, they too suffered chronic family dysfunction, mostly in the form of ongoing family conflict, blended-family issues and unhelpful parenting practices.

Child abuse and neglect

A review of the Department of Community Services' records for the children and young people in the study showed that 37 had suffered child abuse and neglect, with physical abuse and neglect being the most common, as Table 4.2 shows.

Table 4.2

Children and young people's experiences of child abuse and neglect by gender

Abuse/Neglect	Males	Females	Total
Physical abuse	13	9	22
Neglect	11	8	19
Sexual abuse	3	7	10
Emotional abuse	1	6	7
Total*	**28**	**30**	**58**

**** Total numbers do not equal the total number of children and young people in this subgroup (n = 37) as some experienced more than one type of abuse.***

Of the 37 children and young people, one female experienced all three forms of abuse as well as neglect, 10 experienced both physical abuse and neglect, four experienced both physical and sexual abuse, three experienced both sexual abuse and neglect, one female experienced both sexual and emotional abuse, and one female experienced both physical and emotional abuse.

The following sections detail the child abuse and neglect that was experienced by these children and young people. Data are presented separately for physical abuse, neglect, sexual abuse and emotional abuse.

Almost all of the perpetrators of abuse and neglect were biological parents, step-parents or the de facto partners of biological parents. Risk factors for child abuse and neglect that have previously been identified by the CDRT were evident in many of the families, including domestic violence, parental criminality, parental substance use and poverty.

Physical abuse

A body of research evidence suggests a link between high levels of exposure to physical abuse and suicidal behaviour among young people (Hernandez et al., 1993; Brent et al., 1994; Tulloch et al., 1994). The findings from this study support this literature. Long-term physical abuse was most prevalent among those young people who died from risk-taking, the majority of whom died from drug overdoses.

In this study, 22 children and young people (13 males and 9 females) were subjected to long-term physical abuse. These children and young people had dropped out of school, left home early and had become engaged in substance use and crime. The following cases are illustrative.

Jasmine, 15 years old

Jasmine's parents separated when she was young and both formed new relationships. She had been exposed to a great deal of family violence, mostly between her biological parents. Jasmine resided mainly with her mother and

stepfather, although she eventually left home as a result of continuing problems with her alcoholic mother and violent stepfather. On one occasion he assaulted Jasmine so badly that she required hospital treatment. Jasmine reportedly got on well with her biological father, although she was unable to live with him due to her poor relationship with her stepmother. Jasmine often lived on the streets, forming relationships with different men to gain affection and shelter. As a result of those relationships Jasmine was introduced to amphetamines and heroin and died from a combined amphetamine and heroin overdose. In a police statement after her death, one of Jasmine's friends described Jasmine as a 'lonely beautiful kid' who would 'do anything to get love and attention'. She further stated that Jasmine once told her that 'if her mother had given her the love and affection she wanted, she wouldn't have turned out like this'.

Jake, 16 years old

At the time that Jake was born his father was serving 14 years imprisonment for murder. His paternal grandparents assumed care of him and his sister when he was six years old after his mother abandoned them and formed a new relationship. Jake and his sister were first notified to the Department of Community Services for sexual abuse by a cousin when Jake was seven years of age. This abuse was confirmed. Jake's grandmother was physically abusive to him, hitting him with a stick as punishment for minor misbehaviour, hitting him on the head and pushing his head into walls. Jake ran away from home at 14 years of age. Just before he ran away, Jake's father was released from gaol and upon returning home sexually assaulted Jake's sister. Jake later told a youth worker that this incident had always deeply affected him. Jake moved to the streets and became involved in drug use, criminal activity and prostitution. He was eventually returned by the Department of Community Services to the care of his biological mother, although he continuously ran away, claiming that his stepfather drank a lot and physically assaulted him. For 18 months before he died Jake moved from refuge to refuge and engaged in drug use, crime and prostitution. During this time he also exhibited suicidal behaviour, walking around a refuge carrying a rope. He eventually died from a heroin overdose.

These cases illustrate that physical abuse can be associated with substance use. Moreover, Jake's story highlights the overlap between suicidal and risk-taking behaviour.

Neglect

Neglect is characterised as the failure of a parent to act to secure the child or young person's health, safety and well-being. Neglect can include inattention to physical needs so that the child or young person is not adequately fed or clothed, or does not receive treatment for a medical condition. Critical to a child's healthy growth and development is emotional nurturance by a parent or caregiver. In some cases of neglect a child or young person may not receive adequate social or cognitive stimulation to facilitate development and attachment (NSW Child Death Review Team, 2000).

Nineteen children and young people (11 males and 8 females) were the victims of neglect. This included failure of their parents to provide adequate shelter, food, supervision, emotional nurturance and other basic needs, as demonstrated in the following examples.

Camilla, 16 years old

Camilla was notified to the Department of Community Services for the first time at the age of one month for neglect and emotional abuse by her mother. Throughout the first few years of her life there were frequent notifications of neglect, including an episode when Camilla overdosed on Panadol and her mother failed to notify anyone for over one hour. Department of Community Services' records note that Camilla did not appear to be adequately fed or clothed. Her mother would punish her by making her stand naked in her room for hours at a time. At the age of six years, Camilla and her siblings were made wards of the state, when it was alleged that their mother was unable to care for them. During the first few months of wardship, the Department of Community Services' officer noted that there was no attachment between Camilla and her mother. Her mother had requested photographs of all her children except Camilla and had indicated that she did not wish to have access to Camilla for her birthday. Camilla exhibited emotionally disturbed behaviour (such as exposing herself and other sexually inappropriate behaviours) until her death at age 16 years from an overdose of heroin.

John, 15 years old

John was an Aboriginal child who came from a family with a long history of problems. He had been notified to the Department of Community Services four times by the age of six years for his mother's neglect of him. A neighbour reported that from the age of four years John would often roam the streets until late at night and once she had seen him almost run over by a truck. On another occasion, John and his sister were notified by an aunt, who claimed that their mother was an alcoholic and would often stay at the pub for periods of up to 16 hours. The aunt further claimed that John's mother was spending most of her benefits on alcohol and cannabis and would leave John and his sister at home unsupervised, with no food in the house. John had been caught stealing several times, claiming that he needed money to buy food. As John entered primary school, he was suspended several times for swearing and violent behaviour. His problematic behaviour continued into high school. He became a client of the Department of Juvenile Justice at the age of 14 years, spent periods of time in youth refuges, and died from an overdose of heroin at the age of 15 years.

As with the physical abuse cases, these cases of neglect indicate that long-term neglect from a young age can be associated with substance use and other problematic behaviours.

Sexual abuse

There is a large body of research evidence documenting that sexually abused children and young people are more likely to exhibit suicidal behaviour and to use drugs to the point of abuse (for example, Wagner, Cole & Schwartzman, 1995; Beckinsale, Martin & Clark, 1999; Fergusson, Woodward & Horwood, 2000).

In this subgroup, 10 children and young people, seven females and three males, experienced ongoing childhood sexual abuse. Alleged perpetrators were mostly the stepfathers of the children and young people, although in four instances the perpetrator was either another relative or a family friend. In three cases, the child's biological mother was aware of the abuse, but did not report it due to fear of destroying her relationship with her partner. The following cases illustrate the experiences of two young people.

Susie, 16 years old

Susie kept a diary in which she wrote that she and her sister had both been sexually abused by their stepfather when they were young children. Susie's sister had told the police, but Susie said the abuse did not happen. No charges were laid. Following this, Susie's sister went to live with their father and Susie remained with her mother and stepfather. Susie wrote of the abuse in her diary stating that she kept trying to push it to the back of her mind, although she wrote "some things you never forget, no matter how hard you try". At the time of her death, Susie was living independently with friends. Her diary was filled with comments that she hated herself and her life, that no one, including her family, cared about her and that all she wanted was for people to like her. She also wrote about committing suicide and of previous unsuccessful suicide attempts. She eventually committed suicide by hanging. At the time of death, Susie had a blood alcohol level of 0.172g/100mL.

Betty, 16 years old

Betty's parents separated when she was four months old. Her mother sent her and her siblings to live with their father, who died in a car accident six months later. The children went back to their mother who was living with a man engaged in drug abuse. The couple had just had a child. When Betty was one year old, sexual abuse of her and her two siblings by their stepfather was alleged but not proven. When Betty was three years old, she was found to be bleeding vaginally, but medical examination did not confirm sexual abuse. Two years later, Betty alleged that she had been sexually abused by her stepfather. At that time, a paediatrician found evidence of full vaginal and anal penetration and the abuse was confirmed. Home support was provided for 20 hours a week together with Department of Community Services' supervision for 20 hours per week. Nevertheless, a year later, Betty's mother requested that Betty to be removed from her care. Betty was adopted by her foster family when she was 10 years old. When she was 13 years old, the Department of Community Services received several notifications regarding her welfare, including an allegation of sexual abuse by her adoptive father. The abuse was confirmed and Betty was made a ward of the state. She spent the remainder of her life in residential care and refuges. Betty began using drugs and was involved in crime. She eventually died from an overdose of heroin.

Emotional abuse

The *NSW Interagency Guidelines for Child Protection Intervention (2000)* list the following as indicators of parental emotional abuse: constant criticism or belittling, excessive or unreasonable demands, persistent hostility, severe verbal abuse, rejection and scapegoating, belief that the child is bad or 'evil', and using inappropriate physical or social isolation as punishment.

Research evidence documents several long-term consequences of exposure to parental emotional abuse. Such maltreatment can impair the development of emotional self-regulation, empathy, self-concept and social skills (Berk, 2000). Children who suffer emotional abuse may exhibit low self-esteem, high anxiety, self-blame, as well as suicidal behaviour (Toth & Cicchetti, 1996).

The following cases illustrate as examples.

Clare, 16 years old
Clare wrote in her diary that she had always been rejected by her family. She said that neither of her parents had ever told her that they loved her. Feeling unwanted and unloved, Clare spent the last few months of her life moving between friends' and relatives' homes. She said that she felt that wherever she went, she was a burden to people. On one occasion when she returned home overnight, Clare claimed that her mother had told her that she was back at home because she was such a 'little bitch', that nobody wanted her and that she didn't want her either. Clare wrote in her suicide note: "I wish I was dead and I bet everyone especially my 'parents' wishes I wasn't even born".

Rebecca, 15 years old
Rebecca stated that she had experienced emotional abuse by her mother and stepfather for as long as she could remember. She described her family life as miserable and like a gaol, stating that her parents did not trust her. They did not allow her to use the phone or to see her friends outside of school. Rebecca's mother claimed that she expected Rebecca to study hard and have a good education, to have no contact with boys until she was 18 years old and to work hard to obtain material wealth. Six weeks before her death, Rebecca ran away from home. Her friend's father took her to the police station. The Department of Community Services was contacted and arranged for her to stay in a youth refuge. Rebecca disclosed that she was feeling suicidal. She was assessed to be at high risk of suicide and entered into a 'No Suicide Contract'. Rebecca's mother informed the mental health worker that if Rebecca was not able to abide by the rules at home then she was a 'devil's daughter' and she could stay away. Rebecca told the worker that she loved her mother and was grateful for all the things she had given her, although she would give them all up if she could just have love and trust. Rebecca continued to see the mental health worker, with the intended outcome to settle into accommodation and re-establish contact with her family. Rebecca died six weeks later when she was driving her friend's car. She was travelling 10km/h over the speed limit, lost control of the car and collided with several trees. At the time of her death, Rebecca was unlicensed and not wearing a seatbelt.

Other family problems

It has long been established that the quality of parent-child interactions has a marked effect on the mental health and development of the child (Pfeffer, 1987). Moreover, there is evidence that families of suicidal children and young people are less cohesive and more conflicted than the families of non-suicidal children and young people (Bongar, Goldberg, Cleary & Brown, 2000).

Thirty-three children and young people in this subgroup experienced unhelpful family interactions. Typically, they either lived in severely conflict-ridden households or were exposed to ineffective parenting styles. While children and young people from other clusters experienced such aspects of family life from time to time, the children and young people in this subgroup could be distinguished by the intensity and chronic nature of these family characteristics.

Family conflict
The majority (20 out of 29; 69%) of the children and young people who experienced

enduring family conflict came from step or blended families. Moreover, in almost all of those cases, the cause of the family discord was related to step or blended family issues. The typical scenario was that the child or young person expressed dislike of a stepparent and consequently felt betrayed or rejected by his/her biological parent. This resulted in either conflict or discord among the entire family, or the child withdrawing from the rest of the family. Joe's story highlights these issues.

Joe, 16 years old

Joe's parents separated when he was three years old. Joe began living with his mother, although a few years later she claimed that she no longer wanted him and his father was awarded custody. Joe did not see or hear from his mother for the next six years and would often ask his father why she had left him. Joe's father began another relationship when Joe started high school, and eventually married. Joe hated his stepmother and stepsiblings and made little effort to get to know his new family. He would spend all his time in his room, rarely speaking to anyone in his family unless he was spoken to first, and even then answering in a monosyllabic fashion. As a result Joe's father sent him to counselling. Joe indicated that he hated his father because when he had asked Joe if he was okay about moving in with his stepfamily and Joe had indicated that he did not want to, they had moved in anyway. Joe told a friend that he drank alcohol to escape from reality and expressed his hatred for his father and his desire to take his life. Joe eventually committed suicide. After his death, Joe's family members claimed that although they had lived with him, they never really 'knew' him.

Similarly, another young male expressed dislike of his stepmother. His father had remarried after his mother died. This young male told a friend that he and his stepmother did not get on and she would constantly blame him for family problems. He further indicated that his father would always take his stepmother's side over his and that he felt unwanted. As a result, he left home at 14 years of age and went to live with a friend's family.

A third young male expressed feeling caught between his divorced parents. His father had remarried and he indicated that he felt guilty when he returned home to his mother after spending time with his stepmother and her children. He also believed that his mother would try to make him feel guilty for going to see his father, yet at the same time she was the one who was encouraging him to do so. He eventually committed suicide and those who knew him believed that he did so because he was unable to deal with his conflicting emotions regarding his parents.

Negative parenting styles

File records indicate that several children and young people in this subgroup were exposed to negative parenting practices, typically overpermissive, coercive or inconsistent parental styles. In some cases, the mother and father practiced different parental styles, often leaving the child confused about appropriate behaviour.

Nick, 17 years old

Nick's parents separated when Nick was nine years of age and divorced a few years later. Their family continued to be dysfunctional for years afterward; Nick's parents were in an acrimonious separation and continued to argue over the rearing of their children. Nick's mother allowed them free rein, and neither Nick

nor his sister had any respect for their mother as head of the household. With their mother, both children were undisciplined, accustomed to having their own way and showed little respect for adults. In contrast, Nick's father was stricter and would often discipline Nick and his sister. He claimed that his ex-wife would constantly criticise him for attempting to discipline the children. Both Nick and his sister exhibited problematic behaviour at home and were later seen by a psychiatrist, who noted that their parents did not cooperate at all in the management of their children, that Nick and his sister were 'products of their environment' and that both parents shared responsibility for the situation. Nick committed suicide following an argument with his mother.

In this study the coercive disciplinary styles of some parents could be attributed to cultural factors, with families from certain cultures expressing the belief that physical punishment was the way that children in their culture were taught to behave.

Sia, 14 years old

Sia was of Western Samoan origin and arrived in Australia with her family at two years of age. Sia and her family had a long history of Department of Community Services' involvement due to Sia's mother physically assaulting Sia and her siblings, although claiming to be disciplining them. Sia's mother informed a Department of Community Services' officer that in Western Samoan culture physical abuse is acceptable[14]. Sia's father claimed that his wife would lash out at the children with broom handles, straps, belt buckles, plastic bottles, canes and even furniture. Sia's sister told the officer that Western Samoans always beat their children and that parents can even kill their children without anyone worrying about it. The height of Department of Community Services' intervention occurred when Sia's mother threw a coffee mug at her head as punishment for sneaking out of the house. Sia required stiches as a result. Subsequently, Sia's mother expressed to the the Department of Community Services' officer that she was having difficulty merging her Samoan and Australian cultures and indicated that she required help. Not long afterward, however, Sia committed suicide.

The interplay of culture and gender

Although the numbers are small, in two cases there were clearly other sociocultural factors at play that contributed to the unhappy family lives of the young people. The families of these two young people migrated to Australia when the children were 13 and eight years, respectively. Both children experienced great difficulties in attempting to integrate into Australian culture, as their parents expected them to maintain the culture and traditions associated with their country of origin, gender roles and religion. This inevitably created tension and conflict for both young people. Leila's story illustrates as an example.

Leila, 16 years old

Leila migrated to Australia with her family at 13 years of age. Approximately one year later her mother died after being ill for over 10 years. As the eldest female sibling, Leila was forced to take over her mother's role. She had once indicated to

[14] Research evidence documents wide and sometimes excessive use of physical punishment within Samoan families (Cultural Partners Australia, 2002).

a friend that she felt overwhelmed by household responsibilities such as cooking and cleaning for her father and her siblings. She was forced to manage full-time school on top of a heavy workload at home. As a result, she was often absent from school. Leila had many friends, all of whom were aware of her restricted lifestyle. She did not enjoy the same freedoms as other girls her age in Australia. She was not, for example, allowed to go to the movies or to go out with friends unsupervised. At the time of her suicide, Leila's father had been on a religious pilgrimage and had left Leila to run the household.

Leila's story draws attention to the interplay of culture, religion and gender roles. In certain cultures gender roles necessarily follow defined paths, with female roles stressing motherhood and family nurturing. Family pressures, traditional attitudes and religious opposition continue to impose constraints that limit the degree to which females can enjoy the same freedoms as males (Hatch Dupree & Gouttierre, 1997). Leila's story further highlights some of the difficulties associated with living in two separate cultures, illustrating the problems that migrant children and young people can experience as they attempt to merge cultures that hold very different values.

In summary:

- Just over half of the children and young people in this subgroup experienced chronic child abuse and neglect, typically in the form of enduring physical abuse or neglect, or a combination of both.
- Smaller numbers suffered sexual or emotional abuse at the hands of family members or family friends.
- Just under half of this subgroup experienced other family dysfunction, typically enduring family conflict, blended-family issues or negative parenting practices.
- A small number experienced unhappy family lives due to difficulties in living with their new Australian culture and being expected to maintain the culture associated with their country of origin.
- The stories of two young people highlighted the interplay of culture, religion and gender roles and the difficulties that can be experienced by migrant females as a result of these factors.

Enduring difficulties: School-related difficulties 4.4

Thirty-eight children and young people (28 males and 10 females) experienced enduring school-related difficulties. Twenty-six members of this group died by suicide and 12 died from risk-taking.

The children and young people in this group who died by suicide had typically experienced one of three school-related problems – HSC stress, severe learning difficulties or problems in peer relationships. In each case, the problem was perceived by the child or young person to be insurmountable, and this ultimately led to the decision to commit suicide.

In contrast, those in this group who died accidentally by risk-taking all experienced a negative life course or trajectory, resulting in dangerous lifestyles. In each case the child or young person experienced a significant school-related difficulty, typically learning difficulties, behavioural and disciplinary problems, or a combination of both. These experiences resulted in poor academic performance and poor school attendance, and each child or young person then dropped out of school or was suspended or

expelled for behavioural problems. Once out of the education system, these children and young people tended to associate with peers who were also no longer attending school and in each case became involved in drug use and crime. Nine out of the 12 children and young people died from drug overdoses, most of which involved heroin. The other three cases involved motor transport incidents while the child or young person was intoxicated.

Table 4.3 presents the specific school-related difficulties that were experienced and the frequencies with which each was experienced. The sections that follow explore in detail each of those school-related difficulties, using case examples as illustrations.

Table 4.3

School-related difficulties by gender

School-related difficulty	Males	Females
HSC stress	6	4
Behavioural and disciplinary problems	14	3
Learning difficulties	8	0
Problems in peer relationships	4	4
Total*	**32**	**11**

**** Total numbers do not equal the total number of males and females in this subgroup (n = 38) as some children and young people experienced more than one school-related difficulty.***

HSC stress

Of the 10 young people who experienced significant levels of HSC-related stress, all died by suicide. As a group, these were successful students, with records indicating that they set high standards for themselves and worked extremely hard. Documentation also showed that the period leading up to their deaths was typically characterised by feelings of overwhelming pressure to succeed, coupled with an intense fear of failure. One young person committed suicide two days after attempting some practice trial HSC papers and claiming that he couldn't understand the questions. In his suicide note he wrote: 'I'm sorry to do this to you but I have to do it for myself. It's not because of exams I just can't do anything right anymore'.

In addition to being high achievers academically, almost all of these young people took an active role in school life; they were involved in extracurricular activities, were popular with their peers and many of them held prefect or captain positions. Kyle's story is an example.

Kyle, 17 years old

At the time of his suicide, Kyle was sitting for his HSC trial exams. Kyle had always performed extremely well at school. He had won a scholarship to attend his high school and had achieved merit and distinction prizes throughout his high school years. In addition, he had been elected a school prefect and excelled at extracurricular activities, including sports and music, having won awards for both. Kyle's best friend said that he worked hard, was intelligent and took his schoolwork seriously. He further said that Kyle had many friends and an active social life. On the night before his death, Kyle was studying for a trial exam. He told his mother that he 'broke his brain'. The next day, Kyle did not turn up for the exam and it was later discovered that he had suicided.

While most of the young people in this group were above-average students with an intense will to succeed, not all of them were performing well at school. One young male was struggling with some of his HSC subjects and his parents had arranged for a private tutor to assist him. He suicided a few minutes before his tutor was due to arrive. This young male was born in Hong Kong and arrived in Australia with his family at the age of six years. After his death, his father claimed that the family had high expectations for him to do well in his studies. He further stated that as a Chinese male, these pressures were greater for him than other young people his age might experience. This supports the research finding that Chinese young people are under great pressure to study and succeed in order to maintain family honour (Cultural Partners Australia, 2002).

Although previous research has not documented a link between HSC stress and suicide, Smith and Sinclair (2000) found that more than 40% of Year 12 students in their study reported symptoms of depression, anxiety and stress that fell outside normal ranges. Similarly, Hodge, McCormick and Elliott (1997) reported that a high proportion of HSC students in their study were at-risk of severe psychological illness.

Many young people turn 18 years of age during Year 12 and some HSC students are older still. The upper age limit for this study was 17 years 11 months, which suggests that its findings could be an underestimate of the number of HSC-related deaths. In 2000 the HSC candidature was 62,883 (NSW Board of Studies, 2001). It is therefore important to acknowledge that of the large number of people sitting the HSC, only a very small proportion of young people suicided over HSC-related issues.

Behavioural and disciplinary problems

More than half (64.7%) of the children and young people who experienced significant behavioural and disciplinary problems died accidental deaths by risk-taking. Eleven of these children and young people (10 of them male) had been diagnosed with a behavioural disorder. Diagnoses included Conduct Disorder (childhood onset), Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder.

For those who died by risk-taking, the behavioural and subsequent disciplinary problems were followed by a lifestyle of risk-taking, which typically involved leaving school early, drug use and crime, as in Harry's case.

Harry, 14 years old

Harry was an Aboriginal child who had experienced significant conduct and learning problems since first attending school. His entry into the school system coincided with the removal of Harry and his older sibling from his mother's care due to her abuse of alcohol and illicit drugs, and neglect of the children. Harry's grandmother was given custody of them. Due to his disruptive behaviour and marked difficulties in learning, Harry's primary school years had largely been spent with support, one-to-one teaching and specialist units for remediation. There had been intermittent attempts at full reintegration to normal classes. Harry also exhibited problem behaviour at home. Department of Community Services' involvement was, however, limited to financial support. As Harry entered high school, he spent most of his time with older children 'on the street', truanted from school and became involved in drug use and criminal activities. He was subsequently excluded from his school, after which he did not settle into regular attendance at another school. He was eventually the subject of a Control Order

due to his criminal behaviour and while in detention began to exhibit self-harming behaviour, which escalated into two suicide attempts, both by hanging. Harry was assessed by a psychiatrist and diagnosed with Conduct Disorder (childhood onset) and learning disorder (no specific details were provided). A workers' meeting was subsequently held with representatives from the Department of Community Services, Juvenile Justice, paediatric mental health and an Aboriginal worker from a local community health service. Following this meeting, extensive support services were put into place for Harry and his family. Nevertheless, two months later Harry died when he ran into the path of a train, while in a state of cannabis intoxication. It was believed that Harry was attempting to cross the train tracks but did not see the approaching train. For that reason, his death was categorised as accidental, not as suicide.

As with previous case examples, Harry's case highlights the overlap between suicide and risk-taking deaths in that several young people who died by risk-taking had exhibited prior suicidal behaviour. It also highlights the importance of early detection and intervention. Extensive support services were put in place for Harry and a great deal of interagency work was done, although this all took place in the last few months of Harry's life. As his psychiatrist noted, this work needed to have been done at age five years, when Harry was removed from his biological mother and started school.

Learning difficulties

Of the eight children and young people who experienced significant learning difficulties, all were male and six died by suicide. Beautrais (2000) stated that a link between learning disabilities and suicide has been suggested, although strong research evidence is lacking in this area.

The learning disabilities experienced by this group of children and young people included impaired reading and writing ability, language skills, drawing skills and creative ability. Four young males had psychometric assessments indicating IQs in the low-average range. From the information on file, it is evident that all of these children and young people suffered from extremely low self-esteem, feelings of inadequacy and failure due to their learning difficulties.

Chris, 17 years old
Chris's performance at school was consistently well below average. He had no disciplinary problems at school and completed all of his assignments, yet failed most of his subjects in Years 10, 11 and 12. Chris had decided at the beginning of Year 11 that he would leave school, but soon realised that he had limited employment prospects. Chris's father claimed that he never pressured Chris about his schoolwork. When Chris told his father that he was at the bottom of his year, his father said that he didn't mind, he just wanted him to complete his HSC. A few weeks prior to his death, Chris told a friend that he felt 'dumb' and was finding it very difficult to cope with this. He further said that he would rather be dead, in heaven where it was more peaceful.

Another young male expressed similar feelings of worthlessness and inadequacy. He was regarded as developmentally delayed, and both of his parents were mildly developmentally delayed. In his suicide note he wrote, 'all my life I have Been pick on pushed around yelled at my suicide was the Best thing for me it was the only wayout.

Nothing ever goes wright for me i try to make better but they only get worse!!! my birth was the bigest mistake .... I can not live in a World were people are going to haras me...' (Original spelling and punctuation retained).

These cases illustrate the effects of learning difficulties and poor academic performance on children and young people's sense of self worth and consequently on their mental health and well-being. In these young people's lives education concerns were directly related to their deaths.

Problems in peer relationships

Four males and four females, all of whom died by suicide, experienced problems in peer relationships in the form of bullying, severe taunting, humiliation, rumour-spreading and exclusion. With one exception, physical violence was not involved. In that incident, a group of students attempted to hang a young male with a piece of string. He committed suicide some years later by hanging.

The nature of the problems in peer relationships was quite different for each sex. For females, incidents typically involved short episodes of rumour-spreading, name-calling, peer group spitefulness and exclusion. One young female took her life a few days after a major disagreement with her group of friends. They had stopped talking to her and she wrote a letter apologising for whatever it was that had caused them to be angry with her. The suicide of another young girl coincided with several of the students in her class taunting her and spreading rumours about her. Carla's story illustrates the effects that such taunting and spitefulness can have on young girls.

Carla, 16 years old

Carla's sister told the police that in the year prior to her death, Carla had become part of the 'private schools party scene', spending very little time with her family. Despite her involvement with them, she repeatedly told her sister that her friends were 'bitches' and nasty people. Carla's mother claimed that Carla had always suffered from low self-esteem; she did not see herself as good looking or popular and was hesitant to accept compliments. Her mother further noted that Carla never expected to do well at anything and was surprised when she did. Her family believed that her poor self-esteem was exacerbated by the nasty actions of her peer group. Carla was constantly putting herself down, claiming that she was 'stupid' and 'fat'. She would say that a friend of hers was always telling her that she was fat. After her death, Carla's friend told the police that Carla had said that she had no real friends at school, except for one person. Carla had frequently talked to this friend about suicide and on the day before her death had told her that she would commit suicide by walking over a cliff. The next day, that is what she did. Her friend told the police that she was not at all surprised that Carla took her life. Carla left a suicide note stating: 'I guess life just got too hard, I couldn't see the point ....'

In addition to highlighting the possible consequences of peer group spitefulness and taunting, this case raises issues about the need to intervene when a young person indicates his or her intention to suicide. There are many cases like Carla's in this study, where a child or young person had revealed to a friend or family member that he or she was going to commit suicide or that they wished they were dead and the friend or family member did not do anything with this information. The notion that 'people who talk

about committing suicide never do it' is one of the myths about suicide. Rather, talking about suicide can be a plea for help and can be a late sign in the progression towards a suicide attempt.

The difficulty is that many more children and young people threaten suicide than do it. Many use such threats to manipulate others. In addition, most children and young people bind those they tell to silence. Thus, although it is difficult to know which of the many threats may presage action, children and young people must be made aware that suicide threats cannot be dismissed as idle and that those are the secrets that must not be kept.

While females' experiences of problematic peer relationships typically involved episodes of rumour-spreading, taunting and exclusion, males' experiences involved continuous tormenting and bullying. These boys had reacted to the enduring nature of the bullying prior to their suicides. One had previously attempted suicide and one had changed schools. Typically, the boys were taunted for not being athletic. For instance, one young male was constantly teased for being academically inclined and not interested in sports. He later spoke about this experience as a turning point in his life when he began to socially withdraw from people. The example of Simon further illustrates the effects of constant tormenting by peers on mental health and well-being.

> **Simon, 17 years old**
> Simon was an above average student who worked hard and had planned to go to university. He had loving and supportive parents, but suffered a great deal of taunting from his peers. After his death some of his classmates told the police that Simon was 'paid out' by other boys on a regular basis because of the 'dumb' things that he would say and his uncoordinated efforts at sport. He was also teased because the boys in his class thought that his girlfriend was unattractive. One of the boys stated that if he had been the one who was being taunted all the time, he would have left the school. At one point, Simon had told his mother that he was so upset that he felt suicidal.

These cases show the serious effects that peer bullying and taunting can have on the well-being of children and young people. Even short-term peer group nastiness and exclusion can have significant emotional effects. Moreover, the findings are consistent with previous research findings that children who have been frequent victims of peer bullying are significantly more likely to exhibit suicidal ideation (Rigby & Slee, 1999).

In summary:

- The enduring school-related problems experienced by the children and young people in this group who died by suicide were typically HSC-related stress, learning difficulties and problems in peer relationships.
- Those who died by risk-taking were more likely to have experienced a trajectory beginning with behavioural and disciplinary problems at school, leaving school early, becoming involved in drug use and criminal behaviour and dying in drug-related incidents.

4.5 Conclusions

The children and young people in this cluster experienced at least one of three enduring difficulties: mental health problems or distressed emotional state, family dysfunction or

school-related difficulties. Twenty-eight (22.6%) children and young people suffered more than one type of enduring difficulty.

The findings regarding the mental health problems subgroup suggest that some children and young people who die from suicide might have been suffering from an undiagnosed mental health problem. In a national survey of mental health and well-being, Sawyer et al. (2000) found that only a minority of children and young people with mental health problems receive professional help. Families, schools and other agencies therefore play an important role in identifying those children and young people who may be in need of mental health assessment and service provision.

The findings relating to the family dysfunction subgroup add empirical support for claims that enduring and intense family turmoil are risk factors for substance use and suicide, while a new finding from the analysis of the school-related difficulties subgroup was the association between HSC stress and suicide. As already mentioned, these results may underestimate the problem, as significant numbers of young people who sit for their HSC are over 18 years of age and so would not be captured in the present study. In addition, as the population under study is deceased children and young people, we do not have information about the extent to which the pressures associated with the final year at school affect the general mental health and well-being of those who do not take their lives.

The fact that the children and young people who formed the school-related difficulties subgroup were typically male supports previous research findings that males experience more school-related problems than do females. Existing research has shown, for example, gender differences in academic performance (Zubrick et al., 1997), disciplinary problems (Warrington et al., 2000) and learning difficulties (Tinklin et al., 2001), with males experiencing more problems in each of these areas.

The following chapter presents a detailed account of the circumstances of the deaths of the children and young people who experienced enduring difficulties, as well as a summary of their contact with human service agencies.

Chapter five

Children and young people with enduring difficulties: Circumstances of death and human service agency contact

This chapter first presents the circumstances of the deaths of the 124 children and young people who experienced enduring mental health problems, family dysfunction, and school-related difficulties. Their prior contact with human service agencies is then detailed.

5.1 Circumstances of the death

Method of death

Table 5.1 presents the method of death for the 124 children and young people. As with the overall population of deaths in this study, intentional self-harm by hanging was the most common method of death for these children and young people. Accidental poisoning was the next most common method of death.

The following sections detail the circumstances surrounding the deaths of the 124 children and young people. As the death scenarios were related to the types of enduring difficulties that were experienced, the circumstances of the deaths are presented separately for each subgroup: mental health problems, family dysfunction and school-related difficulties.

Table 5.1

Enduring difficulties cluster: Method of death

Method of death	n	%
Suicide		
Intentional self-harm by hanging	46	37.1
Intentional self-harm by firearms	11	8.9
Intentional self-harm by jumping from heights	9	7.3
Intentional self-harm by poisoning	6	4.8
Intentional self-harm-jumping/lying before moving object	5	4.0
Intentional self-harm by motor vehicle exhaust gas	2	1.6
Intentional self-harm by drowning	1	0.85
Risk-taking		
Accidental poisoning	31	25.0
Driver of motor vehicle injured in transport accident	3	2.4
Pedestrian injured in transport accident	3	2.4
Occupant of train injured by fall from train	1	0.85
Undetermined intent		
Poisoning, undetermined intent	4	3.2
Lying/running before moving object, undetermined intent	2	1.6
Total	**124**	**100.0**

1) Mental health problems and distressed emotional state subgroup

All of the fatalities in this category could be grouped under two scenarios: diagnosed mental health problems excluding behavioural problems (19 children and young people died in this context) and extreme hopelessness and despair (22 children and young people died in this context).

Diagnosed mental health problems

For the 19 children and young people who had been diagnosed with either depression or a psychotic disorder, it appears that their deaths occurred either during a psychotic episode or as a direct result of their depressed state. The children and young people who were diagnosed with behavioural disorders typically died in the context of their risk-taking lifestyle, and so the circumstances of their deaths will be detailed later in this chapter.

For those who died during a psychotic episode, this typically occurred at a time when either the child or young person had been non-compliant with his or her medication or had just been released from a period of hospitalisation. Records indicate that they had developed delusions and hallucinations and clearly lost touch with reality. These children and young people appeared to have no insight that their experiences were abnormal. Typically, the delusions and hallucinations were either telling the children and young people to kill themselves, or they saw their deaths as the only way to escape their thoughts and experiences, as in Tina's case.

> **Tina, 17 years old**
>
> Tina was expelled from her school in Year 9 'for smoking cannabis'. After leaving school she began to use cannabis more frequently. Her mother claimed that she soon started to practice witchcraft and worship the devil. Around her sixteenth birthday Tina used LSD, which resulted in her being hospitalised for three weeks. Upon release, Tina was behaving in a paranoid manner. She also became verbally and physically aggressive. Her mother took her to the hospital, where Tina told staff that she was 'connected to a computer' and wanted to be disconnected. Hospital staff noted on file that her thought pattern was disordered and she would interrupt them, asking them if they could hear 'the voices'. She said she could hear a voice that was describing her thoughts and she believed that people were plotting against her. Tina was diagnosed with drug-induced psychosis and hospitalised for eight weeks. Upon her release, her mother claimed that her behaviour had not improved.
>
> One month prior to her death Tina attempted suicide by overdosing on her antipsychotic medication. She told hospital staff that she had a metal chip in her mind that connected her mind to other people's minds. She was tormented by this and claimed that her death was the only way to stop this. Tina was classed as being at high risk of suicide and was transferred to the mental health unit of the hospital. One month later hospital staff felt that she was ready to return home permanently. Her parents refused, claiming that it was too soon, and so a weekend release program was put in place. Tina committed suicide when she was on her first weekend release pass visiting her family.

In cases in which the child or young person died during a psychotic episode, records seemed to indicate that the delusions or other psychotic symptoms were becoming

stronger in the days preceding their death. For example, one young person had been diagnosed with schizophrenia and developed persecutory delusions with auditory, visual and somatic hallucinations. The auditory hallucinations (or 'voices') would tell him to harm himself. On the day before his death he told his mother that the voices were getting louder and stronger and that he was really scared.

However, most of the children and young people with ongoing mental health problems died in the context of a depressive episode. Their suicide notes indicated feelings of utter hopelessness, beliefs that they would be unhappy forever, that their families would be better off without them and that suicide was the only way they could be happy.

Jane, 17 years old

Jane's mother said that when Jane turned 15 years old she became unhappy and moody, although she had not attributed it to anything serious. A few months before her suicide, however, Jane's mood worsened. She told her mother that she would become very angry at times and that she was concerned that she did not know where her life was going. Jane's mother arranged for her to see a psychiatrist, who prescribed her antidepressant medication. Initially, her mood seemed to improve. However, on the day before her suicide Jane rang her mother to say that she felt miserable again. After her suicide, her mother said that she had been concerned for Jane, but did not consider she might commit suicide. In her suicide note to her parents Jane said, 'I know that over the latter years I've been more of a source of sorrow than joy and if I lived I should just continue to hurt you ... I wish things might have been different, but at the moment all I feel is relief that I won't be unhappy any longer'.

Approximately half of the children and young people with depression had experienced significant levels of psychosocial stress, including school failure, feelings of social isolation and familial dysfunction. The other half, however, appeared to have developed a depressive illness in the absence of any known stressors. One of these young people had been diagnosed with endogenous depression. Another expressed the belief that her depression came from within her, writing in her suicide note that there was something inside her that had caused her to be unhappy.

Extreme hopelessness and despair

Twenty-two children and young people were not diagnosed with a mental health problem, although, like those who died while in a clinically depressed state, their suicide notes also expressed feelings of extreme hopelessness and despair. Records indicate that in the weeks preceding their suicides, these children and young people became withdrawn and difficult to communicate with, often staying in their rooms for long periods of time. Typically, their suicide notes included thoughts and feelings of self-hatred, failure, isolation, and that life was no longer worth living.

Peter, 16 years old

Peter was severely dyslexic and health records indicate that he was embarrassed about his disability. His school counsellor records indicate that his family situation was positive, with Peter experiencing strong, supportive relationships with his parents and siblings. However, these records also indicate that Peter's school counsellor referred him for mental health assessment the day prior to his suicide. He had been telling her that he hated himself and that

> he was going to hang himself. Community health records confirm that Peter was at high risk of suicide. His case was listed as urgent and an appointment was made. Peter committed suicide by hanging the following day. It is clear from the spelling mistakes in his suicide note that Peter was severely dyslexic. In his note Peter expressed self-hatred and that his death would be the best thing for everybody:
>
> '... One of the resions I did it was because I hate my selfe ... I know that all I do is hirt people ... I love you all and I am going to help you by not hirting you eneymore ... thanks for everything you did for me sorry I am such a wast of air ...' (Original spelling and punctuation retained).

Like some of those who had been diagnosed with a depressive disorder, all of the children and young people in this group had experienced major psychological stressors. Four young females, for example, expressed extreme concern about their physical appearance, believing that they were very unattractive. One young male expressed severe self-hatred, writing in his suicide note that he had killed himself because he was unable to cope with the belief that he was homosexual[15].

2) Family dysfunction subgroup

As with the mental health problems subgroup, the deaths of the children and young people in this subgroup could typically be grouped under two scenarios. In the period leading to their deaths, almost all who died from suicide had exhibited extreme sadness and hopelessness over their family situations. In contrast, those who died from risk-taking appeared to react differently to their dysfunctional family lives, typically becoming involved in substance use and criminal activity, and subsequently dying in such a context.

Extreme sadness and hopelessness

File records indicate that many of the children and young people who died by suicide and experienced unhappy family lives tended to feel rejected, worthless, unloved and betrayed by their parents. It is postulated that these feelings in turn led to feelings of extreme sadness and hopelessness. The children and young people were unable to cope with these emotions and eventually took their lives. Their suicides can be viewed as their last attempt to escape from an unbearable situation.

Recall the case of 16 year old Joe (page 52) who took his life ostensibly as a result of his intense hatred of his father after he remarried. Joe suffered one seeming betrayal after another by both biological parents and was clearly affected by his experiences. In the first instance, his mother abandoned him at a very young age, leaving him to live with his father and ceasing all contact with no explanation given. For years after this, Joe would ask his father when his mother was coming to visit and why she had left him with

[15] Distress about homosexuality emerged as a significant issue in just one case in this study. Howard, Nicholas, Brown and Karacanta (2002) cite evidence that same-sex attracted youth are at elevated risk for suicide attempts, with one study, for example, showing that gay-identified youth were 3.8 times more likely to report making a suicide attempt. However, same-sex attracted youth are not over-represented in suicide death figures. This is in part due to the general lack of information available to Coroners about suicide deaths (Dudley, Kelk, Florio, Waters, Howard & Taylor, 1998). Another likely explanation is that young people may struggle with sexuality for many years before 'coming out' to others (Nicholas & Howard, 1998; cited in Dudley et al., 1998).

his dad. Several years later, his father remarried and although he did query Joe regarding his feelings, he made no attempt to assist Joe to adjust to the situation despite Joe clearly expressing his unhappiness over his father's remarriage.

Joe's intense hurt and anger was evident in his letters to his friend, as was his belief that suicide was the only way for him to escape his pain:

> 'I don't even consider myself to be related to my dad. Most kids go looking for adoption papers and get upset when they find them. I went looking for them and got upset when I found my birth certificate and found out I was really related to my dad ... I might try to end it ... please don't be sad ... just remember it's what I wanted and at least I'll finally be happy ...'

Similar issues of feelings of betrayal and abandonment by family and the belief that suicide was the way to be rid of those feelings are highlighted in Greg's case.

> **Greg, 17 years old**
> Greg's father died when Greg was 14 years old. Soon afterward his mother entered into a new relationship and married. File records indicate that Greg did not get along with his stepfather, that he felt unwelcome at home and spent considerable periods of time wandering the streets. Greg was asked to leave his family home approximately four months prior to his suicide. A friend of Greg's indicated that Greg would often talk about his biological father and that this would cause him to become upset. His friend also recalled him claiming that nobody cared about him and that he wanted to be with his father and that he wouldn't live to reach his twenty-first birthday.

Thus, Greg was grieving over his father's death, had a poor relationship with his new stepfather, and was subsequently asked to leave the family home. Conversations with his friend indicate that Greg clearly felt unloved and alone.

> **Darren, 16 years old**
> There had always been a great deal of conflict between Darren's mother and the rest of the family. Darren's mother insisted on high standards and was unbending on this. The fighting was so extreme that Darren's father would regularly move out of the family home for periods of time. Darren's friends indicated that Darren showed little positive feelings towards his mother. About one month prior to Darren's suicide, Darren's brother permanently moved out of home due to ongoing arguments with his mother. The night before his suicide, Darren had told his brother that things had become much worse since he had left. He committed suicide following an argument with his mother after he failed to tell her about a meeting at school.

Darren's family life was characterised by intense conflict and turmoil, with little effective resolution. While his brother and father chose to move out of the family home as an escape, Darren chose what he saw as the ultimate escape – suicide.

Drug use and crime

In contrast to those who died by suicide, the children and young people in this subgroup who died from risk-taking tended to react differently to their experiences of family dysfunction. Many turned to substance use to escape their unhappy lives, and this almost inevitably led to engagement in criminal activity in an effort to support their

addiction. The majority of these children and young people eventually died from drug toxicity and overdoses.

Crystal, 14 years old

Crystal experienced a lifetime of neglect by her mother. Crystal's older sister had left home due to constant physical and psychological abuse by their mother. From the time that Crystal was born her mother would regularly take Crystal to her sister to care for her, picking her up after a period of time, only to leave her again some time later. Each time she would leave Crystal for an increasingly longer period. Even when Crystal was a young child, her mother would often leave her at home alone while she went out drinking. Crystal would ring around different houses looking for her mother. When Crystal was 10 years of age, her mother handed her over to her sister again, claiming that she was in financial debt and if she did not take Crystal, she would kill her. At that stage, Crystal did not even have a pair of shoes to wear. By the age of 11 years Crystal was already exhibiting suicidal behaviour, holding a knife to her throat and threatening to kill herself. When she was 12 years of age, Crystal took herself to a Department of Community Services' office, claiming that she could no longer live with her mother. She stated that her mother was constantly abandoning her, ignoring her needs, failing to provide her with food and abusing alcohol. For the remaining two years of her life Crystal was using heroin daily and moving between refuges, her mother's and sister's homes and the homes of older males with whom she would form relationships. She became known to the Department of Juvenile Justice and her case workers concluded that her criminal activity was directly related to her heroin use. Crystal refused all offers of counselling and died at 14 years of age from a heroin overdose.

It would appear that Crystal's substance use and ultimate death were directly related to the neglect and abandonment to which she had been subjected for most of her life. There appear to have been few positive or protective factors to moderate the impact of the neglect and abandonment that Crystal experienced.

Janet, 16 years old

Janet's parents separated when she was a young child. Both of her parents were heroin addicts and Janet's mother started a methadone program when Janet was six years old. Janet's mother had a history of physical abuse of Janet, including attempted strangulation. As a result, Janet had been placed on a 12-month Wardship order, returning to her mother at its conclusion. Janet's mother remarried and her stepfather was extremely violent towards her mother, violence which Janet often witnessed. By 14 years of age, Janet was a polydrug user, using heroin, methadone, marijuana, speed, ecstasy and prescription drugs such as Valium. She was living in her boyfriend's car and engaging in sex work for income. She returned to her mother's home when her boyfriend received a custodial sentence. Several months later, a neighbour notified Janet to the Department of Community Services, claiming that her mother had thrown her out of home and she was living in the garage of her building with an older man. The investigating officer noted that Janet's mother appeared to be more concerned with being evicted by the Department of Housing due to Janet living in the garage than she was about Janet's safety and welfare. The Department of

> Community Services, however, closed Janet's file, citing her itinerant lifestyle as the cause of case closure. In the months prior to her death, Janet continued to engage in drug use and criminal activity. She died from a multiple drug overdose.

Like Crystal, Janet's drug addiction and subsequent death was almost certainly related to the abusive and uncaring family environment in which she had been raised. She was exposed to parental drug use from a young age, witnessed extreme family violence and endured physical abuse and neglect. Few positive relationships mitigated against this negative family background. Like many others in this group, Janet's substance use could be viewed as her way of attempting to cope with an unbearable situation.

It is important to note that engagement in substance use and crime was not limited to those children and young people who died from risk-taking. Although the majority of those who frequently engaged in drug use and criminal activity did eventually die from drug overdoses, a small number of children and young people (5) involved in these high-risk lifestyles died from suicide. All five of these children and young people were exposed to chronic child abuse and neglect and had a great deal of involvement with the child protection system.

3) School-related difficulties subgroup

Deaths related to school difficulties typically occurred in one of three contexts. The young people who experienced significant levels of anxiety and worry due to HSC-related pressures died in a state of acute stress. In contrast, those who suffered learning disabilities or problems in peer relationships died in a context of low self-esteem and feelings of worthlessness. The third group of children and young people, many of whom had diagnosed behavioural disorders, died in the context of a risk-taking lifestyle.

Acute stress

The young people whose records indicated significant stress levels associated with their impending HSC exams all appear to have suicided in a state of acute stress and in close proximity to an event relating to their exams. Recall the case of Kyle (page 55), for example, who committed suicide at the time that he was supposed to be sitting an HSC trial exam. Another young person suicided the day before an assignment, that was to form part of her HSC assessment, was due. She referred to this assignment in her suicide note.

One young person committed suicide on the day that her exams were due to begin. She had placed herself under a great deal of pressure as she wished to study medicine at university and had indicated her fear that she would not attain the necessary marks. Another young person suicided a few weeks after commencing at a new school. He had always set very high standards for himself, had taken his studies very seriously and had been the dux of Year 10 at his previous school. Records indicate that since starting his final school years he had experienced difficulties with some subjects and had been extremely stressed about possible failure and disappointing his parents.

Low self-esteem and worthlessness

Evidence of low self-esteem and feelings of worthlessness was found in the documentation of those children and young people who suffered from learning difficulties or problems in peer relationships. Low self-esteem and worthlessness might well have been the factors mediating the relationship between these specific school-related difficulties and the decision to take their lives.

Recall the case of Chris (page 57) who, prior to his death, confided in a friend the difficulties that he was having with schoolwork and the fact that he felt 'dumb'. He further indicated that he was questioning the value of living. His case provides some evidence of a link between learning difficulties and suicide, mediated by low self-esteem and feelings of inadequacy.

Similarly, Jordan's story suggests the possible mediating role of low self-esteem and worthlessness in the relationship between peer bullying and suicidal behaviour.

> **Jordan, 17 years old**
> Jordan's family first realised that there was a problem when he exhibited suicidal behaviour at 10 years of age, standing on the edge of a window several storeys high in his school building. This was when Jordan revealed that he was being bullied at school. Several years later, Jordan engaged in further suicidal behaviour, this time by self-mutilation. He was referred to a school counsellor, who indicated that Jordan was being bullied at school and as a result had developed feelings of worthlessness and inadequacy. A close friend of Jordan's claimed that in the months prior to his death he would tell her that nobody loved him and that he was worthless. In a letter that he wrote the day prior to his death Jordan indicated that he 'had hardly any proper friends' [and] 'always seemed to get picked out of a crowd', [that he] 'grew up being bullied' [and had a] 'self-esteem problem.'

Lifestyle of risk-taking

The deaths of the children and young people who died accidentally typically occurred in the context of their dangerous risk-taking lifestyles. Many of these children and young people had diagnosed behavioural disorders, all of them had substance abuse problems and all died either from drug overdoses or while in a state of intoxication.

> **Craig, 17 years old**
> Craig's father was an alcoholic and Craig had often witnessed his father in an intoxicated state. In addition, Craig had been diagnosed with Conduct Disorder (early onset) and reported that he never liked school because he had difficulty comprehending the work and was always getting into trouble. He was expelled from school in Year 9 for hitting a teacher and had been unemployed ever since. He spent most of his time with young people who were in a similar situation. At about 15 years of age Craig began abusing alcohol and committing crimes while affected by alcohol. At times, Craig exhibited suicidal behaviour while intoxicated. At a psychological assessment, Craig admitted that he felt that life had been very hard on him and that the majority of his offending was committed while he was abusing alcohol. Craig eventually died when he fell from a train while intoxicated. He had forced open the train doors and hung from a bar near the doors, with most of his body outside the carriage. Toxicological analysis showed a blood alcohol level of 0.186g/100mL.

Similarly, all of the children and young people whose records indicated that they were regular users of heroin eventually died from heroin overdoses. The toxicology examination conducted on one young person revealed a bile morphine reading of greater than 100mg/L. The pathologist noted that he would have had to be injecting heroin on virtually a daily basis to have such a high reading. This young person had dropped out of

school due to continual disciplinary problems resulting from his problematic behaviour. His academic report cards consistently indicated that he was very intelligent and capable of doing very well at school, although he was not working at all.

Coronial investigations

Post-mortem examinations were conducted in all cases. Alcohol was noted in the toxicology reports of 20 children and young people, with blood alcohol levels ranging from 0.014g/100mL to 0.216g/100mL[16]. Drugs other than alcohol were noted in the toxicology reports of 66 (53.2%) children and young people. Fatal or toxic levels were reported in 41 of those cases, with the drugs ingested including heroin, methadone, prescription medication (for example, antidepressants, migraine medication), benzodiazepines, amphetamines and alcohol.

Coronial inquests were held in 14 cases. In one case, an inquest was held into the death of a girl who had experienced enduring mental health problems. The Coroner stated that the reason for holding the inquest was to assist in understanding the reasons behind the girl taking her life in order to help prevent further child deaths from suicide. Toxicology findings indicated that the 14 year old had used cannabis in the hours preceding her suicide, and at the inquest the Coroner stated that cannabis use and abuse had been associated with the deaths of other young people in inquests that had been held in his court. He called for in-depth research to be carried out regarding the general effects of cannabis consumption, although he acknowledged that a direct link between the use of cannabis and these deaths could not be verified.

In summary:

- Hanging was the most common method of death, followed by poisoning.
- The deaths of those with diagnosed mental health problems occurred during a psychotic episode or more typically as a result of their depressed state.
- Overall, the suicide deaths of those who experienced enduring family dysfunction took place in a context of extreme sadness and hopelessness. In contrast, the risk-taking deaths occurred while the young people were engaging in substance use and criminal activity. Most of these young people seem to have turned to drug use as a temporary escape from their traumatic family lives.
- Deaths of the children and young people who suffered ongoing school-related difficulties occurred in one of three contexts. Those who experienced HSC-related pressures died in a state of acute stress. The children and young people who suffered from learning difficulties or problems in peer relationships died in a context of low self-esteem and worthlessness. Finally, several young people died in a context of behavioural disorders and a risk-taking lifestyle, typically one of drug use and crime.

5.2 Human service agency involvement

The types of human service agencies that children and young people have contact with will inevitably depend on the nature of the difficulties that they experience. Thus, the review of human service agency involvement is presented separately for each subgroup.

[16] It is indicated on toxicology reports that 'more than 50% of persons would be grossly intoxicated at a blood alcohol concentration of 0.150g'.

The primary roles played in suicide prevention of each human service agency referred to in this report are detailed in Appendix 3.

The children and young people in this cluster present challenges to practitioners and the human service agencies. They tend to be poorly motivated and their families are often dysfunctional. Often these children and young people first come to the attention of human service agencies once the dysfunction is already severe and entrenched and practitioners can find it difficult to engage with them. Human service agencies need to continually search for new ways of working to assist these children and young people.

1) Mental health problems and distressed emotional state subgroup

This subgroup includes 41 children and young people, 19 who received psychiatric diagnoses (other than behavioural disorders) and 22 who were suffering from severe emotional distress.

Specifically, this section focuses on the human service agencies accessed by this subgroup, with the exception of those who had diagnosed behavioural disorders. This is because those with diagnosed behavioural disorders also experienced either enduring family dysfunction and/or school-related difficulties, and their contact with human service agencies is detailed in those sections.

Twenty-nine of the 41 children and young people had been clients of at least one human service agency. The 12 who had not been involved with any human service agencies were among those who had not been diagnosed with a mental health problem. All of the 29 children and young people who had received the services of at least one human service agency had been to a mental health service.

Contact with mental health services

The extent of contact with a mental health service varied from extensive, ongoing service provision to one-off visits. The type of mental health services accessed included hospital services, Community Health Centres, Child and Adolescent Mental Health Teams, and private or consultant psychiatrists, psychologists and counsellors.

Four case reviews highlighted examples of proactive mental health service provision. In those cases, there was clear evidence of mental health professionals expressing grave concerns for the safety and well-being of their child and adolescent clients, and as a result putting provisions in place in an attempt to secure their safety. For instance, one young person judged to be at high risk of suicide was on a waiting list for admission to an inpatient program. A mental health professional visited him at home daily until the assessment. Examples of proactive service provision are further illustrated in Cathy's case.

> **Cathy, 14 years old**
>
> Cathy attempted suicide by overdosing for the first time about 18 months before her death. She was assessed by a psychiatric registrar in the hospital emergency department and prescribed antidepressant medication, which she did not take consistently. She also began to see a psychologist who worked in her Area Health Service Mental Health unit. Four months later she attempted suicide for the second time, again by overdosing. Cathy then began weekly sessions with her psychologist.

While the case reviews highlighted some examples of proactive mental health service

provision; several areas of inadequate practice also emerged. These centred on:

- Inappropriate agency actions;
- Failure to recognise suicide risk; and
- Ineffective case management.

For 11 of the 29 children and young people who had received mental health service provision; case reviews revealed deficits in service provision. These included not communicating with the children and young people and their carers in an appropriate way, discharging patients from hospital at an inappropriate time following suicidal behaviour, postponing appointments, failing to recognise suicide risk and ineffective case management.

In one case, a young person was diagnosed with depression following his decision to give up the use of cannabis. He was referred to a psychiatrist who prescribed antidepressant and sleeping medications. The young person's mother claimed that the psychiatrist did not explain to her or to her son what he thought the young person was experiencing, and spoke to him 'as an adult when he was really only a boy'. An appointment was made with the family to return to the psychiatrist two weeks later, although the young person stated that he hated the psychiatrist and never wanted to see him again.

Three young people were discharged from hospital without adequate assessment and follow-up. The case of Ben illustrates this.

> **Ben, 17 years old**
> Ben presented to the Emergency Department following a heroin overdose. He was treated and discharged 2½ hours after arrival. Ben died of a heroin overdose later that night. It is believed that he consumed an additional amount of heroin following his discharge from hospital.

This case raises concerns about the practice of discharging patients without adequate observation and assessment. The NSW Health policy guidelines for the management of patients with possible suicidal behaviour state that 'every effort must be made to delay discharge of patients following self poisoning or injury until a psychiatric assessment can be performed' (Centre for Mental Health, 1998).

In another case, a 15 year old girl diagnosed with Dissociative Disorder had made three suicide attempts prior to her death. She also had numerous presentations to the Emergency Department after episodes of deliberate self-harm and threatening behaviour towards her family. Following one such presentation, the duty registrar noted on file that she was not to be admitted to the psychiatric unit again as she was only suffering behavioural problems and further incidents should be dealt with by the police. She committed suicide four months later.

In two cases, appointments with mental health professionals had been postponed or young people were made to wait for appointments even though they were assessed as being at high risk of suicide. One of those young people was referred by his school counsellor to a community health centre, as she was concerned that he was at-risk of suicide. After interviewing him, a mental health worker confirmed that his case was urgent and that the suicide risk was high. Records indicate that an appointment was made, although the young person committed suicide the next day, before the appointment date.

This case highlights the importance of conducting assessments of, and providing services for, patients with suicidal behaviour immediately. Given that his case was listed as urgent, scheduling an appointment for a later date was not appropriate. Such cases also raise concerns about the lack of available after-hours mental health services for children and young people.

Other areas of concern in the provision of mental health services that arose from the case reviews included failure to recognise suicide risk and ineffective case management. In three cases, mental health professionals assessed that the child or young person was not at-risk for suicide, yet within weeks of the assessments each committed suicide. For instance, the parents of a young person found a suicide note in their daughter's bedroom and as a result took her to a psychiatrist. Her parents wanted her to be scheduled as an inpatient, but the psychiatrist assured them that there was 'no real threat' of their daughter committing suicide. She suicided one week later.

While it is not possible to predict which individuals will commit suicide, there are well-recognised warning signs and factors that indicate an individual is at high risk. These cases highlight the importance of having highly skilled professionals who are able to competently assess and manage patients who present with possible suicidal behaviour. While it is acknowledged that not all suicides can be predicted or prevented by mental health professionals, children and young people should experience mental health services that maximise their chance of positive outcomes.

There were also instances of ineffective case management of children and young people with mental health problems. In three cases in particular, it appears that no one was monitoring compliance with medication, and the three young people committed suicide during periods of non-compliance.

James, 17 years old

James was referred to a psychiatrist four months prior to his death. He was experiencing diminished concentration, anxiety, feelings of paranoia, insomnia, 'whispering voices in his head', suicidal thoughts and impulses, and emotional fluctuations. He was diagnosed with a Schizophrenic Disorder and prescribed anti-psychotic medication. One month later James was reported to be improving and the following month he was assessed as having improved even more. After his suicide, however, it was discovered that James had taken only six tablets of his antipsychotic medication instead of 60 in the month prior to his death. The psychiatrist had not seen James in the month prior, although he told the police that James' non-compliance would have had a marked effect on his health.

No contact with mental health services

Twelve young people in this subgroup had not been recipients of any mental health services prior to their death. In at least three of those cases, attempts were made by parents to engage the young people in counselling, without success.

Troy, 17 years old

Troy's father committed suicide when Troy was 12 years old. His father had been physically and emotionally abusive to Troy's mother as well as to Troy and his siblings. Troy left school at 14 years of age and soon became known to the Department of Juvenile Justice for his criminal activities. It is recorded on his Juvenile Justice file that Troy was experiencing unresolved grief regarding his

father's suicide. Troy refused offers of counselling. His mother believed that Troy had been suffering from depression since his father's death and that he would still be alive had this been treated.

Such cases highlight the need for innovative methods to engage young people experiencing difficulties in counselling or to support them to seek some other form of assistance.

2) Family dysfunction subgroup

This section details the involvement of the children and young people with human service agencies. Fifty-three (75.7%) children and young people had been clients of at least one human service agency. Of those, 39 (73.6%) had been clients of multiple agencies. Agencies with which the children and young people had been most frequently involved were the Department of Community Services (39; 55.7%) and the Department of Juvenile Justice (32; 45.7%).

Department of Community Services

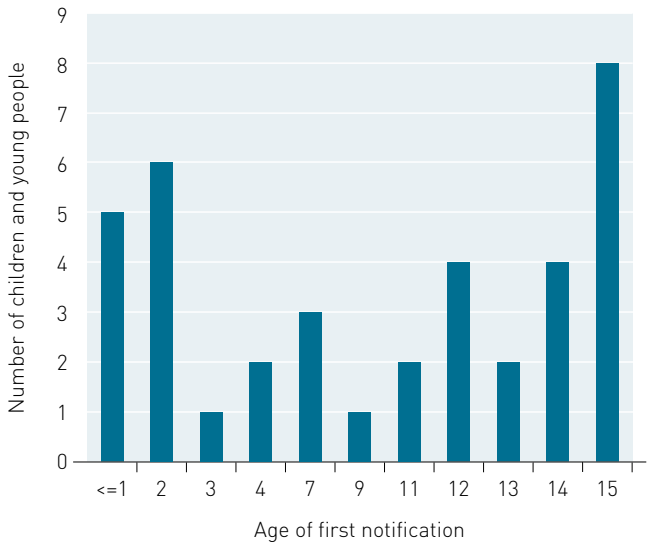
Thirty-nine children and young people in the family dysfunction subgroup had been clients of the Department of Community Services. Of those, 21 had experienced ongoing or extensive involvement, having been clients over many years. For a further 17 cases, involvement was very brief, consisting of a few notifications at various stages in their lives. The Department of Community Services' file for the remaining young person could not be located, thus it was not possible to determine the extent of involvement. The following findings were therefore based on analyses of the 38 cases for which Department of Community Services' records were obtained.

Figure 5.1 shows the ages at which the 38 children and young people were notified to the Department of Community Services for the first time. Just under half (18) were first notified in infancy or early childhood (at age nine years or earlier). There were opportunities for intervention early in their lives. As is noted in later sections, however, those opportunities were often lost as a result of inadequate risk assessment and deficiencies in protective casework.

Figure 5.1 also shows that a further 18 children and young people were first notified to

Figure 5.1

Age of first notification to Department of Community Services



the Department of Community Services during their adolescent years (ages 12 years and above), and information on file suggests that for the majority of those cases significant behavioural issues had already emerged, notably substance use and criminal behaviour. Thus, by the time these children and young people came to the attention of the Department of Community Services, they were already living extremely high-risk lifestyles.

Information on file further shows that for the 17 cases in which no ongoing Department of Community Services' involvement was evident, contact was limited to isolated notifications, although six in this group had been the subjects of multiple notifications. Regardless of the number of notifications, the notifications were either investigated and not substantiated, or not investigated at all. Information on the files suggests that in each case the decision to not investigate was inappropriate. Some of the risk factors that were identified on the files included allegations of abuse, violence, financial stress, parental drug and alcohol abuse, no effective guardian and suicidal behaviour of the child or young person. Based on this information, the decisions not to investigate were considered to be inappropriate. In one case, for example, police notified a 15 year old male to the Department of Community Services when his mother had been taken into custody for drug offences and consequently he was at home unsupervised. He was notified again three months later for similar reasons. There is a note on file indicating that this was the second notification of this nature, although there was no action recorded by the Department of Community Services.

Of the 38 children and young people who were clients of the Department of Community Services and for whom records were obtained, there was evidence of inadequate service provision in 23 (60.5%) cases. Issues emerged regarding Department of Community Services' involvement with this group of children and young people in the following areas:

- Inadequate risk assessment
- Lack of protective casework

'Risk assessment linked to a detailed social, family and parenting assessment is the cornerstone of a successful child protection system' (Victorian Child Death Review Committee, 1998, p.40). For 21 cases, file records indicated inadequate risk assessment and resulting poor casework. Examples of this included failure to respond in a timely way, failure to take the child or young person's views into account, failure to refer to other relevant agencies, and failure to conduct and document in full the investigation and assessment process. Some of these failures are highlighted in Ted's story.

Ted, 14 years old

Ted was a victim of long-term child abuse and neglect. His parents had separated after years of domestic violence and Ted oscillated between their homes. Ted's father had a history of drug use, suicidal behaviour and criminal behaviour and often took Ted with him during his criminal activities. Ted's mother was clearly ambivalent towards Ted, allowing him to associate with a known paedophile and refusing to place Ted's needs ahead of her own. The Department of Community Services had been involved with Ted and his family since he was seven years old. The following is a chronology of Department of Community Services' involvement in Ted's case:

- First contact with the Department of Community Services occurred in relation

to a notification of assault on Ted by his mother. They were arguing and she kicked him. Ted's mother contacted the Department of Community Services requesting assistance; records indicate that she received counselling and Ted stayed with his father for four weeks.

- Two years later the Department of Community Services was again notified when Ted's grandfather walked in on Ted and two girls about to be sexually active. The Department of Community Services concluded this was sexual exploration. No counselling was offered to Ted.
- Six months later (Ted was 10 years old) Ted's mother notified the Department of Community Services again when she saw that he had a welt to his thigh and some cuts from being hit with a strap. At this time, Ted's mother had given custody of Ted to his father. The Department of Community Services records an intention to interview the father and Ted, although there is nothing on file to indicate that the interview took place.
- The next notification came two months later, when Ted's father stated that a 13 year old neighbour had sexually assaulted Ted. This was confirmed and Ted was referred for sexual assault counselling. Records do not indicate whether the referral was taken up.
- Ted was next notified at 11 years of age by his school principal, who informed the Department of Community Services that Ted appeared to be very tired, was falling asleep at school and had told his teacher that his father had attempted suicide. His father denied it and Ted's case was closed. There is no record that the school took any action other than notifying the Department of Community Services.
- Ted was notified again one year later (12 years of age). He had bruising and grazing to his ribs and arm. Ted was interviewed and said that his father hit him with a fishing rod. He also said that his father took a lot of medication and was on a methadone program. Ted indicated that he wanted to live with his mother. Subsequently, Ted was removed from his father's home and a court order was made to have Ted placed with his mother. Counselling was arranged for Ted, although he refused to attend.
- From the time that Ted was placed with his mother, Ted's mother was in contact with the Department of Community Services indicating that she was unable to cope with him, that he was truanting from school, misbehaving, smoking cannabis and physically threatening her. There is no record of whether a risk assessment was conducted. Nor is there mention of whether the school was taking any action regarding his truanting.
- Ted was notified again at 13 years of age. The notifier stated that Ted was living with a 54 year old man. Ted's mother told the Department of Community Services' officer that he was living with a family friend and the officer did not ask any further questions.
- One month later Ted was notified again regarding his living arrangements with the older man. It was revealed by police that the man had previously been charged with aggravated sexual assault on a child under 10 years. Even when

informed of this, Ted's mother expressed relief that someone else had taken responsibility for caring for Ted and she felt that this older man was the only person who could control him. Despite his mother's clear ambivalence toward Ted, the Department of Community Services returned Ted to her care. At that time police did not proceed with charges against the older man arguing that there was not enough evidence. He was later charged for other child sex offences.

- Ted was next notified five months later when his mother's boyfriend punched him in the head, and it was discovered that Ted had dropped out of school. There is no mention that the school was taking any action. The Department of Community Services attempted to find alternative schooling for Ted in the form of a residential support program. Ted was not accepted as it was felt that he had no motivation to undertake the program. The Department of Community Services also arranged for Ted and his mother to attend counselling and made her boyfriend sign an undertaking that he would not physically discipline Ted. Mother indicated that counselling would require her to spend too much time with one child and that she was not willing to put Ted's interests before her own. Counselling was not taken up and there is no record of the counselling service attempting to engage Ted and his mother.
- Mother notified Ted again when he turned 14 years of age. She indicated that he had stolen property from her, he had moved back into his father's home, that he was using drugs and not attending school regularly. The Department of Community Services' officer's response was to remind Ted's mother that she had legal custody of Ted and that it was her responsibility to look after him.
- Three months later Ted's mother notified the Department of Community Services, expressing concern that he was using needles. The Department of Community Services' officer told her to contact the police and again reminded her that she had legal custody of Ted. That was the last contact that the Department of Community Services had with Ted or his family. Three months later, Ted committed suicide. At the time of Ted's suicide, his father was inside the house shooting up.

In summary, Ted's case illustrates a lack of risk assessment and resulting poor casework. First, the Department of Community Services treated each notification in isolation, as if each was the first time that Ted had been notified. This failure to incorporate earlier notifications meant that there was no systematic collection of information regarding Ted's circumstances and therefore no proper risk assessment and consequently no comprehensive case plan. Second, due to inadequate risk assessment, there was a loss of opportunity for early intervention. Case files show that the peak of Department of Community Services' intervention occurred when Ted was 13 years of age and had been a client of the Department for six years. At this time Ted was clearly being pursued by a paedophile, he had dropped out of school and the Department of Community Services actively pursued alternative schooling for him. It could be argued, however, that this more intensive intervention came too late.

Further, the lack of assessment resulted in a lack of services being offered to Ted and his family. Counselling was arranged for Ted after a court order was made to have him placed with his mother, although Ted refused to attend. Records do not indicate

whether the counselling service made any attempts to engage Ted, nor is there mention of any attempts to engage the family as a whole in counselling. It could also be argued that because the Department of Community Services did not recognise long-standing dysfunctional patterns or form an overall history of the family, the workers failed to assess Ted's parents' capacity to change or to make predictions for Ted's future well-being. The Department of Community Services had been involved with Ted and his family for a lengthy period of time and there is no record on file of a discussion as to whether Ted should be removed from both his parents.

Finally, it is important to note that the Department of Community Services alone was not responsible for securing Ted's safety, welfare and well-being. There is no mention of Ted's school taking any action other than notifying the Department of Community Services. It is not possible, however, to critically evaluate the school's response as education records for Ted were not available. In addition, the Department of Community Services arranged counselling for Ted. There is no mention of the counselling service outreaching to Ted following his refusal to attend.

Other agency involvement

Other services with which the children and young people who experienced enduring family dysfunction had been involved included the Department of Juvenile Justice, Health (including Emergency Departments and mental health services), school counsellor services, drug and alcohol services and refuge services, and various other non-government agencies. Due to the lack of detailed documentation on file, it was only possible to critically evaluate health (including Emergency Departments and mental health) service provision and that of the Department of Juvenile Justice.

With regards to Health (including Emergency Departments and mental health) service provision, two areas of concern emerged. The first relates to the shortage of male counsellors. In one case, a mother attempted to encourage her son to see a counsellor in an attempt to assist with his violent outbursts. Her son agreed to see only a male counsellor, but his mother was unable to locate one in their local area. As a result, this young male never received professional assistance.

In a second case, issues similar to those previously raised regarding the management of patients who present to hospital with suicidal behaviour reappeared. One young person was taken to hospital after overdosing on 26 paracetamol tablets. While in hospital he was seen by the psychiatric registrar. He told the registrar that he had not wanted to kill himself and denied any plans to hurt himself. He was deemed medically fit for discharge and the registrar attempted to arrange a follow-up appointment for him, although the young person refused, stating that he could look after himself. Subsequently discharged, with no follow-up appointment secured, he later died from a multiple drug overdose.

[17] As set out in the *Mental Health Act 1990*, a person may be scheduled only if they fall within the definition of a 'mentally ill person' or a 'mentally disordered person'. A 'mentally ill person' must have one or a number of symptoms set out in the Act and as a consequence present a risk of serious harm to themselves or others. The symptoms listed in the Act are hallucinations, delusions, serious thought disorder, serious mood disorder, or sustained irrational behaviour suggesting the presence of one of these symptoms. A 'mentally disordered person' is a person whose behaviour is so irrational that they place themselves or someone else at-risk of serious physical harm.

It is important to note that the hospital staff cannot be considered at fault in such instances. Unless a person is schedulable under the *Mental Health Act 1990*, there is nothing that health professionals can do if an individual refuses treatment[17].

Poor internal communication within the Department of Juvenile Justice was evident in the case of 15 year old Damien. Damien absconded from detention when informed that (due to a very minor unresolved court matter) he was no longer allowed to go on a trip away that had been previously organised. While absent without leave, Damien died from a heroin overdose. File records show that Damien had been well settled and well behaved while in detention. His Aboriginal mentor said that the only time that he was feeling down was when he was stopped from going on the trip. File records further indicate that Damien was informed that he was not allowed to go on the trip only on the very morning that he was supposed to leave. This delay in informing him was put down to inefficient paperwork. His Juvenile Justice counsellor only received the information herself that same morning.

Lack of involvement of some families with human service agencies

Seventeen of the 70 children and young people who had endured chronic family dysfunction had not been clients of any human service agency. With the exception of one case for which intent was unable to be determined, all of the children and young people whose families had no prior involvement with human service agencies died by suicide. Moreover, with the exception of one young female who had been the victim of childhood sexual abuse, there was no evidence of prior child abuse and neglect in these families, which is perhaps the reason they had not come to the attention of any human service agency. Rather, the major disruptions in the family lives of these children and young people were conflict among family members, blended-family issues and negative child rearing practices.

These families could well have benefited from human service involvement, and their lack of involvement raises two important issues. The first relates to what services are currently available for families experiencing conflict, blended-family issues and unhelpful parenting practices. The second relates to the fact that services are structured in such a way that children and families are required to approach the services themselves. Given that children and young people rarely seek help for themselves, the attitudes and perceptions of their caregivers largely determine whether they receive help (Sawyer et al., 2000). These findings highlight the need for innovative techniques to encourage children, young people and their families to engage in help-seeking behaviour and for services to outreach to children and young people.

3) School-related difficulties subgroup

Approximately one-third of the 38 children and young people in this subgroup, all of whom died by suicide, had not been clients of a human service agency. Of the remaining 26 in this subgroup, 14 had received some form of specified school-based support, including school counsellor involvement or behaviour and learning support services.

School counsellor services

Records were obtained for the children and young people who had accessed school counsellor services. However, with the exception of one case there was insufficient detail on file to gain an understanding of what interventions had been put in place by their school counsellor. This lack of information may reflect that contact with the

counsellor was brief or incidental with no major intervention occurring except perhaps a referral to support provision, rather than inadequate record keeping.

One young male presented to his school counsellor with symptoms of re-experiencing a serious accident that had resulted in him being hospitalised for two months. He also expressed fear that long-term damage had occurred to his brain. The counsellor told him that he should speak to his parents. From the information on file, it does not appear that the counsellor sought any further information about the extent of the flashbacks about the accident, or on how severely the flashbacks were affecting him.

This case raises issues about the need for school counsellors to be well trained in the area of mental health so that they can recognise potential problems and arrange referrals to appropriate mental health services. This has been a goal of the *School-Link* program, which between 2000 and 2002 has resulted in all school and TAFE counsellors in NSW receiving awareness training in depression and related disorders. This training occurred jointly with adolescent health workers, with an underlying goal being the improvement of pathways to care at the local level.

Behaviour and learning support

Of the 14 children and young people who received some form of enhanced school-based support, at least five had participated in specialist school-based programs designed to intervene in specific problems, including behavioural and learning difficulties and poor school attendance. Records indicate that the children and young people typically responded well to these programs, although problems arose on their reintegration into regular classes, as in Paul's case.

> **Paul, 13 years old**
>
> File records indicate that Paul performed well academically in primary school and was one of the class leaders. When Paul started high school he began misbehaving in class and his academic performance was well below grade average. His school counsellor referred him to the Support Teacher for Learning Difficulties (STLD), who identified that Paul was having significant learning difficulties. For the next two years, the STLD worked with Paul and a number of other students in groups of up to 15 in several subjects. The STLD said that he had a great relationship with Paul and knew how to approach him in order to get him to apply himself. Problems arose, however, when Paul returned to larger, regular classes, where it appeared that he couldn't cope and his teachers were often critical of him.

Paul's case also highlights the importance of monitoring individual students as they make the transition from primary to high school. During this period there is the opportunity for problems to arise as children leave the protective environment of primary school and enter a larger, more impersonal and departmentalised setting.

Similarly, another child spent one year in a support class for students with behavioural disorders to assist with his disruptive behaviour. It was reported that although his behaviour improved markedly in the support class, it quickly deteriorated when he returned to regular classes. Records do not indicate whether he received any integration support.

These cases raise issues about the need to continue to support children and young people after an intensive intervention has been completed, especially in the initial

stages of returning to their usual environment.

It is perhaps important to note that one young female was chosen by teaching staff to attend a training seminar on youth suicide in order to act in a peer support role for fellow students. This training took place in the months prior to her suicide. Similarly, another young female in this study participated in a Suicide Prevention Workshop organised by her school in the months prior to her suicide. While it is not possible to establish a causal link between these seminars and the suicides of the two girls, the proximity between the events is somewhat concerning. Moreover, research evidence shows that talking openly with young people about suicide can be distressing to some, and even induce negative mood states, making them more vulnerable to suicidal behaviour (see Shaffer & Gould, 2000).

Although suicide prevention programs which focus on direct discussion of suicide with young people are still promoted by some community organisations, the Department of Education and Training does not endorse them. Rather, initiatives such as *School-Link* (NSW) and *MindMatters* are now being implemented in schools; these are aimed at improving the early identification and treatment of mental health problems and providing children and young people with skills to manage stressful situations.

Perhaps of most concern is the finding that less than half (14 out of 38) of the children and young people who had experienced enduring school-related difficulties had received any formal school-based intervention. Recall the case of Chris (page 57), who was clearly failing most of his subjects in Years 10, 11 and 12. From the available records it would appear that no interventions or extra support were offered to him. Similarly, eight children and young people in this study experienced problems in peer relationships, to the extent that their experiences might well have been the trigger to them taking their lives. Moreover, information on file suggests that 10 young people may have taken their lives at least in part because of their inability to cope with the pressures associated with their final school years. It is not known whether the schools were aware of the peer bullying and nastiness, or the difficulties in coping with HSC workloads in these cases. These findings draw attention to the important role that school teachers, principals and counsellors play in recognising those children and young people with significant school or peer problems and responding accordingly.

Other human service agency involvement

The children and young people who formed this subgroup had accessed a range of other human service agencies, including mental health, drug and alcohol services, as well as the Departments of Community Services and Juvenile Justice.

From a review of these cases, several areas of concern were evident. These include the scarcity of services available for children and young people, as well as examples of poor assessment, poor case management and ineffective agency interventions.

A few cases highlighted the scarcity of services available specifically for children and young people. Recall the case of Craig (page 68), for instance, who had a history of alcohol abuse and engaging in criminal behaviour while under the influence of alcohol. Craig was referred to a drug and alcohol service, although records indicate that the program was adult-focused, and thus Craig did not benefit from it. Similarly, a young male was brought by police to an Emergency Department while exhibiting suicidal behaviour. Hospital staff scheduled him, as they believed he was a high suicide risk.

Upon contacting his parents, it was revealed that he had been waiting for two months for psychiatric help.

Problems with case management and ineffective agency intervention were evident from a review of several cases, including that of Jessica.

Jessica, 16 years old

Jessica was a Maori young person, living with her parents and boyfriend at the time of her death. She and her boyfriend were heroin addicts. Jessica was first notified to the Department of Community Services by her school counsellor when she was 13 years old. She had been a chronic truant and when she did attend arrived in a substance-affected state. This pattern of behaviour had had a sudden onset. Since then, Jessica had been seeing her school counsellor and was later assigned to a specialist counsellor. As a result of her chronic truancy, Jessica was assigned a Home School Liaison Officer, who had minimal involvement with Jessica due to constant difficulty in knowing her whereabouts. Jessica was eventually referred to a special school for conduct disordered young people. She forfeited her place after a few months because of chronic non-attendance.

The Department of Community Services did not act on the first notification by Jessica's school counsellor. They were notified a further three times for issues relating to possible sexual abuse, self-harming behaviour and other at-risk behaviours, including running away and sexual activity. From the information on file, it appears that the Department of Community Services' response was limited to telephone calls to the notifiers and to Jessica's mother. No thorough assessment was conducted. There is a note on Jessica's Department of Community Services' file from her caseworker that due to the worker's high caseload she had been able to obtain only limited information about Jessica and that the case remained to be fully investigated. Jessica died from a multiple drug overdose.

Jessica's case is an example of ineffective agency intervention at several levels. Jessica's school had implemented several interventions for her yet none were able to ameliorate her problems. Critical evaluation of the school's service provision is not possible, as records were not obtained.

The Department of Community Services' records indicate a lack of intervention. The Department of Community Services' worker did not gather sufficient information or conduct a full assessment, despite several notifications and suggestions that Jessica was at considerable risk. The worker assigned to Jessica's case even noted on file that she was unable to properly investigate Jessica's circumstances due to her high workload. Like other cases in this study, Jessica's case further illustrates the lack of priority afforded by the Department of Community Services to adolescents.

In summary:

- For the children and young people who experienced enduring mental health problems, case reviews indicated a lack of appropriate services. Several areas of concern also arose in relation to mental health service provision. These included inappropriate agency actions (such as premature discharging of suicidal patients and postponing appointments), failure to recognise suicide risk and ineffective case management.
- The children and young people who suffered significant family difficulties were

most likely to have been clients of the Department of Community Services. Deficiencies in service provision included inadequate risk assessment and failures in protective intervention and casework.
- Less than half of the children and young people who experienced enduring school-related difficulties had received some form of school-based intervention. For those who had been the recipients of such interventions, issues were raised about the need for continued support after the intervention had been completed.
- Case reviews for the children and young people from all three subgroups revealed some instances of poor interagency work.

Conclusions 5.3

This chapter has reviewed the circumstances of the deaths of the children and young people in this study who had experienced enduring mental health, family and school-related difficulties. It also detailed these children and young people's contact with human service agencies.

The children and young people in this cluster present challenges to practitioners and the human service agencies. They often come to the attention of services after dysfunction is already severe and entrenched and practitioners can find it difficult to engage with them. Services need to continually search for new ways of working to assist these children and young people.

The study findings are consistent with existing research that mental health problems are risk factors for suicide. For those with mental health problems, effective service provision is crucial to suicide prevention. The findings from this analysis suggest that effective service provision includes communicating with children and young people in appropriate ways; discharging patients from hospital at an appropriate time; undertaking a thorough psychosocial and psychiatric assessment prior to discharge; identification and effective referral of those at-risk of suicide; and effective case management, including regular follow-up, monitoring compliance with medication and reliability with appointments.

For the children and young people who suffered enduring family dysfunction, child abuse and neglect, constant arguments and dysfunctional parent-child relations were typical. Some children and young people chose suicide as the ultimate escape from their unbearable family situations. Others turned to alcohol and other drugs in an attempt to temporarily escape reality. The findings from these analyses add to the empirical support for claims that specific aspects of family dysfunction are risk factors for substance abuse and suicide for some young people.

The majority of children and young people who experienced enduring family difficulties had considerable involvement with human service agencies. Inadequate child protection service provision was evident in many of those cases, highlighting lost opportunities for protective intervention. In one-quarter of these cases, in the absence of outward signs of abuse or neglect, their traumatic family lives were not obvious to those outside the family.

Finally, case reviews of the children and young people who experienced significant school-related difficulties provide evidence for an association between school problems and suicidal and risk-taking behaviour. The findings relating to HSC pressure and

suicide clearly require further research attention, as do the findings linking learning difficulties and behavioural problems to suicide and risk-taking deaths.

Equally concerning is the finding that more than half of the children and young people in this subgroup had not received assistance for their school-related problems. This draws attention to the important role that school staff play in detecting difficulties that students may be experiencing and in providing assistance.

This report now turns to a review of the cluster of children and young people who experienced a single pivotal adverse life event.

Chapter six

Pivotal life events

Of the study population of 187 deaths, 26 (15 males and 11 females) children and young people experienced some pivotal or significant life event. The deaths of all but two of these 26 were suicides. For each of these children and young persons, the event or circumstance was perceived as life changing, and was either the trigger to their suicide or placed them at-risk of suicide. The most common life events were interpersonal issues, including relationship breakdowns, deaths of significant people, or arguments with partners or family members. Other significant events or circumstances that were experienced by this group of children and young people included events associated with a major illness or accident, sexual assault and unemployment.

It is important to note that children and young people in other subgroups experienced similar events, such as relationship breakdowns or arguments with family members immediately prior to their deaths. In other subgroups, however, the precipitating incident occurred in the context of significant enduring problems, such as family dysfunction or major school problems, and so was really the final straw in a series of major difficulties.

For the children and young people considered in this chapter, the significant event itself was perceived as pivotal or life changing, and appeared to be the reason for suicide in its own right, rather than a trigger in the context of ongoing problems. The children and young people who formed this cluster were grouped on the basis that none of them appeared to have suffered enduring difficulties. Their suicides appear to have been either impulsive responses to a perceived major life event or to have occurred in an acutely depressed state due to the experience of this pivotal event.

This chapter first provides an overall profile of the 26 children and young people in this cluster. Their pivotal life events and circumstances are then detailed, followed by an account of the circumstances of their deaths as well as their prior contact with human service agencies.

Pivotal life events cluster: Overall profile 6.1

Age and sex

The age and gender distribution of the 26 children and young people is presented in Figure 6.1. Almost three-quarters (73.1%) of this group were aged 16 or 17 years at the time of their deaths.

Cultural and linguistic diversity

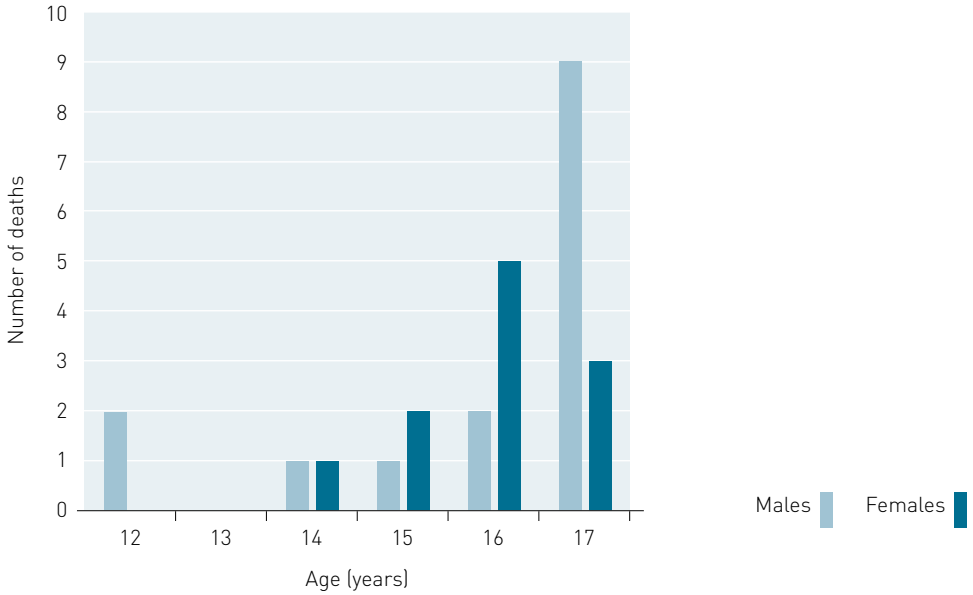
Twenty-two (84.6%) children and young people were born in Australia. Of the four who were born overseas, all spoke English in their family home.

Indigenous children and young people

Three children and young people in this cluster were Aboriginal. All were female and died by suicide.

Figure 6.1

Pivotal life events cluster: Age and gender distribution



Family circumstances

Fifteen (57.7%) children and young people were living with both biological parents. These children and young people were therefore more likely to be living in intact families than were those who experienced enduring mental health, family or school difficulties (30.6% of those children and young people were living in intact families).

Of those who were not living with both biological parents, seven were living in one-parent families (six were living with biological mothers and one was living with his biological father), two were living in step-families and two were living away from their families, one of them in a de facto relationship.

Education and employment

Just over half (53.8%) of the children and young people in the pivotal life events group were enrolled in some form of education (school or TAFE). In contrast, less than half (48.4%) of those who experienced enduring difficulties were enrolled in school. Of those children and young people in the pivotal life events cluster who were no longer attending school, four were employed, seven were unemployed, and for one there was insufficient information with respect to his education and employment history.

Mental and physical ill-health

In contrast to the children and young people who suffered enduring difficulties, none of the children and young people in this cluster was diagnosed with mental health problems, although several were suffering from mood states that were causing obvious distress. File records show that these distressed mood states typically appeared after the occurrence of a pivotal life event. One young person, for example, had possibly been suffering from an undiagnosed depression ever since a close friend had died by accidentally falling off a cliff at a party. He had talked the friend into going to the party and blamed himself for his death. He had expressed suicidal ideation ever since the incident. Similarly, two young females had been exhibiting symptoms of depression after being sexually assaulted in separate incidents. From the information on file, neither girl had been her 'normal' self since the assault.

Four young people in this cluster were suffering from physical illnesses and information on file suggests that three of them might have taken their lives as a result. One young male was diagnosed with insulin-dependent diabetes and prior to his death expressed concern about various body parts falling off. Another young male had been in a motor vehicle accident and as a result suffered frontal lobe damage. A third young person had been sick with several viruses for a few months prior to his death, to the extent that he had missed three or four school days at a time, and would sleep for periods of up to 36 hours. His parents indicated that his illness could have caused him to become depressed. A fourth young male suffered from severe asthma and several months prior to his suicide had nearly died as a result of an asthma attack.

Drug use

Exactly half (13) of the children and young people in this group engaged in drug use, eight of them using drugs frequently (at least once per week). Cannabis and alcohol were the drugs most commonly used, amphetamines and heroin were less commonly used, while three engaged in frequent polydrug use.

Offending behaviour

Four out of the 26 children and young people had a history of offending behaviour, with criminal activities typically being theft-related. One of those young people, an Aboriginal female, had been a client of the Department of Juvenile Justice. In contrast, almost half (47.6%) of the children and young people who experienced enduring difficulties had come to the attention of police for their offending behaviour.

Prior suicidal behaviour

Sixteen (61.5%) children and young people had exhibited suicidal behaviour prior to their deaths, in the form of either ideation alone, deliberate self-harm or suicide attempts. As with the previous cluster, most of these children and young people had expressed suicidal thoughts to family members and friends, although for most nothing was done with this information. Once again, this highlights the necessity of intervening when a child or young person indicates their intention to commit suicide.

In summary:

- Fifteen males and 11 females experienced a significant life event or circumstance which they perceived as pivotal or life changing.
- All but two in this cluster died by suicide.
- Over half were living with both biological parents and just over half were enrolled in some form of education (school or TAFE).
- Fifty per cent engaged in drug use, with alcohol and cannabis being the most commonly used.
- Approximately 60% (16) had a history of prior suicidal behaviour.

Children and young people's pivotal life events 6.2

The specific life events experienced by the children and young people in this group, together with the frequencies with which each was experienced, are presented in Table 6.1. Interpersonal issues, which included deaths of significant people and relationship problems and arguments with partners and family members, were overwhelmingly the most commonly experienced. While almost equal numbers of males and females

experienced significant interpersonal problems, males were more likely to have experienced the death of a significant person in their lives, whereas females experienced more relationship problems with partners and family members.

Table 6.1

Pivotal life events by gender

Pivotal life event	Males	Females	Total
Interpersonal issues	8	9	17
Illness or accident	4	0	4
Sexual assault	0	2	2
Unemployment	2	0	2
Legal problems*	2	0	2
Total	**16****	**11**	**27**

**** One young male had received two traffic infringements and was very concerned that he might lose his driver's license. The second male had an altercation with police on the day of his death, which caused him great distress.***

***** The total number does not equal the total number of males in this cluster (n=15) as one male suffered both a major accident and legal problems prior to his death.***

Interpersonal issues

Previous research has found that interpersonal issues, such as relationship breakdowns, arguments and losses due to bereavement, are the life events most commonly associated with suicide (see Beautrais, 2000 for a review). Similarly, the pivotal life events experienced by almost two-thirds (65.4%) of the children and young people in this cluster were interpersonal issues. In the present study, relationship problems with a boyfriend or girlfriend were the most commonly experienced interpersonal problems, closely followed by the death of a significant person and relationship breakdowns. Arguments with family members were experienced less frequently. With the exception of one young person who died by an accidental heroin overdose, all of these children and young people died by suicide.

The circumstances of the 17 children and young people who experienced significant interpersonal issues are outlined in Table 6.2. The relationship between these life events and the child or young person's death is shown.

Table 6.2

Interpersonal issues as pivotal life events

Age and gender	Type of interpersonal issue and incident prior to death
	Arguments and relationship problems with partner
15 years, female	Child and boyfriend broke up several months prior to death. Child was very keen to reunite. Prior to suicide, she saw ex-boyfriend with another girl and was devastated.
16 years, female	Young person and boyfriend had a violent argument. Boyfriend assaulted young person. She committed suicide following the argument.
16 years, female	Young person was in de facto relationship. They argued frequently and she had spoken about suicide several times due to deteriorating relationship. She left a suicide note indicating that she was taking her life due to relationship problems with her de facto.
16 years, female	Young person's boyfriend was a drug dealer. Due to relationship problems between them, young person had begun to use heroin again just prior to her death. She died accidentally from a heroin overdose.
16 years, male	Young person's girlfriend heard rumours that he was seeing somebody else. Girlfriend confronted young person about rumours and they argued. Young person was very distressed over argument and grossly intoxicated at time of death.
17 years, male	Girlfriend's parents disapproved of relationship, which caused tension between young person and his girlfriend. Young person told friends that he believed his girlfriend didn't love him anymore. Young person was grossly intoxicated at time of suicide.
	Death of significant person
12 years, male	A boy from child's neighbourhood committed suicide by hanging. A few days later the child committed suicide by hanging.
12 years, male	Child learned that father was soon going to die due to cancer. Child's friend said that he was unable to express his feelings regarding his father's imminent death, although was clearly very sad. It is also noteworthy that a boy from his school suicided seven months prior. This boy took his life in the same manner, stating that he was going to do what that boy had done.
15 years, female	Child was deeply affected by friend's suicide and had been wearing her friend's clothes as a way of being close to her. She committed suicide seven days after friend's suicide.
17 years, male	Young person's friend died when he fell from a cliff at a party. Young person had talked friend into attending the party and therefore blamed himself for friend's death. Since friend's death young person had said he would commit suicide by jumping from a cliff. Young person was grossly intoxicated at time of death.
17 years, male	A very close friend of young person committed suicide nine days prior to young person's suicide. Young person committed suicide on the day of his friend's funeral.
	Relationship breakdown
16 years, female	Young person's boyfriend ended the relationship a few weeks prior to her death. She wrote in her diary about her desire to commit suicide due to intolerable hurt and pain since the relationship breakdown. It is also noteworthy that she knew a boy who had committed suicide, although it is unknown when this occurred.
17 years, female	Young person had broken up with boyfriend, who had been physically violent towards her. Ex-boyfriend assaulted her on the day of her suicide.
17 years, male	Young person was very upset over recent relationship breakdown. He attempted to reconcile with girlfriend without success just before his suicide.
17 years, male	Young person had been distressed for several weeks due to his girlfriend ending the relationship. He left a suicide note for his ex-girlfriend stating that he would commit suicide in the manner that he did.

Table 6.2 Continued

Interpersonal issues as pivotal life events

Age and gender	Type of interpersonal issue and incident prior to death
	Arguments with family members
14 years, female	No apparent ongoing conflict with parents, although child argued with her parents immediately prior to her suicide.
17 years, female	No apparent ongoing conflict with parents, although young person argued with her parents immediately prior to her suicide. It is also noteworthy that a close friend committed suicide four months prior.

The suicides of six of the children and young people who experienced interpersonal problems followed, within a short time period, another suicide by a child or young person, suggesting possible contagious factors. In three of those cases, the suicides followed the suicide of a close friend; in a fourth case, the boy specifically stated that he was going to commit suicide in the same manner as a boy from his school had done several months earlier.

Although it is not possible to draw a causal relationship between interpersonal problems and suicide from this study, Beautrais (2000) notes that there are at least two ways in which such a causal relationship could occur. First, it may be a direct causal relationship whereby the suicide is an attempt to escape from the stress and pain associated with the interpersonal problem. Alternatively, the relationship could be an indirect one, mediated by psychiatric disorders, most notably depression. That is, the pivotal event leads to depression, which in turn leads to suicidal behaviour. Whatever the relationship, the diary of 16 year old Sonia clearly indicates her suffering following her relationship breakdown. Moreover, she draws a direct connection between her distress due to the break-up and her suicidal ideation.

> 'Today was tough! The toughest you could imagine in your whole life. This evening my life came upon me. It tumbled on my shoulders and crushed me, it will take more effort than anything to stand back up. It was yesterday that I felt this such pain for the first time. Yes, I'm talking about real pain, and it only took one, just one person to give it to me … I pulled my laces out of my shoes, threw them away, threw my bag down, found a tree, tide a loop in the shoe laces and conected it to a tree but I sat there, it was close, death was right there! … I can't believe how much he doesn't care! … The pain was just hitting me so hard. I thought about slitting my wrists to bad there wasn't a blade around! … All this pain all this hurt can come from just one male. No one cares. No one knows my pain. No one sees it … I didn't sleep much last night. I was in pain, in such great pain but no one new, no one'. (Original spelling and punctuation retained).

Illness or accident

Previous research has typically failed to provide evidence that physical illness is an independent risk factor for suicide. As with interpersonal problems, however, it has been suggested that the relationship between physical illness and suicide is an indirect one, mediated by psychiatric conditions such as depression and substance abuse disorders (Moscicki, 1995).

Once again, it is not possible to draw conclusions about causal relationships, although the life histories of four young people in this study suggest that their suicides might have been a response to a pivotal event associated with a physical illness or a major

accident. Moreover, there is additional evidence that the immediate trigger to each of the suicides was severe emotional distress, perhaps an acute depressed state. Derek's case provides some evidence for a possible indirect relationship between major physical illness or accident and suicide, mediated by emotional distress.

Derek, 17 years old

Some years prior to his death, Derek was involved in a major motor vehicle accident and suffered frontal lobe damage. Some consequences of the brain damage were reportedly bouts of depression and aggression. His social skills were also affected, leaving him about three years behind his peers. Derek's parents reported that since the accident Derek would easily become upset or angry and it was difficult to calm him down. Several weeks prior to his death, the court case regarding Derek's compensation for the accident was settled. The court case was reportedly a very humiliating experience for Derek as issues relating to his impaired mental and social ability were raised. Derek wrote a story indicating that it was the worst day of his life. The trigger to his suicide appears to have been an incident where he was searched by police and fined for carrying a pair of scissors in his pocket. Since one consequence of Derek's condition was aggression, he was angered by the search and began to swear at the police. This resulted in him receiving further infringements. Derek's friends were at the scene and later stated that Derek was clearly distressed over the incident and was sobbing as a result. He committed suicide several hours later.

Although Derek suffered from a chronic physical illness, like others in this group his suicide appears to have been an impulsive reaction to a specific event (that most likely occurred as a result of his illness). At the inquest into Derek's death the Coroner noted that the police officer could not be blamed for the incident; he was unaware that Derek was suffering from frontal lobe damage and simply believed that he was behaving in a socially unacceptable manner. However, the Coroner also pointed out the unfortunate fact that many mentally ill people end up in the criminal justice system for similar reasons.

Sexual assault

There is research evidence documenting a link between prior sexual assault and suicidal behaviour. For instance, Wilkie, Macdonald and Hildahl (1998) found an association between previous sexual assault and suicidal ideation. Similarly, Davidson, Hughes, George, and Blazer (1996) found a significant relationship between prior sexual assault and attempted suicide, even when other risk factors were controlled for. Moreover, females who reported a sexual assault that occurred before 16 years of age were at an increased risk for a suicide attempt.

There is some evidence to suggest that the suicides of two young females in this study occurred in response to their experiences of sexual assault. Sixteen year old Jodie's case is illustrative. From the information on file, it appears that the sexual assault by Jodie's relative led to depression and substance use, which in turn led to her suicide.

Jodie, 16 years old

Jodie was an Aboriginal young person living in a rural area. Five months before her death Jodie was offered a job in the city, which she accepted. About two months later, Jodie was sexually assaulted by a relative. Soon after the incident

she returned to her parents' home. Jodie's parents reported that she had been depressed ever since the assault and had started smoking marijuana heavily. After Jodie's suicide, a relative told the police that Jodie had confided in her about the assault. Jodie had reportedly said that her father had been unable to look at her since the incident, that she felt that he was blaming her for the assault and as a result did not love her anymore. She said that these feelings were making her even more depressed. Jodie also allegedly told her cousin that she did not know how to handle what had happened to her.

Unemployment

Many researchers have examined the role of unemployment in suicidal behaviour using controlled studies. In general, these studies have failed to provide evidence for a direct causal relationship between unemployment and suicide risk. Rather, the higher suicide rates among the unemployed probably reflect the presence of other disadvantageous social and personal factors (see Beautrais, 2000 for a review).

Nevertheless, documentation indicates that at the time of their suicides, two 17 year old males in this study were distressed regarding their inability to gain employment. One had left school during Year 10 and worked approximately four weeks out of the following 18 months at menial jobs. He began to engage in heavy marijuana use and argued with his mother over his unemployment. He saw a psychologist once for counselling regarding his unemployment. He indicated that the psychologist didn't call him for another appointment and so he never returned. Prior to his suicide, he presented to the Emergency Department on several occasions following episodes of deliberate self-harm and had overdosed on heroin on another occasion. In his suicide note he wrote:

> '... I can't handle this life anymore. I can't handle waking up nearly every day thinking life sux and wanting to go back to sleep so I could be out of life for a bit longer and I can't handle thinking about how I tottaly stuffed my life up completely...' (Original spelling and punctuation retained).

Legal problems

Several researchers have documented evidence for an association between legal problems, such as being in trouble with police, and suicidal behaviour (Brent et al., 1993; Beautrais et al., 1997).

There is evidence that the suicides of two males in this study occurred in response to legal problems. The first was the case of Derek (page 90), who was greatly distressed following an altercation with police on the day of his suicide that caused him to receive two infringements. The second male was 17 years of age and on the day prior to his suicide expressed extreme distress over two traffic infringements. He was reportedly very concerned that he might lose his driver's license.

In summary:

- Interpersonal issues, including deaths of significant people, relationship problems, arguments with partners and family members, and relationship breakdowns, were the most commonly experienced pivotal life events.
- Other significant life events included events associated with physical illness and accidents, sexual assault, unemployment and legal problems.

Circumstances of the death 6.3

Method of death

The method of death for the 26 children and young people in this cluster is presented in Table 6.3. Once again, intentional self-harm by hanging was the most common method of death.

Table 6.3

Pivotal life events cluster: Method of death

Method of death	n
Intentional self-harm by hanging	16
Intentional self-harm by jumping from heights	2
Intentional self-harm by carbon monoxide poisoning	2
Intentional self-harm by firearms	1
Intentional self-harm by lying before moving object	1
Intentional self-harm by crashing of motor vehicle	1
Intentional self-harm by poisoning	1
Accidental poisoning	1
Hypoglycaemic coma*, undetermined intent	1
Total	**26**

**** Young person was diagnosed with insulin-dependent diabetes and death was due to an overdose of insulin.***

The death scenarios

Although none of these children and young people had been diagnosed with a psychiatric disorder, records show that 15 of the 26 deaths occurred while the child or young person was in an acute depressed mood state. In some instances this was coupled with acute intoxication. The other 11 deaths appear to have been impulsive responses to adverse life events. Typically, these suicides occurred following a major argument with a partner, family member or other person, while in a state of acute intoxication.

Acute depressed mood state

File records show that many in this cluster were suffering from severe emotional distress in the period prior to their deaths. The information indicates that these children and young people were experiencing a variety of symptoms, including feelings of overwhelming sadness, hopelessness, feelings of guilt, low self-esteem and lack of motivation.

For instance, one young male saw a counsellor approximately three months prior to his suicide. He told the counsellor that he was having difficulties with his girlfriend because her parents did not approve of the relationship. He said that he was distraught by the situation, felt 'hopeless and bad all the time' and had even thought about stabbing himself. In addition, his best friend later told the police that he would often express thoughts that 'nobody loved him'. This young man was intoxicated at the time of his suicide, with a blood alcohol level of 0.151g/100mL.

The case of Philip further illustrates the feelings of sadness and hopelessness that many young people were experiencing prior to their suicides.

Philip, 17 years old

About five months before his suicide Philip attended a party at a lookout point. He had talked his best friend into going to the party with him and during the night, his best friend fell from the cliff and died. Philip blamed himself for his friend's death and had been distraught since the incident. He would often look at photos of his friend and listen to the music that had been played at his funeral. Philip cried and said that he should have been the one to fall off the cliff. In the weeks prior to his suicide Philip had been drinking heavily and exhibiting suicidal behaviour. At the time of his death, Philip had a blood alcohol level of 0.186g/100mL.

Like Philip, several children and young people across all clusters had high blood alcohol recordings in toxicology reports. Apter and Freudenstein (2000) note that across all age groups acute intoxication often precedes suicidal behaviour. Acute intoxication can lead to depressive feelings, impaired judgement and decreased inhibition, facilitating suicidal behaviour. They further suggest that adolescents may engage in excessive alcohol use prior to their suicide in order to bolster their courage to carry out the suicidal act.

Impulsive response

There is substantial research evidence to indicate that child or adolescent suicides are often impulsive, unplanned acts (Hoberman & Garfinkel, 1988; Shaffer et al., 1988; Beautrais, 2001). Similarly, file records suggest that many suicides in this study were impulsive responses to stressful situations. In those cases, there was no evidence of preparation for the suicide nor did the children and young people exhibit any prolonged depressed state.

Wayne, 17 years old

File records indicate that Wayne lived in a supportive, cohesive family environment. In the days preceding his death he and his girlfriend had broken up and on the night of his death Wayne had been attempting to reconcile with her. At some point, Wayne's brother said that he needed to use the phone and they began to argue. Wayne was forced to hang up the phone without having reconciled with his girlfriend. Wayne was angry and upset and drove away in his car. He committed suicide by carbon monoxide poisoning.

Coronial investigations

Alcohol was recorded in the toxicology reports of seven children and young people, with a mean blood alcohol level of 0.116g/100mL. Drugs other than alcohol were recorded in the reports of five young people. Fatal drug levels were reported in two cases, with the drugs ingested being heroin and methadone.

Coronial inquests were held in five of the 26 cases. At the Inquest into the suicide death of one 12 year old boy, the Coroner made the point that the reasons for the boy's suicide were conjectural and that a Coroner does not really need to know why people take their lives. While it may not be the function of the Coroner to investigate the reasons for people taking their lives, there is a clear need for systematic inquiries into the circumstances of deaths by suicide. In fact, Beautrais (2001) recommended that parallel to the police inquiry, there should be an inquiry into the circumstances of every death of a child or young person by suicide, including family and school circumstances, contact

with human service agencies and precipitants to the suicide. As has been noted earlier in this report, the quality of information contained within coronial files is highly variable. Beautrais (2001) argued that systematic data collection for coronial inquiry is most likely the best opportunity for examining and monitoring child and adolescent suicide deaths.

In summary:

- Intentional self-harm by hanging was the most common method of death for the children and young people who had experienced a pivotal life event.
- Deaths typically occurred while the child or young person was in a state of severe emotional distress or as an impulsive reaction to a stressful event. In five cases the young person was in a state of acute intoxication, which could have facilitated the suicidal behaviour.

Human service agency involvement 6.4

Almost half (48.1%) of the children and young people in this subgroup had not received the services of a human service agency. Of those who had, contact was with health (including mental health) services, school counsellors, Juvenile Justice, and drug and alcohol services. Areas of concern arose with respect to health (including mental health) and drug and alcohol service provision.

Health and mental health services

Ten children and young people had accessed health and mental health services to varying degrees. For four of them, health service provision was in the context of physical illness and two young people had been hospitalised following suicide attempts. Three young people had accessed counselling services, although the extent of their contact was very limited, typically presenting for just one or two sessions.

As with three cases from the mental health problems subgroup, the two young people in this subgroup who were hospitalised following suicide attempts appear to have been discharged without adequate assessment. One young female was admitted to hospital following an overdose of headache tablets and discharged without a mental health assessment.

In the second case, a young male who had insulin-dependent diabetes was admitted to hospital one month prior to his death on exhibiting suicidal behaviour. He was kept in hospital for one day. At the time it was suggested that his behaviour was impulsive and due to alcohol intoxication rather than suicidal intent, yet records indicate that he had a history of suicidal behaviour and overdosing on his insulin. This 14 year old boy died from an insulin overdose a few weeks later. Records do not indicate whether a thorough mental health assessment was conducted, although it would appear that his history of insulin overdosing was not taken into account.

Once again, these cases raise concerns about the practice of discharging suicidal patients without adequate observation, assessment and follow up. Effective assessment and mental health referral for young people with suicidal behaviour seen in hospital Emergency Departments are crucial.

Drug and alcohol services

Two young people, both female, had received treatment for drug addiction.

Natalie, 17 years old

Natalie went to her general practitioner four days before her suicide, stating that she was a heroin addict and seeking a referral to a methadone program. A referral was provided and Natalie was assessed by a psychiatrist at a methadone clinic. She told the psychiatrist that she had begun using illegal methadone via the streets in addition to daily heroin use. The psychiatrist arranged for a methadone prescription, noting that the reason for her suitability to commence the program was 'risk of death due to overdose, risk of physical injury.' Natalie was not a candidate for takeaway methadone, being given her methadone under supervision. Her friend, however, was on the takeaway methadone program, and Natalie committed suicide by overdosing on her friend's methadone.

There are three additional cases in this study in which young people died from overdosing on other people's takeaway methadone. Together, these cases highlight the risks associated with takeaway methadone programs, especially when clients fail to store their takeaway doses safely.

In summary:

- Almost half of the children and young people had not come into contact with a human service agency.
- Of those who had, concerns were noted with respect to inadequate mental health assessment and referral by hospital Emergency Departments.
- Concerns were also raised regarding the dangers associated with poor storage of takeaway methadone doses.

6.5 Conclusions

The findings reported in this chapter are consistent with previous research findings that adverse life events are risk factors for suicide. Also consistent with existing literature, interpersonal issues, including relationship problems, arguments with significant people and deaths of significant people, were overwhelmingly the most commonly experienced.

Significant environmental and biological changes occur during adolescence (for example, transition to high school, and puberty) and with these changes the opportunity for stressful experiences increases. Hauser and Bowlds (1990) distinguish between 'normative' and 'non-normative' stressful events. Examples of normative stresses are peer pressure and the disappointments that can accompany romantic relationships. In other words, normative stresses are those 'everyday stresses' that tend to occur with entry to the developmental stage of adolescence. In contrast, Hauser and Bowlds (1990) claim that non-normative stresses, such as sexual assault or chronic physical illness, increase the likelihood of maladaptive outcomes. The children and young people in this cluster experienced both normative and non-normative stresses, events that to an outsider would appear to vary in severity or intensity. Regardless of the type of event that was experienced, however, each event was perceived as pivotal or life-changing by the child or young person.

Hauser and Bowlds (1990) further argue that from the perspective of stress and coping, suicide is conceptualised as a failure of coping, and that intervention programs should be organised to develop the coping skills of both children and adolescents. All of the

children and young people in this cluster experienced significant or stressful life events, and it is suggested that their suicides were primarily due to their inability to deal with those adverse experiences. Children and young people need to be equipped with coping skills and knowledge about how to deal with such stressful or adverse events. Almost half of the children and young people in this cluster had not been clients of any human service agency.

Given the amount of time that children and young people spend in an educational setting, schools are ideal for providing them with information on coping skills. The NSW Departments of Education and Training and Health have already acknowledged the important role that schools play in building resilience in children and young people, with their implementation of the *School-Link* program. This is elaborated on in later sections of this report.

Chapter seven

Adolescent experimentation and risk-taking

Twenty-eight children and young people formed this cluster, all but one of whom died by risk-taking. Across all clusters, 66 children and young people died in this way. Thus, this cluster represents more than one-third (40.9%) of all risk-taking deaths of children and young people in this study. The life histories of the 28 children and young people who formed this cluster appeared to be vastly different to those in the two clusters previously discussed. There was no record that these children and young people had suffered significant enduring family, school, or individual problems or difficulties, nor had they experienced any major, life-changing, adverse events. Rather, their deaths appear to have occurred in a typical adolescent experimentation or risk-taking context. That is, they all died tragically while engaging in risk-taking behaviours, notably drug and alcohol use or dangerous driving.

While children and young people from the other two clusters also died while drug or alcohol affected, members of this cluster could be distinguished on the basis of the different context of their alcohol and other drug use. In this group, substance use typically occurred in a social or group context. Young people were drinking or using drugs with their friends, usually at a party or a pub, in order to 'have fun' or to 'experiment'. They died engaging in various behaviours while under the influence of substances. None of these young people was a chronic substance user. In contrast, the young people from the other clusters who died while in a drug-affected state were chronic substance users who were quite obviously engaging in substance use in an attempt to cope with or forget about their specific problems.

While there is no evidence to confirm or deny suicidal intent, it is possible that some of these children and young people could have been suicidal prior to their alcohol or other drug use, or may have become suicidal while under the influence of these substances. This highlights the lack of a clear boundary between risk-taking and suicidal behaviour.

7.1 Adolescent experimentation cluster: Overall profile

Age and sex

As shown in Figure 7.1, 26 out of the 28 children and young people in this cluster were male. This is perhaps not surprising, given research findings that males start drinking alcohol at an earlier age than females and are more likely than females to drink heavily (see Spooner et al., 1996), and that males are more likely than females to engage in risky driving behaviours, such as substance impaired driving and speeding (Hewitt et al., 1995). Eighty-two per cent (23) of the children and young people were aged 16 or 17 years at the time of their death.

Cultural and linguistic diversity

Twenty-three of the 28 children and young people, two of whom were Aboriginal males, were born in Australia. English was the language spoken in the homes of all but two.

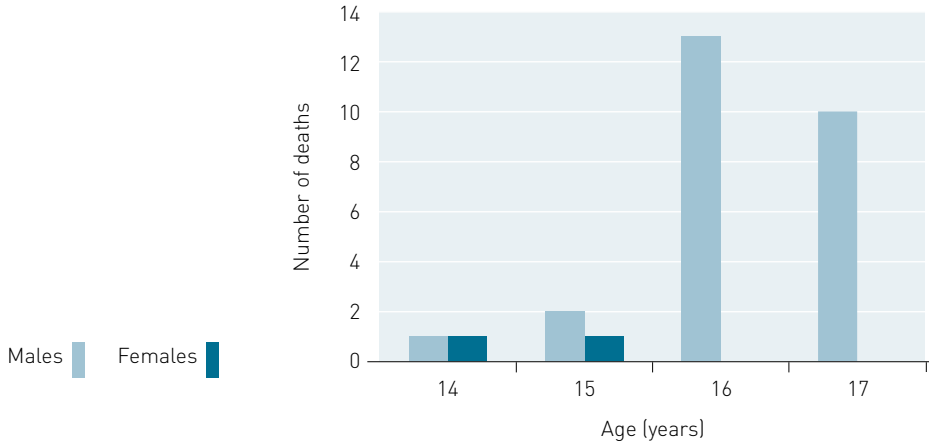


Figure 7.1

Adolescent experimentation cluster: Age and gender distribution

Indigenous children and young people

Two of the 28 children and young people born in Australia were Aboriginal. Both were male.

Family circumstances

Like those in the pivotal life events cluster, more of these children and young people were living in intact families than those who experienced enduring difficulties. Specifically, half (14) were living with both biological parents at the time of their death. Of the remaining 14, nine were living with one biological parent only (7 of the 9 were living with their biological mothers), one was living in a step-parent family, one was living with his best friend's family, and three were living independently.

File records show that several children and young people experienced close, supportive relationships with all family members. For the overwhelming majority, however, there was insufficient information on file to determine the quality of their family environments.

Education and employment

Like those who experienced enduring difficulties, less than half (46.4%) of the children and young people in this cluster were still enrolled at school. One was attending TAFE, seven were employed, four were unemployed and for three there was insufficient information to comment on their employment history.

Drug use

Seventeen (60.7%) of the children and young people in this cluster engaged in drug use, four of them using drugs frequently (at least once/week). As with the other clusters, cannabis and alcohol were overwhelmingly the most commonly used drugs. Unlike the other clusters, however, none of these children and young people engaged in frequent polydrug use, nor received treatment for substance abuse.

Offending behaviour

Eleven (39.3%) of the 28 children and young people in this cluster had come to the attention of police for their offending behaviour. Offences were typically theft- or drug-related. Just two had been charged for their offending behaviour, receiving fines and a community service order. A third was officially cautioned for his criminal behaviour.

None of this group had been diagnosed with a mental health problem. Moreover, unlike the previous clusters, none of these children and young people appeared to be suffering from emotional distress in any form and none had exhibited any prior suicidal behaviour.

In summary:

- Twenty-eight children and young people, 26 of whom were male, died while engaging in risk-taking behaviours, including alcohol and other drug use and risky driving.
- In contrast to the previous two clusters, none of these children and young people had experienced any severe emotional distress, had engaged in frequent polydrug use, or had exhibited suicidal behaviour of any form.

7.2 Circumstances of the death

As already mentioned, all in this cluster died while engaging in behaviours under the influence of alcohol or other drugs, because of an overdose of illicit substances, or because of risky driving behaviour. Table 7.1 presents the death scenario and cause of death for each child and young person.

Table 7.1

Adolescent experimentation: Death scenario and cause of death

Age and gender	Death scenario	Cause of death
Alcohol and other drug-related deaths		
14 years, male	Child collapsed following butane gas inhalation. A half empty bottle of butane lighter fluid was found in his bedroom. Friends stated child had been experimenting with butane gas inhalation for just a few weeks.	Effects of butane inhalation. Propane and butane detected in child's lungs.
15 years, male	Child was out with friends and considerably affected by alcohol. He fell from a bridge into a river 20m below. His body was never found.	Autopsy not conducted as body never located.
15 years, female	Child at friend's house and had consumed alcohol. She then went for a bicycle ride and attempted to jump a median strip, but fell off her bike and was fatally hit by a passing car (BAL: 0.068g/100mL).	Multiple injuries.
16 years, male	Young person attended a party and consumed alcohol. He walked onto the road without checking if the road was clear of traffic and was fatally hit by a car (BAL: 0.263g/100mL).	Multiple injuries.
16 years, male	Young person and friend were drinking alcohol and taking tablets in order to 'get high'. They went to sleep and young person died during the night.	Aspiration pneumonia due to inhalation of vomit as a result of alcohol and multiple drug ingestion.
16 years, male	Young person attended a party and consumed alcohol. He died later that night when he was hit by a train while sleeping on the tracks (BAL: 0.076g/100mL).	Multiple injuries. Coroner noted that although BAL was not very high, the alcohol would have affected him considerably as he did not drink regularly.

Table 7.1 Continued

Adolescent experimentation: Death scenario and cause of death

Age and gender	Death scenario	Cause of death
16 years, male	Young person attended party in an open field. He was intoxicated and began damaging cars with some friends. He was arrested. Police thought he was only moderately intoxicated and released him. Young person later hit by train while standing on tracks (BAL: 0.204g/100mL).	Multiple injuries.
16 years, male	Young person found dead at home with a bag covering his head and an aerosol can inside the bag. Those who knew young person claimed that he never used drugs.	Toxic effects of aerosol inhalation. Propane and butane gases detected.
16 years, male	Young person was out with friends and had consumed a large quantity of alcohol. He was wrestling with friends on the roadside and moved onto the road in an attempt to stop an approaching car to ask for a ride. Young person fatally hit by car (BAL: 0.226g/100mL).	Multiple injuries. Alcohol toxicity was a contributing factor.
16 years, male	Young person was driving with friend and complained of no feeling in his legs and stopped the car. He lost consciousness and died half an hour later.	Morphine detected in post-mortem urine, although no opiates detected in blood. Cause of death probably inhalation of vomit following opiate use.
17 years, male	Young person at home with friends. All consumed alcohol. Went to railway station and decided to beat train to next station by running along tracks. Young person hit by train and fatally injured (BAL: 0.143g/100mL).	Multiple injuries. Alcohol toxicity was a contributing factor.
17 years, male	Young person illegally obtained methadone and died from multiple drug overdose.	Heart failure due to toxic levels of methadone and other drugs.
17 years, male	Young person found deceased in the local school.	Morphine overdose. Friend stated young person was not a regular user of heroin.
17 years, male	Young person was drinking and smoking cannabis with friends. They all fell asleep and young person found dead a few hours later.	Respiratory depression due to combined effects of alcohol and narcotics.
17 years, male	Young person attended work Christmas party on a river bank. He consumed a large amount of alcohol and went swimming. He was pulled out of the water on two occasions. Young person found dead in river next morning (BAL: 0.248g/100mL).	Asphyxia due to drowning.
17 years, male	Attended a dance with a friend. Both consumed large quantities of alcohol. While walking home at the end of the night they stopped on the road to rest. Young person fatally hit by passing car. (Negative blood alcohol level, urine indicated BAL of 0.046g/100mL).	Multiple skull fractures with cerebral oedema. Pathologist noted that the transfusion received in hospital could have affected blood alcohol levels.
Risky driving deaths		
14 years, female	Child was unlicensed and driving a car with two passengers, lost control of car and collided with a tree.	Massive internal injuries causing exsanguination. Cannabis detected in blood.
15 years, male	Child was unlicensed and driving a stolen car with a friend at high speeds, lost control and collided with a pole.	Head injury.
16 years, male	Young person driving a car at excessive speed which collided with another vehicle. Young person was holder of a learner's permit and was carrying a passenger who was a disqualified driver.	Head and multiple organ injury.

Table 7.1 Continued

Adolescent experimentation: Death scenario and cause of death

Age and gender	Death scenario	Cause of death
16 years, male	Young person and friend attended a pub. Both consumed alcohol and drove home, with young person as passenger. Car collided with a motorcycle. Young person killed instantly (BAL: 0.140g/100mL).	Multiple injuries consistent with involvement in motor transport accident. Driver also had high blood alcohol level and was charged with Dangerous Driving Occasioning Death.
16 years, male	Young person and friend stole two cars and were detected by police. A police pursuit commenced and young person lost control of car and hit a pole. The car caught fire and young person was incinerated.	Incineration, smoke inhalation and head injury.
16 years, male	Young person was unlicensed and riding a motorcycle. He collided with a vehicle that he did not see, despite witnesses flashing their car lights to get him to stop.	Massive head injuries. Cannabis detected in blood.
16 years, male	Young person and two friends were riding their motorcycles. Young person was intoxicated, lost control of vehicle and died (BAL: 0.160g/100mL).	Extensive cerebral oedema.
16 years, male	Young person attended a party and consumed alcohol. He left on his motorcycle despite attempts from friends to stop him from driving. He lost control of the vehicle and collided with a tree (BAL: 0.053g/100mL).	Head injury.
17 years, male	Young person fell asleep while driving and was awakened by his two passengers. The vehicle hit a pole and young person killed instantly (BAL: 0.135g/100mL).	Multiple injuries due to effects of alcohol, delta-9-THC, and delta-9-THC acid (cannabis).
17 years, male	Young person driving at excessive speeds, lost control of car and collided with a tree.	Shock due to massive fractures of skull and lower limbs.
17 years, male	Young person attended a party, consumed alcohol and drove home. He crashed into a tree and was killed (BAL: 0.181g/100mL).	Head and chest injuries due to MVA. Alcohol and inexperience were factors.
17 years, male	Young person was drinking at a local pub with some friends and then rode his motorcycle. He collided with a parked car (BAL: 0.152g/100mL).	Combined massive brain and heart injury.

Alcohol and other drug intoxication

Shanahan and Hewitt (1999) interviewed young people aged between 15 and 17 years across three Australian states and found that alcohol plays a significant role in adolescent culture. Young people reported that drinking alcohol is very much a group behaviour and that the goals of most teenagers' alcohol use were to get drunk, to experiment, to lose control and to bind them to a peer group. Respondents further suggested that adolescents who drink alone generally have deep rooted problems.

Several case histories of the young people in this cluster support the findings of Shanahan and Hewitt (1999), in particular that for the majority of young people, alcohol and other drug use is a group behaviour and that most engage in such behaviour to 'get wasted' and lose control.

Adrian, 16 years old

Adrian was a keen sportsman, popular with his peers and attaining satisfactory

academic grades. He socialised in a group of approximately 20 peers and the group would go out on a weekly basis. His friend reported that when they drank alcohol, they drank excessively in order to get drunk. Also, in the year prior to Adrian's death, the group started to take pills when they drank in order to get 'messed up'. Adrian had reportedly used Panadeine Forte, headache tablets, carsickness tablets and anything else that was available. Adrian's friend said that the carsickness tablets would make them hallucinate and when taken with alcohol would make them forget what they had done the night before. Adrian died following one such episode from inhalation of vomit due to the ingestion of alcohol and multiple drugs.

The death scenarios reported in Table 7.1 further indicate that for almost all of the alcohol and other drug-related deaths in this group, children and young people had been using drugs in a social context. In most cases they had been drinking alcohol with friends, either at a pub, a party or at home, and died later that evening while in a state of intoxication. The reasons for these children and young people's alcohol and other drug use thus appear to be very different to the reasons for the alcohol and other drug use of the children and young people in the other clusters. Alcohol and other drug use in the other clusters coincided with major negative life experiences, such as extreme family dysfunction and school-related problems.

Previous researchers have also found this distinction in the reasons for adolescent substance use and abuse. For instance, Spooner et al. (1992) found that most of the adolescents in their study used drugs for fun or to experiment. Only a minority used illicit substances to cope with problems or because they were addicted. It is also important to note that none of the children and young people in this cluster engaged in frequent polydrug use or had substance abuse problems. That is, the findings of the present study are consistent with previous research findings that adolescents who are not experiencing substance abuse problems reportedly use drugs in a social context because it is fun. More problematic substance abusers tend to engage in drug use to cope with or forget about their problems (Spooner et al., 1996).

Risky driving

The second major class of behaviours engaged in by this group at the time of death was risky driving behaviours, including unlicensed driving, drinking and driving, and speeding.

In general, there is very little information available about the life circumstances of the children and young people who died while engaging in risky driving. This is because most of them had not been clients of any human service agency, thus the only information obtained was that in the coronial file. Coronial documentation for this group of children and young people was typically limited to a detailed account of the circumstances of death, with no investigation of psychosocial or behavioural aspects. Family members were typically not interviewed in preparation of Briefs of Evidence for the Coroner.

There was, however, some information contained in coronial documentation indicating that several of these children and young people had been warned or cautioned by police prior to their deaths for their alcohol use or dangerous driving. For example, one 17 year old male who died when he fell asleep at the wheel with a blood alcohol level of

0.135g/100mL, had been cautioned by police for alcohol use some months before his death. Another 17 year old male died when he lost control of his car and collided with a tree. He had a blood alcohol level of 0.181g/100mL and a few days prior to his death had been cautioned by police for dangerous driving. Yet another 17 year old male had been cautioned by police one month before his death for stealing a car with some friends. He died when he lost control of his vehicle while travelling at a speed of approximately 120kph in a 65kph zone.

Coronial investigations

Post-mortem examinations and toxicological investigations were conducted in all cases with the exception of one 15 year old male who fell from a bridge into a river and whose body was never located. Alcohol was noted in the toxicology reports of 16 (57.1%) children and young people. Blood alcohol levels ranged from a low of 0.023g/100mL to a high of 0.263g/100mL, with a mean level of 0.135g/100mL. Seven of the 16 had blood alcohol levels of greater than 0.150g/100mL, indicating acute intoxication.

Drugs other than alcohol were noted in the post-mortem reports of 11 (39.3%) children and young people. In four of those cases, fatal or toxic levels were reported, indicating that death was due to fatal overdoses or poisoning. Drugs ingested in these cases included methadone, heroin and paracetamol. In a further two cases, propane and butane levels were detected. This child and young person died from butane gas inhalation and inhalation of aerosol fumes. In the remainder of cases, toxicology reports indicated the presence of delta-9-THC and delta-9-THC acid (cannabis).

Coronial inquests were held in nine cases.

In summary:

- At least 17 of the 21 children and young people who died while in a substance-affected state had been using those substances in a social or group context at the time of death.
- Three children and young people who died while engaging in risky driving behaviours had received prior warnings by police for dangerous driving or alcohol use.
- Alcohol was noted in the toxicology reports of more than half of the children and young people in this cluster; in almost 40% drugs other than alcohol were detected in the reports.

7.3 Human service agency involvement

Three-quarters (21) of the children and young people in this cluster had not been clients of a human service agency. Services used by the remaining seven were school counsellor services, the Department of Community Services and Juvenile Justice. With respect to school counsellor service provision, as with the previous clusters, in two cases records were not detailed enough to enable an evaluation of services. In a third case, the school counsellor had attempted to engage the young person in counselling, without success.

Three young people had very brief involvement with the Department of Community Services, each having been the subject of one notification. For two of them, the notifications were investigated and not confirmed. For instance, one young male had been notified to the Department of Community Services by his mother at 10 years of age. She expressed concern that her three sons might have been sexually assaulted by her

boyfriend. A Department of Community Services' officer interviewed all three boys and none disclosed sexual abuse. The mother nevertheless ended the relationship and the case was closed.

The mother of a third young male notified her son to the Department of Community Services when he was 13 years of age and had run away from home. He later returned home and his mother advised the Department of Community Services that they had sorted things out for themselves. The Department of Community Services' officer tried to arrange a home visit to see the boy but his mother refused any involvement. The case was closed.

Two young males had been clients of the Department of Juvenile Justice, although involvement was very brief. One was arrested on the charge of entering enclosed lands and was released on probation for 18 months on the condition that he be of good behaviour and obey his father's directions. The second had been charged on three occasions prior to his death for offences including assault, shoplifting and entering enclosed lands. The third time he received 12 months probation with supervision, although file records note that his response to supervision was of a 'reasonable standard' and that active supervision was terminated after four months.

Lack of police intervention was evident in the case of one 16 year old male who was fatally struck by a train while standing on the railway tracks in an intoxicated state (BAL: 0.204g/100mL). Earlier that evening he had been arrested by police for breach of the peace for damaging cars at a birthday party he was attending. At the police station the young male apologised for his behaviour and the arresting officer formed the opinion that he was only moderately affected by alcohol. The police released him and told him to call his friends to pick him up. The boy was unable to do this as his friends were still at the party. He was therefore left to make his own way home.

After the boy's death, an internal police investigation was undertaken because the police officers had not made alternative arrangements for him to be collected from the station. The investigation was later dropped as one hour had lapsed between the boy leaving the station and being struck by the train. It was argued that there was sufficient time for him to consume more alcohol prior to being hit by the train and therefore his level of intoxication at the police station could not be determined.

This case raises the question of whether police had a duty of care to arrange for this boy to arrive home safely. The young person was only 16 years of age and intoxicated. Appropriate action would have included either an escort home by police or arranging for him to be collected from the station by a responsible adult.

In summary:

- The overwhelming majority of children and young people had not received the services of a human service agency.
- Of the seven who had been clients of a human service agency, involvement was typically very brief.

Conclusions 7.4

This group of children and young people, almost all of who were male, had not experienced any significant family, school or health problems, nor had they suffered any pivotal adverse life events. Rather, they died tragically while engaging in behaviours that

are common in adolescence, notably alcohol and other drug use and risky driving.

For the children and young people who died while in a substance-affected state, their alcohol and other drug use typically occurred in a social context. In most cases the children or young people had been drinking alcohol with friends, either at a pub, a party or at home, and died later while in a state of intoxication. None was a chronic substance user.

Several children and young people died while engaging in risky driving, with behaviours including speeding, unlicensed driving and drink driving. Some had been warned by police about dangerous driving or alcohol use prior to their deaths.

Two points are of note from the findings presented in this chapter. First, a developmental approach highlights adolescence, and late adolescence in particular, as a stage of development in which there is potential for an adverse or fatal outcome. At this stage of development, experimentation is the norm (Spooner et al., 1996); risk-taking is typically viewed as part of 'growing up' (Baumrind, 1987; Shedler & Block, 1990; Kelly, 2000). Although experimentation is socially accepted as part of adolescence, few adolescents escalate from experimental to chronic risk-taking (Moore & Parsons, 2000) or become 'multiple risk' adolescents who engage in a large number of risk-taking behaviours (Porter & Lindberg, 2000).

While these deaths appear to have occurred in the context of adolescent experimentation, it is possible that their risk-taking behaviour may have masked hidden emotional difficulties. The literature documents that behavioural difficulties, substance misuse and risk-taking among males may be proxies for depressive symptoms, which are often undetected due to the normalisation of these behaviours for males (Merikangas et al., 1994; Weissman & Klerman, 1997).

Second, it is important to draw attention to the gender dimension of the fatalities. The results of this study indicate that fatal risk-taking is predominantly a male phenomenon. All but two of the fatalities were of males. Risk-taking, which had fatal consequences for these males, took the form of combinations of risky driving, alcohol and drug use.

While the relationship between behaviour and gender remains complex, research suggests that there are gender differences in the prevalence of risk-taking behaviours. The activities that males report engaging in for thrills and excitement are riskier than activities that females report engaging in. Males also have higher rates of sensation-seeking and risky behaviour than females (Lefkowitz, Kahlbaugh & Sigman, 1994; Langhinrichsen-Rohling et al., 1998). For example, teenage males are significantly more likely than teenage females to engage in such risk-taking behaviour as regular alcohol use and binge drinking, carrying a weapon and physical fighting (Boggess, Lindberg & Porter, 2000). While research suggests that there is no gender difference in the number of male and female adolescents who engage in drug use (Ketterlinus & Lamb, 1994), males are more likely than females to engage in excessive substance use, which places them at greater risk for serious adverse outcomes (Shanahan & Hewitt, 1999).

The findings from this study indicate that prevention strategies must address the contributions of gender and development to risk-taking behaviour. Risk-taking increases with adolescence, and fatal risk-taking is a predominantly male phenomenon.

Chapter eight

Summary of findings and implications

This study examined the deaths of all 12-17 year olds in NSW by suicide and risk-taking between January 1996 and December 2000. The primary aims were to:

- Identify the factors associated with and the circumstances surrounding suicide and risk-taking deaths of children and young people;
- Specify the level and extent of contact with human service agencies; and
- Suggest ways to prevent further deaths of children and young people from suicide and risk-taking.

This final chapter discusses the findings with respect to each of the study aims and draws attention to important implications for the prevention of deaths of children and young people from suicide and risk-taking.

Overall, the findings are in agreement with those from previous research studies in that child and adolescent suicides are rare. The infrequent nature of such deaths nevertheless does not alter the fact that suicide in children and young people is a tragic matter. Moreover, over the five-year period, those who died by suicide and risk-taking made up almost one-quarter (23%) of deaths (aged 12-17 years) from all causes (natural and external) in NSW, indicating that suicide and risk-taking are significant causes of death in this age group. Over the five-year period, suicide deaths accounted for 13.6% of deaths and risk-taking deaths accounted for 8.1% of deaths from all causes. The prevention of further suicide and risk-taking deaths among children and young people requires that these deaths be investigated and understood.

Factors associated with and circumstances surrounding suicide and risk-taking deaths of children and young people 8.1

Both Australian and international studies have consistently found several factors to increase risk for suicide (Hoberman & Garfinkel, 1988; Centre for Mental Health, 2000; Beautrais, 2001; see also Beautrais, 2000; Cantor et al., 2000). This study shows that some of these factors are consistently found regardless of whether the death resulted from suicide or risk-taking. The following risk factors were shown to be common to both the suicide and risk-taking deaths.

Gender

The majority (71.1%) of suicide and risk-taking deaths were of males. For every death of a female there were more than twice as many deaths of males.

Age

Almost three-quarters (72.7%) of the children and young people who died were aged 16 or 17 years at the time of death. Twelve and 13 year olds made up less than five per cent of the population of deaths.

Indigenous children and young people
Aboriginal children and young people were over-represented in suicide and risk-taking deaths compared with their numbers in the population (7.5% of the population of this study compared with 2.8% of the NSW population).

Living arrangements
Well under half (38.5%) of the children and young people who died were living in intact biological families at the time of their deaths.

There were, however, several factors for which the suicide and risk-taking deaths were shown to differ.

Education
Just under half (47.1%) of the children and young people had left school before completing Year 12. Children and young people who experienced risk-taking deaths were far less likely to be attending school than those who died from suicide (33.3% of the population risk-taking deaths were attending school versus 69.4% of the population of suicide deaths).

Drug use
Over one-third (35.3%) of the children and young people who died engaged in frequent drug use (at least once/week), with cannabis, alcohol and heroin being the substances most commonly used. Children and young people who died by risk-taking were more likely to engage in frequent drug use than those who died suicide deaths (56.1% of the population of risk-taking deaths engaged in frequent drug use versus 39.4% of the population of suicide deaths).

Offending behaviour
Two-fifths of the children and young people had been in trouble with the police for engagement in criminal activity, although more risk-takers (55.3%) were known to the police for their offending behaviour than those who died by suicide (38.2%).

Prior suicidal behaviour
Eighty-two (43.9%) children and young people had exhibited prior suicidal behaviour, in the form of ideation, attempts and deliberate self-harm. Those who died by suicide, however, were more likely to have exhibited prior suicidal behaviour than those who died by risk-taking (58.6% of suicide cases had exhibited prior suicidal behaviour versus 22.7% of risk-taking cases). The fact that approximately one in five children and young people who died from risk-taking had engaged in suicidal behaviour draws attention to the overlap between suicidal and risk-taking behaviours.

Stressful life events
Almost three-quarters (72.7%) of the children and young people had experienced at least one adverse life event in the year prior to their deaths. The most common adverse life events experienced by those who died by suicide were interpersonal conflicts relating to relationship breakdowns and arguments. In contrast, those who died by risk-taking were more likely to have experienced legal problems, such as apprehension by police for criminal activity, charges and children's court appearances.

Precipitating incident to death
Most of the precipitating incidents to the suicide deaths involved a relationship breakdown or an apparently trivial argument with a significant person in their lives (boyfriend/girlfriend, family member, or friend; 62.2%). In contrast, alcohol or other drug

intoxication was the precipitating incident most frequently recorded in the risk-taking cases (72.4%).

Method of death

Drug overdose was the most common method of risk-taking death for both males and females, of which the majority were heroin overdoses. In contrast, hanging was the most frequently used method of suicide death for both males and females.

Profile of children and young people dying from suicide and risk-taking

Over the five-year period, the typical child or young person who died from suicide or risk-taking was male, aged 16 to 17 years, and born in Australia. There were, however, several differences between the profiles that emerged for the suicide and risk-taking groups. For those who died by suicide, the precipitating incident to death tended to be an apparently trivial argument with a significant person in their lives and the mechanism of death was typically by hanging. Most of these children and young people were enrolled in some form of education and interpersonal problems tended to be the most typical adverse life events experienced.

The children and young people who died by risk-taking were almost all substance affected immediately prior to their deaths and the most common method of death was poisoning. This group was typically not involved in any form of education and was engaged in drug use and crime. The most common stressful life events experienced by these children and young people were problems with police and the law.

Circumstances surrounding children and young people dying by suicide and risk-taking

Perhaps most importantly, this study found that children and young people who die by suicide and those who die by risk-taking are not a homogeneous population. Rather, there is diversity in their backgrounds and experiences. The deaths of these children and young people could be classified into three distinct clusters on the basis of their life histories and precipitating incidents to their deaths:

- Enduring difficulties
- Pivotal life events
- Adolescent experimentation

1) Enduring difficulties

This cluster was overwhelmingly the largest, comprising 124 of the 187 fatalities (66.3%). These children and young people had experienced enduring or chronic difficulties in the form of mental health problems, family dysfunction, school-related difficulties, or any combination of these. This group died both by suicide (80; 72.1% of all suicide deaths) and by risk-taking (38; 55.9% of all risk-taking deaths)[18]. This suggests that some of these children and young people took their lives as a result of their enduring difficulties, whereas others turned to substance use in an effort to temporarily escape from their chronic problems and consequently died in a substance-affected state.

Twenty-eight of the 124 children and young people experienced more than one enduring difficulty.

[18] Intent was unable to be determined for six children and young people in this cluster.

A. Mental health problems and distressed emotional state
Thirty-two children and young people had been diagnosed with a mental health problem. The most common diagnoses among those who died by risk-taking were behavioural disorders, while depression was most frequently diagnosed among suicide deaths.

File records indicated that a further 22 children and young people, 20 of whom died by suicide, were experiencing extreme sadness and a distressed emotional state. Acknowledging that the majority of children and young people with mental health problems never come to the attention of mental health professionals (Sawyer et al., 2000), it is possible that these children were suffering from an undiagnosed depression.

B. Family dysfunction
Seventy out of the 124 children and young people with enduring difficulties experienced chronic family dysfunction. The nature of the family problems experienced included physical, sexual and emotional abuse, neglect, ineffective parenting, and ongoing conflict and argument. Cultural issues were evident, in particular, difficulties in living within the Australian culture while being expected to maintain the culture of their country of origin.

C. School-related difficulties
Thirty-eight children and young people experienced a range of significant school-related problems. The nature of these problems differed between the suicide and risk-taking groups. The difficulties endured by those who died by suicide included HSC-related pressures, learning difficulties and problems in peer relationships, with a minority experiencing behavioural and disciplinary problems. In contrast, those who died by risk-taking were most likely to have experienced extreme behavioural and disciplinary problems, with 11 being diagnosed with a behavioural disorder. For these children and young people, the experience of behavioural and disciplinary problems was followed by early school exit, substance use and engagement in criminal activity, and ultimately death in a substance affected state.

2) Pivotal life events

Twenty-six (13.9%) of the 187 children and young people were placed in this cluster and all but two died by suicide. Enduring difficulties were not evident in this group. Rather, prior to their deaths they all experienced an isolated incident which they perceived as pivotal or life-changing. Their suicides appear to have been either an impulsive response to this major life event or to have occurred in an acute depressed state due to their experience of the event. The most commonly experienced pivotal life events were interpersonal issues, typically a relationship breakdown, the death of a significant person, or an argument with an important person in their lives. The other significant life events that were precipitants to this cluster of deaths were associated with a major illness or accident, sexual assault, unemployment and legal problems.

3) Adolescent experimentation

Twenty-eight (15%) of the 187 children and young people formed this cluster, all but one of whom died by risk-taking. This group did not experience enduring mental health problems, family dysfunction or school-related difficulties, nor did they suffer an adverse pivotal life event prior to their deaths. Rather, they died while engaging in risk-taking behaviours, notably substance use or dangerous driving. This cluster could be

further differentiated from the other two clusters on the basis of the context of the alcohol and other drug use involved, which typically occurred in a social or group context. These children and young people had consumed alcohol or ingested illicit substances with friends, either at a pub, a party or at home, and died while in a substance-affected state. Perhaps most importantly, all but two of the fatalities in this cluster were of males, indicating that fatal risk-taking is predominantly a male phenomenon.

Contact with human service agencies 8.2

In this study, 41.7% of the children and young people who died had no record of human service provision (with the Department of Community Services, the Department of Juvenile Justice, health or mental health, school counsellor, or drug and alcohol service provision)[19]. Of those who had been clients of these agencies, the nature and extent of service provision varied among the three clusters.

The children and young people who were involved with these services were typically those who experienced enduring difficulties, and especially those who were:

- Diagnosed with mental health problems;
- Victims of child abuse and neglect; or
- Engaged in drug use and crime.

In contrast, the children and young people who had minimal or no involvement with human service agencies were typically those who were experiencing:

- Extreme emotional distress, but had not received a mental health diagnosis;
- Family dysfunction other than child abuse and neglect;
- HSC stress or problems in peer relationships; or
- Pivotal life events.

For those children and young people who had been clients of human service agencies, several inadequacies in service provision were detected. It is important to note that a lack of thorough documentation and the resulting shortage of information limited the ability to critically evaluate human service provision for many cases. This lack of information reflects either poor record keeping or the policies of the human service agencies. For instance, school counsellor files are established only in cases where there has been a significant intervention by the school counsellor.

Prevention of suicide and risk-taking deaths of children and young people 8.3

Given that multiple factors are associated with suicide and risk-taking, prevention requires the cooperation and collaboration of a wide range of groups, communities, agencies and individuals (Commonwealth Department of Health and Aged Care, 2000). In Australia, suicide prevention initiatives are currently being implemented across all levels of government.

[19] Police records are not included as NSW Police do not provide services in the way that the other human service agencies do. There was at least one entry on the Computerised Operational Policing System (COPS) for all but three young people. In many instances, the entry was simply a record of the child or young person's death. Thus, the presence of a COPS record for a child or young person is not indicative of NSW Police service provision in the way that, for example, the presence of a Juvenile Justice record is indicative of Juvenile Justice service provision.

At the national level, the Commonwealth Government funded the *National Youth Suicide Prevention Strategy* (NYSPS) from 1995 to 1999. Over 70 projects were funded under the NYSPS, using multiple approaches. Examples of the major achievements under the Strategy include the initiation of suicide prevention strategies in each Australian state and territory, parenting skills programs using proven primary prevention and early intervention approaches, suicide prevention training to a large number of primary health care professionals, and community education aimed at developing the skills of professionals and community members to recognise and respond to young people at-risk (Mitchell, 2000).

In NSW, the *We Can All Make A Difference: NSW Suicide Prevention Strategy* was released in 1999 and focuses on all age groups (NSW Health, 1999a)[20]. The strategy adopts a whole of government approach to suicide prevention and incorporates five key strategic directions:

1) We can all make a difference: Increasing communities' ability to prevent suicide;
2) Connect and care: Providing outreach and support for groups at higher risk;
3) Suicide, an emergency: Enhancing the effectiveness of services in suicide prevention;
4) Care and support: Providing support for people affected by suicide;
5) We need to know more: Improving information on suicide prevention.

Linkage of the *NSW Suicide Prevention Strategy* with Commonwealth initiatives in mental health promotion and suicide prevention such as *CommunityLIFE* and *MindMatters* programs is important and should assist in the achievement of the five key strategic directions.

In accordance with the fifth strategic direction – improving information on suicide prevention – the findings from this study suggest avenues for the prevention of further suicide and risk-taking deaths. Some of the findings from this study are already adequately recognised within the Strategy, others are recognised to some extent within the Strategy. The remainder of the study findings are not currently recognised within the Strategy.

The following sections present the study findings within the five key strategic directions of the *NSW Suicide Prevention Strategy*.

Strategic direction 1: We can all make a difference

Increasing communities' ability to prevent suicide

The aims of this first strategic direction are to strengthen people's and communities' resilience and ability to deal with difficult life situations and to improve people's knowledge and skills to recognise and support people at-risk of suicide.

The study findings falling under this first strategic direction are:

- Family dysfunction was a factor for more than one-third of the children and young people.
- Many children and young people did not seek assistance for their difficulties.
- Many children and young people were unable to manage stressful situations.

[20] The majority of deaths in this study occurred prior to the introduction of the *We Can All Make A Difference: NSW Suicide Prevention Strategy.*

- Narrow male stereotypes created difficulties for several males.
- Many children and young people informed a friend or family member of their intention to commit suicide, but this person did not act on the information.
- Some children and young people were unable to cope with the stress of the Higher School Certificate.

Family dysfunction was a factor for more than one-third of the children and young people.

Families have a crucial role to play in developing resilience among children and young people. Parents therefore need to be equipped with the skills to care for and support their children. This task is made even more difficult for those families that are dysfunctional, marginalised and under-resourced.

The family lives of more than one-third of the children and young people in this study were characterised by chronic dysfunction. Some of those children and young people chose suicide as the ultimate escape from their intolerable family situations, whereas others turned to substance use in an attempt to temporarily escape from their unbearable family lives.

Not all children and young people who experience enduring family dysfunction will commit suicide or engage in substance use. Individuals exposed to similar risks are differentially equipped to deal with those risks, and it is commonly believed that protective factors seem to moderate the impact of the risk (Jessor, 1992; Huon & McConkey, 1998).

Jessor (1992) identified several domains of protective factors that serve to attenuate, counter or balance the effects of risk factors. For example, in the social domain, a caring adult or a supportive school can serve as protective factors. Other protective factors that have been identified as minimising the impact of exposure to risk factors include temperament characteristics (for example, flexibility), active coping styles, and intelligence (Losel & Bliesener, 1994). These research findings suggest that effective suicide and risk-taking prevention programs must aim to simultaneously reduce risk and promote protection.

Evidence-based research shows that interventions to promote family cohesion and reduce conflict can assist in the attenuation of risk factors for suicide. Strategy 1.2 of the *NSW Suicide Prevention Strategy* (The Families Program, for all families) includes several programs to promote families' well-being, including the *Families First* initiative and the *Family Help Kit*, which was developed for every family in NSW and disseminated widely.

The CDRT awaits the evaluation of these important initiatives.

Many children and young people did not seek assistance for their difficulties.

In this study, many children and young people (as well as their families) were in need of professional assistance, although they did not seek that assistance. From the information that was obtained, it is not possible to determine why this was the case.

This study raises the issue of the need to develop the emotional literacy[21] of children

[21] Emotional literacy is made up of three abilities: the ability to understand personal emotions, the ability to express emotions productively, and the ability to listen to others and to empathise with their emotions (Steiner, 1997; cited in Stewart-Brown, 2000).

and young people, so that they are able to ask for help when they need it.

Strategy 1.3 of the *NSW Suicide Prevention Strategy* (Promote mental health in schools) includes several mental health education programs provided by the Department of Education and Training. This study suggests that education about mental health issues is not sufficient. The Strategy should be broadened to engage the wider community in developing the emotional literacy of children and young people so that they can obtain help on any issue when it is required.

Many children and young people were unable to manage stressful situations.
Many children and young people in this study experienced stressful life events of varying intensity or severity (from relationship breakdowns to sexual assaults), and their suicide or drug use can be interpreted as a failure to cope with these stresses. These findings suggest that children and young people need to be equipped with the skills to manage stressful situations and cope with emotional disappointments.

Schools are in an excellent position to equip children and young people with coping skills, and have begun to do so with the *School-Link* program[22] as well as other initiatives such as *MindMatters.* These initiatives fall under Strategy 1.3 of the *NSW Suicide Prevention Strategy* (Promote mental health in schools).

The CDRT awaits the evaluation of these important initiatives.

Narrow male stereotypes created difficulties for several males.
The social construction of gender is significant in any society. Traditionally, risk-taking, athleticism, power over women and power over other men all act as important signifiers of masculinity. Thus the boy who takes risks, is good at sport and who can demonstrate his power over girls and other boys is likely to achieve recognition from his peers. Boys, in particular, need to explore the ways in which idealised forms of masculinity have been constructed (Mills, 2001).

Findings from this study showed that at least four males were harassed by peers for not being athletic or interested in sports, one male committed suicide because he was unable to cope with his belief that he was homosexual, and the majority of risk-taking deaths were of males. These cases raise the issue of the expectation of males to conform to very narrow stereotypes. Teachers and parents are important in promoting to children and young people the diversity of gender role models. By educating boys and girls in this way, children and young people themselves will be in a position to destabilise the 'taken-for-granted' nature of gender-based behaviours (Alloway, 2000). Prevention efforts must examine the role of risk-taking in male socialisation, and in partnership with other recognised programs, should collate, develop and implement effective strategies that aim to modify forms of male risk-taking that have a high potential for lethal consequences.

The CDRT considers that there is a need for the Strategy to address this important issue.

[22] *School-Link* provides a framework for programs to improve the understanding, recognition, treatment and prevention of depression and related disorders in adolescents. *School-Link* also supports schools to incorporate mental health programs such as the *Resourceful Adolescent Program* (RAP) and *Adolescents Coping with Emotions* (ACE).

Many children and young people informed a friend or family member of their intention to commit suicide, but this person did not act on the information.
Findings from this study show that many children and young people who took their lives informed a friend or family member of their intention to do so. Most often they informed a friend of their suicidal intent. In almost every case, the person who had been informed of the suicidal intent failed to act on this information. This failure to act was attributed to either the suicide threat not being taken seriously, or to the child or young person insisting their friend promise not to tell anybody.

These findings show that peers play an important role in the identification of children and young people at-risk of suicide. Peers need to be aware of the importance of passing on concerns to an appropriate person. It is important to actively challenge peers' worries about breaching confidentiality and to increase their understanding that, in these instances, breaking a promise to their friend may save their friend's life. Children and young people need to know what to do and who to tell when they are told of someone's intention to commit suicide.

The CDRT considers that there is a need for the Strategy to address this important issue.

Some children and young people were unable to cope with the stress of the Higher School Certificate.
Sixty thousand people sit for the HSC each year in NSW. A new finding from this study was the association between HSC stress and suicide. Over the five-year period of this study, 10 young people (9% of suicide cases) indicated prior to their deaths that they were unable to cope with the stress of their final school years.

The finding of an association between HSC stress and suicide warrants urgent investigation of how to support young people during this stressful period and how to work with parents and the community to provide realistic guidance to students.

The CDRT considers that there is a need for the Strategy to address this important issue.

Strategic direction 2: Connect and care

Providing outreach and support for groups at higher risk

The aims of this strategic direction are to improve the knowledge and skills of key workers and community members so that they can recognise and respond to groups at higher risk of suicide, and to improve well-being and mental health outcomes for people who may be at higher risk of suicide.

The following study findings fall under this second strategic direction:

- Several children and young people experienced significant problems in peer relationships.
- Several children and young people experienced significant learning and behavioural problems.
- Many children and young people died while engaging in typical adolescent risk-taking behaviours.
- The majority of suicide and risk-taking deaths were of males.
- Aboriginal children and young people were over-represented in suicide and risk-taking deaths compared with their numbers in the population.

- Several children and young people were victims of extreme child abuse and neglect.
- Just under half of the children and young people had no record of contact with human service agencies.

Several children and young people experienced significant problems in peer relationships.

Peer harassment is a significant issue for many children and young people. Alloway (2000) claims that as a community we often rely on biological theories to explain peer harassment. Based on those theories, girls' harassment of one another is often dismissed as 'the 'bitchy' ways that girls relate, as though a description of the behaviour explains its origins and somehow negates any obligation to intervene' (Alloway, 2000, p.53). Drawing on the same theories, for many boys being 'tough' forms part of their understanding of what it is to be male.

While schools have an obligation to ensure that they are a safe place for students, Griffiths (1996; cited in Healey, 2001) states that whole school and community approaches are crucial in attacking bullying. Students, teachers, parents and other members of the school community should all be involved. Perhaps most importantly, both children and young people and adults need to be aware that peer group nastiness often takes on very subtle forms and they must be assisted to recognise those forms.

The findings from this study show that the suicides of at least eight young males and females were associated with problems in peer relationships. For females, incidents typically involved short episodes of rumour-spreading, name-calling, peer group nastiness and exclusion. Males' experiences involved continuous tormenting and bullying. Boys were typically taunted for being more interested in their schoolwork than in sports. These cases show the serious effects that peer bullying, taunting and exclusion, even in the short-term, can have on the well-being of children and young people.

Many schools have introduced anti-bullying and anti-harassment responses as part of their whole school approach to student welfare.

The CDRT considers that anti-bullying and anti-harassment programs should be implemented in every school in NSW.

Several children and young people experienced significant learning and behavioural problems.

Although a link between learning difficulties and suicide has been suggested, strong research evidence is lacking in this area (Beautrais, 2000). In contrast, research findings have demonstrated that behavioural and disciplinary problems are associated with leaving school early (Mayer, 2002), substance use (White, Xie, Thompson, Loeber, & Stouthamer-Loeber, 2001), offending behaviour (National Crime Prevention, 1999) and suicide (Beautrais, 2000). These children and young people often alienate families, schools and services by their difficult behaviour. A consequence is that opportunities for intervention are missed.

Seventeen children and young people (14 of whom were male) experienced significant behavioural and disciplinary problems and eight children and young people (all of whom were male) suffered learning difficulties. Eleven of the 17 who experienced behavioural and disciplinary problems had been diagnosed with a behavioural disorder. The majority left school early, became involved in drug use and crime, and died by risk-taking.

In contrast, six of the eight children and young people who experienced significant learning difficulties died by suicide. They suffered low self-esteem, feelings of inadequacy and failure due to their learning difficulties.

Special attention needs to be afforded to researching available programs that intervene early with these children and young people, the majority of whom are male and have behavioural and learning problems.

The CDRT considers that there is a need for the Strategy to address this important issue.

Many children and young people died while engaging in typical adolescent risk-taking behaviours.

Risk-taking in adolescence is often viewed as a 'normal part of growing up' (Baumrind, 1987) and researchers have noted that healthy risk-taking behaviours can positively impact upon the developing adolescent (Abbott-Chapman & Denholm, 2001). It is argued that some degree of risk-taking is important for adolescent identity formation and consolidation and the push toward autonomy. Yet the taking of certain risks can have grave and lasting consequences. Alcohol and other drug use and reckless driving are two risk-taking behaviours commonly associated with adolescents, both of which can have serious ramifications (Hewitt et al., 1995).

One cluster of children and young people died while engaging in typical adolescent risk-taking behaviours, notably involving alcohol and other drug use and reckless driving. Moreover, the majority of reckless driving cases involved alcohol and other drug use.

Effective alcohol and other drug prevention programs are critical in addressing adolescent risk-taking. Weatherburn, Topp, Midford and Allsopp (2000) identified the elements of effective school-based drug use preventive programs. These include delivery before behavioural patterns are established, concentration on drugs that are most widely used by children and young people, the use of interactive teaching techniques, and the use of peer educators to provide drug education.

The CDRT considers that there is a need for the Strategy to address this important issue.

The majority of suicide and risk-taking deaths were of males.

Seventy-one per cent of children and young people who died from suicide and risk-taking during the study period were male. These findings indicate that suicide and risk-taking are predominantly a male phenomenon.

Any activity that is undertaken to improve the knowledge and skills of workers and the community must target males.

The CDRT considers that there is a need for the Strategy to address this important issue.

Aboriginal children and young people were over-represented in suicide and risk-taking deaths compared with their numbers in the population.

Fourteen children and young people (7.5% of the population of deaths) were identified as Aboriginal. In comparison, Aboriginal children and young people aged 12-17 years make up 2.8% of the NSW population. This finding is consistent with the existing literature. For example, suicide rates among Aboriginal males aged between 15 and 19 years have been found to be four times higher than those for non-Aboriginal males (see Centre for Mental Health, 2000).

As part of the *NSW Suicide Prevention Strategy*, the Centre for Mental Health, in collaboration with the Aboriginal Health and Medical Research Council of NSW were to develop an Aboriginal and Torres Strait Islander suicide prevention program. In addition, the NSW Aboriginal mental health policy identifies key principles for the specific mental health needs of Aboriginal people in NSW, including those relating to suicide risk. The Department of Aboriginal Affairs is supporting and advising other government departments and community organisations to assist in the development of culturally appropriate programs for Aboriginal communities across NSW.

The CDRT awaits the evaluation of these important initiatives.

Several children and young people were victims of extreme child abuse and neglect. Research has documented many negative outcomes for victims of long-term child abuse and neglect, including behavioural problems (such as aggression, violence, crime), emotional deficits (such as attachment disorders, relationship problems, social insensitivity), and social-cognitive problems (such as poor social and moral judgement; Wolfe, 1987).

Child protection is the responsibility of the whole community and a responsibility specifically shared by those government and non-government agencies which provide any form of care for children, young people and their families or which come into contact with them in the course of their work. In NSW, the Department of Community Services has the 'lead responsibility' in providing and coordinating the community response where intervention is necessary for the care and protection of children and young people. TheDepartment of Community Services' lead role, however, does not detract from the joint responsibility of all relevant agencies to protect children and young people who are at-risk of harm and to work together to provide a coordinated and comprehensive response to their needs (NSW Commission for Children and Young People, 2000).

In 2000/2001, the Department of Community Services received 27,261 contact reports of children and young people aged between 12 and 17 years (Department of Community Services, 2001). Just over one-quarter (49; 26.2%) of the children and young people who died had been notified at some stage during their lives and one-third (16) of those had active Department of Community Services' involvement at the time of their death.

While the level and extent of Department of Community Services' involvement varied, there was evidence of inadequate service provision for 23 children and young people. All were subjected to long-term child abuse and neglect and all became engaged in high-risk lifestyles, notably substance use and crime. It is postulated that unresolved child abuse and neglect was the precursor to these tragic outcomes.

Evidence from the analysis of the child protection cases in this study show that in at least six cases the Department of Community Services clearly needed to protect children and young people from the effects of long-term child abuse and neglect, possibly by removal from the family home.

For at least five of the 23 children and young people who received inadequate Department of Community Services' service provision, there was also evidence of unsatisfactory service provision by other human service agencies. In those instances, the Department of Education and Training (three cases), the Department of Health (one case), and the Department of Juvenile Justice (one case) reported to the Department of

Community Services children and young people believed to be at-risk of harm, although there is no record that these Departments took any other action to protect these children and young people. Thus, although the *NSW Interagency Guidelines for Child Protection Intervention* state that child protection work should be a coordinated effort, rather than unilateral action by a single agency, the findings from this study suggest that in practice, this is not always the case.

The most appropriate course of action must be taken in order to adequately protect the most vulnerable children and young people. While not all suicides can be prevented, it is possible that better service provision may have assisted in preventing these suicide and risk-taking deaths. The findings from the analysis of these cases provide support for the claim that 'preventing child abuse is likely to have direct benefits in preventing juvenile crime and probably youth suicide and other societal "disorders" ' (National Crime Prevention, 1999; p.165).

The CDRT considers that there is a need for the Strategy to address this important issue.

Just under half of the children and young people had no record of contact with human service agencies.

Recent research findings indicate several factors that encourage children and young people to seek help. These include feeling safe and comfortable to approach a support person, feeling confident that their privacy will be respected and confidentiality ensured, feeling confident that they will be listened to, and knowing the person could offer advice and help solve the problem. Factors that prevent children and young people from seeking help include feeling uncomfortable, unsafe, embarrassed, scared or nervous, and worrying about negative consequences, such as getting into trouble, as well as a perception that no one is available to help (NSW Commission for Children and Young People, 2002).

The findings from this study indicate that many children and young people who required professional assistance did not receive help. These findings raise two issues in relation to service provision. The first relates to the narrow range of services available for children and young people. The second relates to the presentation of the services themselves – services need to be attractive to children and young people and to present themselves in non-stigmatising ways. Both of these issues were raised in the 2001 Cottrell Conference, which focused on youth suicide prevention in Australia and New Zealand.

The findings from this study suggest a need to invest in research and develop new ways of working with children and young people who have contact with human service agencies and those who do not have contact but might benefit from service provision. An audit of service provision at a local level may be of benefit to identify services that are available for children and young people and the appropriateness of these.

The CDRT supports Strategy 2.1.4 of the *NSW Suicide Prevention Strategy* (Enhance local youth mental health and related services) and awaits its evaluation.

Strategic direction 3: Suicide, an emergency

Enhancing the effectiveness of services in suicide prevention

The aims of this strategic direction are to improve the effectiveness of health services and workers in caring for people in contact with health services who have attempted

suicide or may be at-risk of suicide, to improve the mental health outcomes for people in contact with health services, to improve the responsiveness of all services to those at high risk of suicide, and to strengthen prevention, early intervention and management of those at high risk of suicide by child and adolescent mental health services.

The following study findings fall under this third strategic direction:

- For several children and young people there was an underestimation of suicide risk by health professionals.
- Several children and young people who presented to hospital with suicidal behaviour or having overdosed on drugs were discharged without sufficient observation or assessment or joint management plans in place.
- The suicide deaths of a number of children and young people occurred during a period of non-compliance with medication.

For several children and young people there was an underestimation of suicide risk by health professionals.

Appleby (2000) cited several studies that have documented an underestimation of risk prior to suicide. In the findings of the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in the UK,* most suicides had been judged to be at no or low immediate risk at the last contact with services, which in around 50% of cases occurred within a week of death (see Appleby, 2000).

Similarly, several cases in this study presented to mental health professionals or emergency departments with suicidal intent. In each case, the professional assured parents that there was no real threat of their child committing suicide, yet in each case the suicide occurred within weeks of the assessment. As Appleby (2000) noted, these findings raise concerns about understanding of risk and imply the need for training for risk recognition, risk monitoring and follow-up.

It is acknowledged that risk assessment is not always easy or foolproof. Many adolescent suicides are impulsive, unplanned acts (Hoberman & Garfinkel, 1988; Shaffer et al., 1988), making risk assessment extremely difficult. In addition, just prior to suicide many depressed people present as 'better' because of a sense of relief after having made the decision to commit suicide (Canadian Mental Health Association, 2002). Thus, not all suicides can be predicted or prevented. Yet the findings from this study highlight the importance of having highly skilled professionals who are able to competently assess and manage patients who present with possible suicidal behaviour. This includes close and regular monitoring of patients until suicide risk is reduced.

Strategy 3.2.1 of the *NSW Suicide Prevention Strategy* (Improve education and training of primary health care workers and general practitioners) includes several suicide prevention training programs aimed at primary care workers, including general practitioners. These programs provide information on recognition, assessment and treatment of people at-risk of suicide.

The CDRT awaits the evaluation of this important initiative.

Several children and young people who presented to hospital with suicidal behaviour or having overdosed on drugs were discharged without sufficient observation or assessment or joint management plans in place.

In this study, several children and young people presented to Emergency Departments having attempted suicide or overdosed on drugs. In many of these cases, the children

and young people were discharged without having been observed for a sufficient period of time or prior to a thorough psychiatric and psychosocial assessment being performed. Discharge often occurred without the necessary interdepartmental planning required for case coordination and management.

In line with Strategy 3.2.2 (Establish best practice assessment, management and follow-up of people who attempt or are at-risk of suicide), the Centre for Mental Health developed a policy circular[23] as part of the implementation of the *NSW Suicide Prevention Strategy*. The circular contains detailed policy guidelines for the management of patients with possible suicidal behaviour for NSW Health staff and staff in private hospital facilities. Health Services and private hospital facilities are putting procedures in place so that the circular is applied. Of particular relevance is the statement:

> 'All patients who present with possible suicidal behaviour must have thorough, well documented psychosocial and psychiatric assessments. Every effort must be made to delay discharge of patients following self poisoning or injury until a psychiatric assessment can be performed' (p. 6).

The CDRT considers that there is a need for this Strategy to be broadened to include an interdepartmental focus on case management.

The suicide deaths of several children and young people occurred during a period of non-compliance with medication.

Much literature documents the general non-compliant nature of adolescence (King & Lewis, 1994; Lewis, 1995; Kyngas, 1999; Dinwiddie & Muller, 2002). Reasons for this may include adolescents' emphasis on autonomy and activity, orientation towards peers and concerns over physical stigmata (King & Lewis, 1994). Dinwiddie and Muller (2002) cite struggles with authority, cultural pressures to be 'normal' and a chaotic home environment as factors that may affect adolescents' compliance with treatment.

In the findings of the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in the UK*, approximately 25% of psychiatric patients who died by suicide were not compliant with treatment. When mental health professionals were asked what aspects would have lowered suicide risk in those cases, most cited closer supervision and better treatment compliance (Appleby, 2000). This author noted that measures to improve compliance might include motivational interviewing; the use of drugs with fewer side effects; closer supervision; and family members assisting in the supervision of patients in the community, with the ability to promptly report any concerns to the mental health service.

Consistent with those findings, in this study four suicide deaths among children and young people occurred during a period of non-compliance with their medication. Three involved children and young people with diagnosed mental health problems and one child was an insulin-dependent diabetic who had been non-compliant with the taking of his insulin.

The CDRT considers that there is a need for the Strategy to address this important issue.

[23] *Circular 98/31* Policy guidelines for the management of patients with possible suicidal behaviour for NSW Health staff and staff in private hospital facilities (Centre for Mental Health, 1998).

Strategic direction 4: Care and support

Providing support for people affected by suicide

The aims of this strategic direction are to improve the systems and skills of staff to manage the consequences of death by suicide in a compassionate and apt manner and to provide helpful and needed support to families, friends, workers, local communities and others involved after suicide has occurred.

The following study findings fall under this fourth strategic direction:

- Friends or family members were often informed of children and young people's intention to commit suicide.
- Several suicide deaths were associated with copycat or imitative factors.

Friends or family members were often informed of children and young people's intention to commit suicide.

Many children and young people in this study informed a friend or family member of their intention to commit suicide. Being informed that a friend or family member intends to commit suicide is a huge burden to carry. Supports must be available for those people if the suicide does occur.

The CDRT considers that there is a need for the Strategy to address this important issue.

Several suicide deaths were associated with copycat or imitative factors.

A review of the association between media portrayal of suicide and suicidal behaviour found evidence of a causal association between media portrayal of suicide and actual suicide in the case of non-fictional presentations of suicide in books, newspapers and on television. The evidence was more equivocal with respect to fictional presentations of suicide in films and music (Pirkis & Blood, 2001).

In this study, 17 (15.3%) suicide deaths were associated with copycat or imitative factors. Four of those deaths occurred immediately after the child or young person's viewing of fictional films that portrayed suicidal behaviour or after listening to heavy metal music that included songs of a suicidal nature.

Thus, 'although the jury is still out on fictional portrayals of suicide' (Pirkis & Blood, 2001; p. ix), film producers and those in the music industry still have a responsibility to exercise caution, especially when their target audience includes children and young people.

Media professionals must portray suicide in a responsible manner. Guidelines have been developed for Australian media professionals in an attempt to make this occur (Penrose-Wall, Baume & Martin, 1999). This initiative falls under Strategy 4.3 of the *NSW Suicide Prevention Strategy* (Enhance local community capacity to prevent and respond to increases in suicide).

The CDRT awaits the evaluation of this important initiative.

Strategic direction 5: We need to know more

Improving information on suicide prevention

The aims of this strategic direction are to ensure that suicide prevention programs in NSW are evidence-based and effective, and to provide timely data on suicide deaths and accurate information on suicidal behaviour in NSW.

The following study finding falls under this fifth strategic direction:

- For just under half of the children and young people, the only information available was that contained in the coronial file.

For just under half of the children and young people, the only information available was that contained in the coronial file.

Beautrais (2001) drew attention to the fact that systematic data collection during coronial inquiry represents the best opportunity to examine and monitor the suicide deaths of children and young people. The findings from this study are in agreement, given that many children and young people had no record of contact with human service agencies.

The quality of information that was obtained for each child and young person in this study was highly variable. In addition, approximately 42% of these children and young people had no record of human service provision. This means that for those cases, the only available information was that contained on the coronial file.

Thus, the best opportunity for the investigation of suicide and risk-taking deaths of children and young people is at the point of coronial inquiry. Protocols are required to enable systematic data collection for coronial inquiry for every suicide and risk-taking death of a child or young person. This would greatly enhance further study, monitoring and understanding of this population of deaths.

Under Strategy 5.1 of the *NSW Suicide Prevention Strategy* (Establish suicide surveillance systems for NSW), detailed profiles of suicide and suicidal behaviour in NSW are to be produced and updated annually. These profiles will include information on suicidal ideation, suicidal behaviour, and risk factors for suicide in NSW.

The CDRT awaits the evaluation of this important initiative.

Other avenues for prevention

- Several young people died by overdosing on friends' or family members' takeaway methadone, or by illegally obtaining quantities of methadone.

Several young people died by overdosing on friends' or family members' takeaway methadone, or by illegally obtaining quantities of methadone.

In this study, four children and young people died by overdosing on friends' or family members' takeaway methadone or by illegally obtaining quantities of methadone. In one of the cases, the Coroner called for the abolishing of the takeaway methadone system, forcing people to consume their methadone at the site of supply, through a pharmacy or a medical practitioner.

Methadone treatment is the main clinical response to heroin addiction in Australia and greatly reduces heroin addicts' risk of death. However, illicit methadone use has been found to be widespread both in Australia and overseas, and several studies have identified mortality associated with methadone programs (Ali & Quigley, 1999; Caplehorn & Drummer, 1999). Almost half of methadone deaths occur among individuals not registered in methadone maintenance treatment; rather these deaths are related to diverted sources of methadone (that is, black market methadone; Sujinc & Zador, 1998).

In Western Australia, methadone-related deaths were virtually eradicated after methadone maintenance patients were required to take their methadone under

supervision, suggesting that the number of deaths from diverted sources of methadone is related to the number of takeaway doses dispensed to maintenance patients (Swensen, 1988; cited in Caplehorn & Drummer, 1999).

Acknowledging the dangers of takeaway doses, the *NSW Methadone Maintenance Treatment Clinical Practice Guidelines* (NSW Health, 1999b) state that takeaway doses should only be provided after a careful assessment of the patient's stability and reliability, and never if there is concern that the drug may be misused. The Guidelines also detail procedures for the safe storage of takeaway doses (for example, doses to be kept in a high cupboard, locked if possible). While these procedures are likely to prevent young children from accessing takeaway doses, they are less applicable to adolescents. Of direct relevance to this study, the Guidelines also note that the risk of an accidental overdose is much greater for people who have not developed a tolerance to opioids.

The Drugs Programs Bureau is conducting an audit of methadone takeaway prescriptions in NSW, which in part aims to increase compliance with the *NSW Methadone Maintenance Treatment Clinical Practice Guidelines* for the prescription of takeaway doses.

The CDRT awaits the findings of this audit.

8.4 Conclusion

This research study documented the profile of suicide and risk-taking deaths of children and young people aged between 12 and 17 years in NSW over a five-year period (1996-2000). The findings suggest avenues for suicide and risk-taking prevention and intervention and have implications for service provision. Most importantly, they highlight that the prevention of further suicide and risk-taking deaths among children and young people is the responsibility of the whole community and that in order to be maximally effective, preventive interventions need to be multi-faceted, addressing all the significant domains in children and young people's lives.

Some of the findings from this study are currently recognised within other NSW strategies. For example, NSW Health is addressing the issue of takeaway methadone. A range of drug education, road safety and crime prevention programs target the issue of risk-taking among children and young people. It would, however, be useful for these strategies to be linked to the *NSW Suicide Prevention Strategy*, to increase the impact of the effort.

The current Child Death Review Team legislation restricts consultation of the findings with anyone outside the Team until the report has been tabled in Parliament. Consequently, the Team has chosen to present the findings and then to allow a period of 12 months in which the *NSW Suicide Prevention Strategy* is reviewed and updated to reflect the study findings.

8.5 Recommendation

That over the next 12 months the NSW Government reviews and updates the *We Can All Make A Difference: NSW Suicide Prevention Strategy* to reflect the findings from this study.

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Glossary

Blended family

A couple family containing two or more children, of whom at least one is the natural child of both members of the couple, and at least one is the stepchild of either member of the couple.

Control order

An order enforcing the detainment of a child or young person in a Juvenile Justice centre for a given period of time.

Culturally and linguistically diverse

This definition is based on the *Standards for Statistics on Cultural and Language Diversity* (ABS, 1999). The Standards are based on four core variables: Country of birth, main language other than English spoken at home, proficiency in spoken English, and Indigenous status.

Deliberate self-harm

The deliberate and often repetitive destruction or altercation of one's own body tissue, without suicidal intent. The most common practice of deliberate self-harm is skin-cutting, but other methods include burning, self-hitting, severe skin-scratching, hair pulling and bone breaking.

Human service providers

Those agencies that provide services to people that promote their safety, welfare and well-being. In New South Wales they include the NSW Department of Community Services, NSW Health, Department of Education and Training, Department of Juvenile Justice and related non-government organisations.

NSW interagency guidelines for child protection intervention

A document setting out the roles, responsibilities, policies and procedures for agencies in their work with children and families where child protection concerns exist. These guidelines provide a background to the interagency approach to child protection, detail what are regarded as essential pre-requisites to interagency practice and present a practical framework for child protection intervention.

Interagency work

Agencies working together to combine their expertise and resources in a coordinated and cooperative effort so that a child or young person is safe. It is the task of agencies to coordinate their efforts to achieve a good outcome for the child or young person.

Investigation

Investigation is the process of gathering information in response to a report concerning abuse or neglect.

Juvenile Justice facility

A facility providing secure accommodation for young people remanded into custody or sentenced to a period of custody by the courts.

Notification

Information provided in accordance with Section 22 of the *Children (Care and Protection) Act 1987*, by a person who forms a belief on reasonable grounds that a child has been abused, is in danger of being abused or is in need of care.

Protective intervention

The action taken by agencies to protect a child from abuse and neglect by the provision of care, services and support, or the apprehension and prosecution of those responsible for their abuse.

Risk-taking behaviour

Any behaviour engaged in by a child or young person where there was a high probability of death as an outcome.

Step-family

A couple family containing one or more children, at least one of whom is the stepchild of either member of the couple and none of whom is the natural or foster child of both members of the couple.

Suicidal ideation

Thoughts about suicidal acts.

Suicide

A self-inflicted, non-accidental injury resulting in death.

Suicide attempt

A self-inflicted non-accidental injury that does not result in death.

Suicidal behaviour

Suicidal ideation, suicidal attempts, or suicidal acts.

Ward of the State

A child or young person for whom the NSW Minister for Community Services has guardianship.

Appendix 1

Key domains in data collection tool

Demographics

- Place of residence (capital city, metropolitan other, large rural centre, small rural centre, other rural, remote centre, other remote)
- Age of child or young person
- Sex of child or young person
- Ethnicity
- Indigenous child or young person – determined from several sources
- Religion
- Family composition

Individual circumstances

- Chronic medical condition
- Mental health status
- Developmental disability
- Learning disability
- Drug use
- Prior suicidal behaviour
- Juvenile offending
- Sexual orientation

Family characteristics and childhood experiences

- Family composition
- Carers of the child
- Child abuse and neglect
- Family conflict
- Family's financial difficulties
- Domestic violence
- Was child a Ward of the State, homeless, or in institutional care at time of death?

Education and employment-related experiences

- Attendance at school, TAFE, or university
- School-related difficulties
- Employment experiences

Environmental factors

- Stressful life events
- Imitative and contagious factors

Circumstances of the death

- Place of incident leading to death
- Cause of death
- Precipitating incident to death

Agency involvement

- Prior agency involvement
- Agency action
- Evidence of interagency cooperation

Appendix 2

ICD-10 codes classifications for means of suicide and risk-taking deaths

Suicide deaths

Means of suicide deaths were identified by the following ICD codes:

Poisoning

- X61 Intentional self-poisoning by and exposure to antileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified.
- X62 Intentional self-poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified.
- X63 Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system.
- X64 Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances.
- X68 Intentional self-poisoning by and exposure to pesticides.

Firearms

- X72 Intentional self-harm by handgun discharge.
- X73 Intentional self-harm by rifle, shotgun and larger firearm discharge.

Hanging

- X70 Intentional self-harm by hanging, strangulation and suffocation.

Jumping from high places

- X80 Intentional self-harm by jumping from a high place.

Carbon monoxide poisoning

- X67 Intentional self-poisoning by and exposure to other gases and vapours.

Jumping/lying before moving object

- X81 Intentional self-harm by jumping or lying before moving object.

Crashing of motor vehicle

- X82 Intentional self-harm by crashing of motor vehicle.

Drowning

- X71 Intentional self-harm by drowning and submersion.

Risk-taking deaths

Means of risk-taking deaths were identified by the following ICD codes:

Poisoning

- X41 Accidental poisoning by and exposure to antileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified.
- X42 Accidental poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified.

Car driver in transport accident

- V44.5 Driver injured in collision with heavy transport vehicle or bus (traffic accident).
- V47.0 Driver injured in collision with fixed or stationary object (non-traffic accident).
- V47.5 Driver injured in collision with fixed or stationary object (traffic accident).
- V48.0 Driver injured in noncollision transport accident (non-traffic accident).

Pedestrian in transport accident

- V03.0 Pedestrian injured in collision with car, pick-up truck or van (non-traffic accident).
- V03.1 Pedestrian injured in collision with car, pick-up truck or van (traffic accident).
- V05.0 Pedestrian injured in collision with railway train or railway vehicle (non-traffic accident).

Motorcycle rider injured in transport accident

- V20.4 Motorcycle rider injured in collision with pedestrian or animal (driver injured in traffic accident).
- V25.4 Motorcycle rider injured in collision with railway train or railway vehicle (driver injured in traffic accident).
- V27.0 Motorcycle rider injured in collision with fixed or stationary object (driver injured in non-traffic accident).

Pedal cyclist injured in transport accident

- V13.0 Pedal cyclist injured in collision with car, pick-up truck or van (driver injured in non-traffic accident).

Car passenger injured in transport accident

- V42.6 Car occupant injured in collision with two- or three-wheeled motor vehicle (passenger injured in traffic accident).

Fall from train

- V81.6 Occupant of railway train or railway vehicle injured by fall from railway train or railway vehicle.

Drowning

- W69.8 Drowning and submersion while in natural water.

Deaths of undetermined intent

Means of deaths classified as undetermined intent were identified by the following ICD codes:

Poisoning

- Y11 Poisoning by and exposure to anitleptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent.
- Y12 Poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified, undetermined intent.
- Y17 Poisoning by and exposure to other gases and vapours, undetermined intent.

Hanging

- Y20 Hanging, strangulation and suffocation, undetermined intent.

Pedestrian in transport accident

- V05.0 Pedestrian injured in collision with railway train or railway vehicle (non-traffic accident).

Falling/jumping from high place

- W16 Diving or jumping into water causing injury other than drowning or submersion.

Lying/running before moving object

- Y31 Falling, lying or running before or into moving object, undetermined intent.

Insulin-dependent diabetes mellitus

- E10.0 Diabetes mellitus with coma.

Appendix 3

Roles of human service agencies in suicide prevention

NSW Health Department

The NSW Health Department plays a key role in suicide prevention. Major initiatives include the coordination of the *We Can All Make A Difference: NSW Suicide Prevention Strategy* by the Centre for Mental Health (NSW Health), the development of *Circular 98/31 Policy Guidelines for the management of patients with possible suicidal behaviour for NSW health staff and staff in private hospitals,* and the implementation of promotion, prevention and early intervention strategies to prevent suicide.

The *We Can All Make A Difference: NSW Suicide Prevention Strategy* was released in 1999, setting out a whole-of-government approach to suicide prevention. The strategy is coordinated by the Centre for Mental Health (NSW Health) in consultation with 16 other government departments, Area Health Services, non-government organisations, community leaders and others. The Strategy addresses suicide prevention for all age groups. It embraces a public health approach emphasising the importance of promoting mental health and well-being and prevention, early intervention and treatment for a range of suicidal and related behaviours and disorders. Strong emphasis is also placed on the use of evidence-based practice, involvement of consumers, meeting the needs of local communities, and having objectives consistent with national and international goals.

The Strategy incorporates five key strategic directions:

- Involving all of the community and strengthening families;
- Outreach and support for people who are most at-risk;
- Better targeting of health and other services to suicide prevention;
- Better supports for those affected by a suicide death; and
- Improving information on suicide prevention.

One of the main initiatives of NSW Health addressing suicidal behaviour under the *NSW Suicide Prevention Strategy is Circular 98/31 Policy Guidelines for the management of patients with possible suicidal behaviour for NSW health staff and staff in private hospitals,* which was released in 1998. Circular 98/31 provides:

- simple, practical advice on the management of patients with possible suicidal behaviour such as thinking about suicide, harming oneself or attempting suicide.
- guidance on the policy development, planning and organisation required to implement the Circular at Area Health Service or private hospital level.
- protocols for assessment, management and discharge planning of patients with suicidal behaviour with specific requirements for the management of suicidal behaviour in five key settings: General Community Health Services, Emergency Departments, General Wards, Mental Health Inpatient Units, Community Mental Health Services and Corrections Health Service.

Implementation of the policy was accompanied by a comprehensive training program in all NSW Area Health Services. In addition, the *Introduction to Clinical Aspects of Suicide Prevention for Young People: Training Manual* and the *Older People's 98/31 Training Module* were developed to further support the implementation of Policy Circular 98/31. These address the identification and management of suicidal behaviour in young and older people.

The Centre for Mental Health is currently undertaking a review of Circular 98/31.

NSW Health is also involved in the implementation of promotion, prevention and early intervention strategies to prevent suicide. These initiatives aim to address a number of mental health problems and disorders through: identifying the risk and protective factors that contribute to mental health, mental health problems and disorders and implementing initiatives to address them; and raising awareness of the early signs and symptoms of mental health problems and disorders and ensuring that people know where to get help and can access effective treatment at the earliest stage of illness.

Examples include the *Triple P* (Positive Parenting Program), *School-Link* and the *NSW Early Psychosis Program*. *Triple P* is a program for parents of preschool aged children with behavioural problems. It aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.

Suicide risk is high for people with depression and related disorders. *School-Link* is a collaborative initiative between NSW Health and the Department of Education and Training. This initiative aims to facilitate the early recognition and intervention for young people with depression and related disorders, as well as promoting mental health and the prevention of mental health problems. The *School-Link* Training Program is a three-day training program for school counsellors, TAFE counsellors and adolescent mental health workers. It focuses on depression and related disorders in adolescents and working collaboratively to improve the understanding, recognition, prevention, early intervention and evidence-based treatment for young people with mental health problems. Suicide risk, assessment and management are included in the Training Program.

Young people who experience a first episode of psychosis are at an increased risk of suicide. Early psychosis programs aim to improve outcomes for young people experiencing psychosis and for their families and develop and promote state wide policy and best practice in identification of early psychosis and optimal early intervention. Early psychosis programs also provide professional education and training across NSW to enhance the skills of mental health workers to meet the needs of people experiencing psychosis, and their families, in particular to identify risk in the early stages of a psychotic illness. This includes identifying, monitoring and providing care during the prodromal phase and ensuring that mental health services are accessible and provide timely assessment.

Department of Education and Training

The Department of Education and Training assists in the prevention of suicide and extreme risk-taking behaviour in several ways. These include the introduction of relevant courses and programs in the syllabus, targeted programs aimed at children and young people identified as being at-risk, the presence of student welfare teams in

each school, and access to school counsellors and other services, such as home school liaison officers and support teachers.

Teaching and learning in Personal Development, Health and Physical Education provides opportunities for all government school students from Kindergarten to Year 10 to develop knowledge, skills and attitudes that are important in understanding and managing their own health and well-being. Coping, problem solving and help seeking skills are included in these school programs which are designed to meet outcomes in syllabuses provided by the NSW Office of the Board of Studies and to be responsive to the particular needs of students in particular schools.

In addition, government schools provide the *Crossroads* program for senior students. This program consists of 25 hours of learning focused on the two content strands of relationships and drug use. There are further opportunities for study on related issues within Higher School Certificate courses.

Targeted programs provide additional educational support to improve the equity and participation of particular groups of students identified as being at-risk of leaving school early.

Government schools recognise the importance of the context in which formal education occurs through their student welfare support programs. The Student Welfare Policy specifies the importance of a safe and caring environment in which students are nurtured as they learn. Schools conduct a range of formal and extra-curricular activities to encourage students and parents to develop a sense of belonging with the school.

The *MindMatters* Program is being used by many secondary schools to enhance their whole school approach to mental health promotion. The program includes curriculum components on enhancing resilience, loss and grief, bullying and understanding mental illness. *MindMatters* encourages school communities to conduct a review of existing curriculum and other practices, taking into account the perceptions of students as well as other groups in the school community as the basis for further actions.

Each school has its own student welfare team made up of executive members, year advisers or co-ordinators, the school counsellor and support staff such as support teachers behaviour or learning difficulties and Aboriginal educational assistants. The student welfare program in the school incorporates agreed approaches to discipline, student support and whole school approaches to student health, gender equity, peer support, countering bullying and discrimination, leadership and well-being.

School counsellors provide psychological expertise in the school's student welfare team. They are trained and experienced in identifying and supporting students with depression and anxiety disorders. School counsellors consult with teachers in helping to identify and support students at-risk. Where a suicide has occurred within the school community, school counsellor teams work closely with the school executive and Health professionals to develop and implement an ongoing response plan which takes into account the needs of students, staff and parents.

Students are encouraged to seek direct support from school counsellors and other members of the student welfare team at the school. Students at-risk of self-harm are a high priority for assessment and immediate support by school counsellors. Parent

involvement is sought and referrals to other professionals may be made. School counsellors are often involved in case planning for students involved with a number of agencies.

Since 2000, school and TAFE counsellors have received additional training as part of the *School-Link* program in the recognition and management of depression and related disorders in young people. Programs such as *MindMatters*, *Adolescents Coping with Emotions* and the *Resourceful Adolescents Program* complement and extend this work.

Students also benefit from a broad range of services, such as home school liaison officers and support teachers. The Department conducts a range of support classes and schools in specialist settings for students with high support needs. These include a range of provisions for students with behaviour problems, including those with diagnosed conditions such as Conduct Disorders.

Where Departmental staff have current concerns related to risk of harm (as described in the *Children and Young Persons (Care and Protection) Act 1998*) for students under 18 years, a report is made to the Department of Community Services. The Department's staff play an ongoing support role for these students, guided by advice from the Department of Community Services.

Department of Community Services

There are several ways in which the Department of Community Services assists in the prevention of suicidal behaviour among children and young people. These include assessment and protective intervention for children and young people reported to be at-risk of harm, the funding of prevention programs, the management of such programs and the production of parenting magazines.

A child or young person at-risk of suicide could come to the attention of the Department of Community Services by way of a Request for Assistance or a Risk of Harm report. In those instances, the Department of Community Services works with NSW Health and other agencies to fully assess the risk, issues and needs of the child or young person and their family and provide appropriate supports and referrals. The Department of Community Services can take action in the Children's Court to ensure the present and future safety of the child or young person when this has been assessed as being the most appropriate course of action.

The Department of Community Services also funds preventative programs. Through the *Community Services Grants Program* (CSGP) the Department of Community Services funds projects that aim to provide direct support to children and young people to enhance safety, self-esteem and quality of life. The Department of Community Services also funds Family Support Services that offer a range of supports and referrals when adolescent mental health issues are identified.

The *Supported Accommodation Assistance Program* (SAAP) funds agencies who provide services to assist children and young people who are homeless or at-risk of being homeless through a range of support and supported accommodation services. The level of support ranges from casual to high. High support is provided where there is chronic risk-taking behaviour particularly through excessive use of alcohol and/or other drugs, self-harm or suicide attempts.

The Department of Community Services also manages several NSW Drug Summit

projects with a focus on positive interventions for children and young people who are vulnerable to and/or involved in risk-taking behaviours. These services offer case management and brokerage to vulnerable children and young people who would not access conventional services.

Finally, parenting magazines have been produced as part of the positive parenting campaign. The edition *'Parenting – the teenage years' (April 2001)* specifically covers suicide prevention together with addressing a number of other activities that expose young people to high risk such as drug use and dangerous driving.

Department of Juvenile Justice

Children and young people in custody are known to be at high risk of self-harm and suicidal behaviour. Young Aboriginal people and young people with a history of self-harm are particularly at-risk. The Department of Juvenile Justice has incorporated strategies to address this issue.

All children and young people are assessed for suicide risk on their admission to custody. Those considered to be at-risk are placed under more intensive supervision and monitoring. Depending on the degree of risk, the level of monitoring ranges from more frequent observation, continuous observation or one-to-one supervision of the child or young person by a staff member who remains in close proximity to the child or young person at all times.

Psychologists based at the Juvenile Justice centres provide mental health assessments for all children and young people identified at-risk and liaise with each centre's Centre Support Team of health professionals in developing appropriate management strategies. At-risk children and young people are also offered supportive counselling. A consultant psychiatrist is also available at each centre. These psychiatrists are of particular assistance in identifying and managing children and young people at-risk of self-harm.

Staff at the Juvenile Justice centres maintain links with local NSW Health Area Mental Health Services. These services help staff to respond to mental health crises or when psychiatric hospitalisation may be required.

With the assistance of funding provided by the Commonwealth Department of Health and Aged Care, the Department of Juvenile Justice has been providing *Work Practice II Suicide Awareness Training* to centre-based and community-based staff in 2002. This competency-based training, which includes awareness of factors relating to suicidal behaviour, communication with children and young people, self-esteem, links between suicidal behaviour and mental illness and management of suicidal behaviour, will form part of the *Certificate IV in Juvenile Justice* accredited training available to Department of Juvenile Justice staff.

Finally, the Department's Specialist Crisis Team provides after hours support for detainees experiencing serious suicide or self-harm attempts, major assaults, critical incidents or natural disasters where detainees are likely to have been traumatised. The Psychological and Specialist Services staff in the team provide assessment and crisis intervention, assistance and liaison to emergency mental health services. They also provide consultation and support for centre staff in relation to managing difficult behaviour.

NSW Police

The *NSW Suicide Prevention Strategy* makes specific reference to:

- the work of Police Youth Liaison Officers in assisting young people and maintaining networks of support,
- the Memorandum of Understanding (MOU) with NSW Health,
- support and safety mechanisms for Aboriginal people in custody,
- training for Police negotiators
- training for Custody Managers in 'safe custody' and
- welfare support through the Police Psychology Unit and the Peer Support Program.

Wherever possible children and young people attempting or threatening suicide are treated as needing medical or psychiatric assistance rather than as 'offenders'. Police negotiators have been trained to deal with persons threatening suicide. Children and young people threatening or attempting suicide or self-harm, are identified as being at-risk of harm and are reported to the Department of Community Services. Youth Liaison Officer training and support includes suicide prevention. Youth Liaison Officer forums have included workshops run by suicide prevention specialists. As suicide is a multi-faceted problem and policing, a multi-faceted task, training in suicide identification, response and prevention occurs within specific areas, rather than as a unique issue. Suicide prevention is incorporated into the different operational Standard Operating Procedures, as appropriate.

The Police response to suicide prevention will be determined by the situation involved:

1. Sudden and unexpected behaviours. General Duties officers respond to situations where a child or young person is exhibiting unusual behaviour. General Duties officers are guided by the Police Handbook reference on mentally ill people if appropriate, or the *Children and Young Persons (Care and Protection) Act 1998* if a child or young person is involved. General Duties foundation training deals with the protocols on emergency procedures in such situations.
2. Attempted suicide in custody is a major issue and is well documented in the Custody Managers Manual, CRIME Code of Practice and the Police Handbook.
3. Police respond to attempted suicides according to the *Mental Health Act* and as an emergency response. Mental Health contact officers often assist with resolving issues in these situations. There is a comprehensive MOU with NSW Health covering this issue.
4. Children and young people threatening suicide are dealt with under the *Children and Young Persons (Care and Protection) Act 1998.* Training during the implementation of the Act incorporated attempted suicide as a care and protection issue. Information covered in the Mandatory Continuing Police Education (MCPE) package will be integrated into the pending 'Crimes Against Children and Young People Policy' (currently in draft).
5. Attempted suicides captured on local council CCTV or State Transit Authority (STA) or Roads and Traffic Authority (RTA) CCTV are covered in the Code of Practice dealing with the CCTV programs. Once police are called in relation to these situations, it is dealt with as an emergency situation.
6. Children and young people voicing suicidal ideation with Youth Liaison Officers, or officers attached to the Police and Citizens Youth Clubs (PCYC) are responded to under the directives and training which encourage Police to listen to children and

young people, talk to them and refer them on to appropriate help. Suicide risk assessments are not part of the function of Police. While a Youth Liaison Officer may have contact with a family of a child or young person who has attempted suicide, follow up for families is a welfare issue. Entering an 'Alert' on the Computerised Operational Policing System (COPS) if a child or young person has threatened or attempted suicide is a function of the Youth Liaison Officer and informing other officers, if appropriate, if that child or young person comes in contact with police again. Youth Liaison Officers will take a pro-active approach to suicide prevention with a child or young person known to be at-risk of suicide that has regular contact with Police.

State Coroner

All apparent suicides are reportable deaths under the *Coroners Act 1980* and are reported to either the State Coroner, his Deputies or to Coroners throughout New South Wales.

These deaths are fully investigated by police on behalf of the Coroner and a Brief of Evidence is prepared in each case and presented to the Coroner who makes a decision as to whether an inquest will be conducted. An important part of the investigation is to eliminate foul play. In many cases Coroners are unable to say whether or not a person actually intended to take his or her life. In such cases a finding of suicide is not made.

The reason a person may commit suicide is only relevant to the Coroner to the extent that it assists to establish that this is in fact what happened. The concerns and wishes of relatives are often considered when decisions are made by Coroners as to whether inquests will be held. Coroners are empowered to make recommendations with a view to preventing further suicides and they regularly make such recommendations.