Responses from Dr John Howard

to the Committee's questions

1. An ongoing issue for the CDRT has been the limited information available on the mental health state of the children and young people who die by suicide. The Trends Report recommended that the existing information requirements of the Police Report of Death to Coroner be reviewed in consultation with NSW Health and that the review aim to align the information collected with current knowledge about what is important for understanding these suicide deaths.
   Are you aware whether any progress has been made on the recommendations? If implemented and how effective do you think it might be, and how might the CDRT be able to use this information in the future?

Response: I have not been involved in this review and am not aware if it has occurred and, if so, what the findings and recommendations are. I have been provided with a copy of the Report of Death to the Coroner form P79A, and make some comments on this form in my response to your Question 2 below.

2. Can you explain to the Committee what type of information is important for understanding these deaths?

Response: I have reviewed the Report of Death to the Coroner form (P79A) of NSW Police. I believe the form is attempts to be comprehensive. It obviously requires extensive (necessary) police activity to complete. I believe that Section 12, Suspected Suicide should include Acute mental distress (or similar phrasing) and School or employment crisis/severe distress (or similar phrasing). I also speculate that it might be possible to include some questions related to mental health that police could ask of various key informants (eg family members, teachers, peers). These may not be included in the actual form, but could guide investigating police. They could be quite useful in detecting undiagnosed mental illness if routinely asked. For example 'Has there been any noticeable change in the way *X* has been dealing with day to day stress?'; "Did they appear to be more nervous?'; 'Did they say things that made you think they were feeling hopeless?'; 'Did they appear to be more fidgety or restless and could not sit still?'; 'Was it like everything was an effort for them?'; 'Did they seem so sad that nothing much could cheer them up?'; 'Did they appear to feel worthless?'. These questions are adapted from those contained in a widely used short screening instrument used to screen for those with possible mental health concerns.

Other areas worth commenting on could be concerns re sexuality, increased time on the Internet, interest in celebrity suicides or accidental/violent death, increased interest in/membership of particular subcultures that appear to hold more bleak views of life and existence, or which have a strong interest in death, self-mutilation, esoteric practices, and so on.

3. In November 2004, the Committee examined the Commissioner on the CDRT Report on Suicide and risk-taking deaths of children and young people, at which time the Commissioner noted that the Government would be reviewing the NSW Suicide Prevention Strategy to reflect the findings of that study.
   Has this review taken place, and, if so, what changes have occurred to the strategy over the intervening period? Do you consider that linking related strategies, such as drug education and road safety, would enhance the effectiveness of the Suicide Prevention Strategy?

Response: I understand that NSW Health undertook a review of the NSW Suicide Prevention Strategy which concluded that the Strategy's strategic directions remain current and appropriate. I believe that there is no ***one*** way of helping young people, prevention is definitely the best and there are many prevention strategies around. I do not have an opinion on where these strategies should be located but rather efforts should be linked and coordinated. Certainly, strategies to reduce problematic drug use and increase road safety are important. What is know in the 'drugs area' is that interventions provided across the years (and, in schools, relevant K-12 curricula) where young people are assisted to build the skills to lead positive and satisfying lives. This includes attention to *enhancing protective factors* and attempting to *minimise the impact of risk factors*. Over-emphasis on *the drug/drugs* does not bring about much protection in and of itself.

In relation to driving, there is evidence that 'risk takers'/sensation seeker/impulsive young people are at greater risk of accidents, and also of drug use. Such young people may not be necessarily respond to driving, and drink/drug driving awareness strategies that focus on rational decision making. They may require different strategies to engage them. Increasingly young people use the *web* to seek and obtain assistance. Sites such as Reach Out (www.reachout.com.au) provide an essential service to young people and should be supported.

I have noticed some, albeit fairly small, increase in clinical staff capacity to recognise and manage children who are at risk of suicide and changes to mental health services for young people including integrated health services for young people with mental health problems in youth friendly settings. I expect this could give young people better access to mental health services, drug and alcohol services, GPs and other services.

While the Commonwealth's *Headspace* initiative is welcomed, and has raised awareness of issues and of the need to provide comprehensive, integrated, easy access services, the initiative not really provide for the necessary clinical scale up. This means that few experienced Child and Adolescent psychiatrists remain in public access settings, and, if in a private setting, very few will entertain 'bulk billing'. The impact of this is that it can be difficult to get an urgent psychiatric assessment of a suicidal young person, and in particular young people presenting with acute psychotic conditions. It is well known that those diagnoses with schizophrenia, in particular, have a much higher than average chance of dying by suicide. When, if urgent psychiatric intervention is

essential, the 'Liaison Psychiatry' service available may be being provided by a Psychiatrist or Registrar with limited child and adolescent experience. This situation is obviously much more critical in rural and remote areas.

To allow the NSW Suicide Prevention Strategy to have a larger impact in preventing death by suicide, especially where a young person is presenting with distressing and/or acute mental health concerns, more needs to be in place. I believe NSW Health could to explore models for developing and adequately funding readily available experienced child and adolescent psychiatry services. While specialist nurses would be central to such services, especially in an ED triage process, a psychiatrist is essential for diagnosis, medication and, if needed, involuntary containment. Possibly engaging with experienced private practitioners who are appropriately remunerated to be available in public settings on a roster basis could assist.

4. It was also noted at that hearing that school-based programs such as School-Link and MindMatters, and programs addressing suicide prevention initiatives for ATSI communities were being evaluated.

   Are you aware whether these evaluations have take place and could you elaborate for the Committee on the content, and measured effectiveness of such programs?

Response: I am not directly involved in the School-Link and MindMatters programs. I understand that as each new component of School-Link is introduced it is evaluated. I understand that other material to be present to the Committee will outline the content of such programs.

5. Are you aware whether there has been a formal evaluation of the guidelines for media professionals in relation to enhancing local community capacity to prevent and respond to increases in suicide? If so, what recommendations have come out of the evaluation?

Response: I do not know if there has been any evaluation of the impact of the guidelines. I understand the guidelines for Australian media professionals have been reviewed twice since 1999 with the most recent version published in 2007. I do not know of any evaluation of the impact of the guidelines.

6. With respect to the impact of family dysfunction upon youth suicide, in its review of the 2004 CDRT Report, the Committee was advised that the Department of Community Services was undertaking a major reform program for improving identification of and responses to children that were at high risk of potential suicide due to family dysfunction. Has this reform program concluded, and what changes have occurred to the service system as a result?

Response: I have not been involved in this review but understand the Department of Community Services have completed a review of 27 young

people who died by suicide or risk taking. I do know that the results have not yet been implemented

7. The Committee notes that, unlike most causes of child deaths, the rate of deaths by suicide in NSW actually increases for higher socio-economic areas? Could you advise the Committee as to whether there is any evidence to explain this anomaly?

Response: There were increases in both the middle and high groups for suicide deaths. I think it is important to keep this finding in the spirit it is provided – it is interesting that we found this but the finding in is not statistically significant for either group. I wouldn't be inclined at this stage to describe the finding as an anomaly but rather something to keep our eye on.