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PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

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Please accept this submission from the School of Psychology

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in response to
NSW Committee on Children and Young People
Inquiry into the Prevention of Youth Suicide

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Note:
Project Air Strategy for Personality Disorders
is located at the School of Psychology, University of Wollongong and is supported by the NSW Ministry of Health. http://www.projectairstrategy.org Views expressed here are not to be taken as the view of the NSW Ministry of Health but the School of Psychology, University of Wollongong

Executive summary

We welcome the opportunity to respond to the NSW Committee on Children and Young People Inquiry into the Prevention of Youth Suicide. We commend the Committee on Children and Young People in undertaking this important piece of work.

Suicide is the leading cause of death in children and young people in Australia. Despite the increased attention this issue has received over the last decade, there has been little progress made in reducing the number of Australian's who die by suicide or make attempts. The issue of youth suicide effects the whole community, touching everyone. For education, health and child protection institutions, established to protect, educate, treat and heal our children and young people this is an issue of great importance. The subject is one of our most challenging societal problems, but there are steps as a community we can take and indeed some of these have commenced. Intervening early in the lives of vulnerable infants, children and young people, supporting vulnerable families, enhancing wellbeing in school settings and providing timely and evidence based treatment for children and young people with mental health disorders are key in our responses to youth suicide.

For most young people their suicide occurs in the context of a long list of risk factors, some of which may have been present since infancy which may include attachment difficulties, abuse and neglect. Many of these risk factors are amenable to change through early intervention in childhood and in schools. By viewing child development through a holistic lens we can examine the multiple opportunities to intervene in the context of a young person's community to produce the most effective outcomes.

In particular we highlight to the inquiry five specific area of focus of our recommendations:

- Recommendation 1: there is a need to consider self-harm within the dialogue about suicide
- Recommendation 2: there is a need to consider young people with emerging personality disorder
- Recommendation 3: there is a need to focus on other specific groups, including Aboriginal and Torres Strait Islander children and young people
- Recommendation 4: there is a need for uniform data aggregation
- Recommendation 5: there is a need to focus on emerging problems in primary school children and through the transition to high school

Introduction

This inquiry takes place in the climate of several government strategies and initiatives including the NSW suicide prevention strategies. The 2010-15 versions focused on a whole of government strategy promoting a whole of community approach, there is also a Proposed Suicide Prevention Framework in NSW as well as Life Span. A whole of community repose to this issue supported by government and informed by the evidence but also driven by local communities may well be our best opportunity to make progress on this issue and reduce the number of young Australians dying by suicide.

The next section overviews the current research and data about suicide and children and young people.

Risk factors for suicide

The suicide phenomenon is complex, with interrelated risk factors, that include environmental, biological, and social factors. Some risk factors are proximal – recent events or triggers and some are distal –vulnerabilities which increase over time. A combination of risk factors often poses significant risk (The Australian Government Department of Health and Ageing, 2007). A prior suicide attempt is likely to be the most significant predictor of subsequent attempts (Christiansen & Jensen, 2007).

Internationally some common risk factors have been identified for suicide and self-harm in adolescents including:

Sociodemographic and educational factors

- Sex (female for self-harm and male for suicide) – most countries*
- Low socioeconomic status*
- Lesbian, gay, bisexual, or transgender sexual orientation
- Restricted educational achievement*

Individual negative life events and family adversity

- Parental separation or divorce*
- Parental death*
- Adverse childhood experiences*
- History of physical or sexual abuse
- Parental mental disorder*
- Family history of suicidal behaviour*
- Marital or family discord
- Bullying
- Interpersonal difficulties*

Psychiatric and psychological factors

- Mental disorder*, especially depression, anxiety, attention deficit hyperactivity disorder
- Drug and alcohol misuse*
- Impulsivity
- Low self-esteem
- Poor social problem-solving
- Perfectionism
- Hopelessness*

* Factors with an asterisk have been shown to be related to suicide and all the factors listed have been shown to be related to self-harm (Hawton, Saunders, & O'Connor, 2012).

Self-harm is a further risk factor for suicide (Grenyer, Gray, & Townsend, 2016). Self-harm and suicide are two distinct behaviours: A young person may self-harm without suicidal intent, and a young person may suicide without ever engaging in self-harming behaviours. However, it is important to note that unintentional death may occur as a result of self-harm and that self-harming behaviours, even without suicidal intent, are a risk factor for suicide (Hawton et al.,

2012). Furthermore, the behaviours co-occur at a high rate in adolescents (Andover, Morris, Wren, & Bruzzese, 2012; Cloutier, Martin, Kennedy, Nixon, & Muehlenkamp, 2010).

A further factor that is increasingly understood as heightening the risk, is young people who have recently experienced the loss of a close friend who died by suicide (NSW Child Death Review Team, 2015, 2016). Social learning theory helps in understanding suicide contagion; that the suicidal behaviour of one individual may facilitate the occurrence of subsequent similar behaviours in others (Amitai & Apter, 2012). International studies have suggested up to 5% of all suicides may be a result of clustering and exposure to behaviours (de Leo & Heller, 2008).

Abuse and neglect is another significant factor related to ideation, attempts and death by suicide (Hunter, 2014). Children with a child protection history in NSW have a suicide mortality rate 4.1 times higher than children without a child protection history (NSW Child Death Review Team, 2014). However, there has been a significant decline (41%) in the number of children aged 10-17 with a child protection history over the period 2002-2011 who died by suicide. Male children (64%) were more likely to die from suicide than female children (36%) (NSW Child Death Review Team, 2014). Indigenous children with a child protection history had a higher mortality rate; 11.9% compared with 1% non-indigenous children without a child protection history (NSW Child Death Review Team, 2014).

There is growing evidence of situational factors and life stressors being associated with increased risk of suicide (Currier, Spittal, Patton, & Pirkis, 2016); however, mental health continues to be an important factor that underlies the increased risk and likelihood of suicidal behaviours. Across Australia, the prevalence of mental health issues in children and young people aged 4-17 has been stable over last 15 years (14%) (Lawrence et al., 2015). When the secondary school aged cohort (12-17) is examined the prevalence of mental health disorders increases to 19% in Australian adolescents (Lawrence et al., 2015). Of note, 3.3% of all 12-17 year olds were identified as having a severe mental disorder.

The rates of suicide are much higher for Aboriginal and Torres Strait Islander children and young people across Australia. For the ages 5-17, over a 5 years period (2011 to 2015), Aboriginal and Torres Strait Islander children and young people accounted for more than a quarter of all deaths by suicide in this age group (26.8%) (Australian Bureau of Statistics, 2016). The rates for Aboriginal and Torres Strait Islander children and young people was 9.3 deaths per 100,000 persons, compared with 1.8 per 100,000 for non-Indigenous persons (Australian Bureau of Statistics, 2016). In NSW, the Child Death Review Team report that Indigenous young people represent 8% of all young people who died by suicide over the 15 years from 2001 (NSW Child Death Review Team, 2016). As noted previously this group of young people were significantly more likely to have had a child protection history (NSW Child Death Review Team, 2014).

Addressing this overrepresentation is vital. A systematic review of suicide prevention interventions for Indigenous populations found risk-factors for suicide specific to Aboriginal and Torres Strait Islander populations included mental illness, alcohol abuse and a prior history of self-harm (Clifford, Doran, & Tsey, 2013). The literature also suggests that low levels of access to mental health services, low levels of help seeking behaviours, imprisonment, social powerlessness and high levels of exposure to trauma and violence (Clifford et al., 2013).

Suicidal behaviours in Australian children and young people

Mental health is a primary contributing factor for young people who experience suicidal ideation. The second Australian Survey on Child and Adolescent Mental Health and Wellbeing (2015), demonstrated the high levels of suicidal behaviours among Australian adolescents. About 1 in 13 (7.5%) 12-17 year olds have seriously considered attempting suicide in the previous 12 months; 1 in 20 (5%) had made a plan; 1 in 40 (2.5%) reported attempting suicide in the previous year. Suicidal behaviours are more common in females and older ages. The rates of all suicidal behaviour are markedly higher for young people with major depressive disorder, particularly young women (Lawrence et al., 2015).

The Australian Bureau of Statistics Causes of Death (2016) reports that suicide is the leading cause of death in 5-17 year olds. In NSW, and nationally, males markedly outnumber females in all age groups. Rates of suicide in 5-17 year olds have also increased, over time with;1.5 deaths per 100,000 in 2009, 2.5 deaths per 100,000 in 2013 and 2.3 deaths per 100,000 in 2015 (Australian Bureau of Statistics, 2015, 2016).

In NSW, the Child Death Review Teams (2016) reported an increasing number of young women have died by suicide and differences between male and female rates has been decreasing across the last three years. Over the past 15 years, young people are dying by suicide at younger ages; 19% of all suicide deaths are 14 years or under and 25% are aged 15 (NSW Child Death Review Team, 2016). Of the young people who died by suicide in 2015, 77% had a history of self-harm, suicide attempts and/or had discussed thoughts of suicide, however, a small number showed no indication of suicidal behaviour or intent or emerging mental health issues prior to their deaths.

The most recent Australian research is *The Longitudinal Study of Australian Children Annual Statistical Report 2016* released in August 2017 (Daraganova, 2016). This large representative sample established the 12-month prevalence of self-harm and suicide-related behaviours among Australian 14-15 year olds. The author found 15% of girls and 4% of boys reported engaging in self-harm in the previous 12 months (Daraganova, 2016). Among girls, 12% reported suicidal ideation, 9% developed a suicide plan, and 6% attempted suicide. Whereas in boys: 6% of boys experienced suicidal ideation, 5% developed a plan, and 4% attempted suicide (Daraganova, 2016). Impulsivity was identified as a risk factor important to monitor as it was estimated that at least 40% of suicide attempts were unplanned, particularly among boys than girls (58% compared with 31%). Of importance was the finding that four out of five young women who reported a suicide attempt, engaged in self-harm behaviours, compared with 36% of boys. However, among young people who did not engage in self-harm behaviours, males were more likely to report attempting suicide than females (33% vs 7%). The author concluded that the key risk factors for suicide attempts were engagement in self-harm, non-heterosexual identify and delinquent behaviour (Daraganova, 2016).

Overview of this submission

The focus of the submission is on the following terms of reference:

c. Provision of services in local communities, particularly in regional and rural areas
d. Provision of services for vulnerable and at-risk groups

e. Data collection about the incidence of youth suicide and attempted suicide
f. Provision of high quality information and training to service providers
e. Approaches taken by primary and high schools

c. Service provision

- Recommendation 1: there is a need to consider self-harm within the dialogue about suicide

Prevention of self-harm and suicide require both universal measures and targeted initiatives focused on high-risk groups including young people with personality disorders (Calear et al., 2016; Hawton et al.). Service provision for young people in distress and experiencing suicidal ideations can be difficult to access and navigate. The Fifth National Mental Health Plan outlines many of the challenges in the Australian mental health service system:

> While much is achieved by Australia's mental health service system, there are some areas where it is not working as well as it could. Key issues include fragmentation; unclear roles and responsibilities; inefficiencies and duplication; poor planning and coordination; unmet need and service gaps; and insufficient focus on promotion, prevention and early intervention. The workforce within the system is under pressure, with shortages, distribution issues, high rates of turnover, and challenges in recruiting appropriately skilled and experienced staff. [1] Services within the system are often difficult to navigate, and can be both stigmatising and stigmatised.[2]
>
> There are ongoing calls for a better integrated mental health service system that focuses on the holistic needs of consumers and carers; responds to local needs and circumstances; rebalances efforts towards promotion, prevention and early intervention; and builds workforce capacity to support system change.[3,4,5] The Fifth Plan responds to these calls and seeks to provide a foundation for longer term system reform.

d. Provision of services for vulnerable and at-risk groups

Addressing these issues will go a long way to improve service provision. However, there are two higher risk groups of young people that we would like to highlight to the committee.

- Recommendation 2: there is a need to consider young people with emerging personality disorder

The first group is young people with emerging personality disorder. One of the eight diagnostic criteria for borderline personality disorder (BPD) is chronic suicidality (American Psychiatric Association 2013). Many individuals with BPD will attempt suicide but a smaller proportion (approx 10%) will die by suicide (Courtet, 2016). Zanarini et al. (2008) found 60% of adults

[1] National Mental Health Commission (2014), op. cit.
[2] Victorian Government (2015), Victoria's 10-Year Mental Health Plan. Melbourne, Department of Health and Human Services.
[3] National Mental Health Commission (2014), op. cit.
[4] New South Wales Mental Health Commission (2014), op. cit.
[5] Western Australian Mental Health Commission (2015), op. cit.

with BPD report multiple attempts. Early intervention and diagnosis prior to the age of 18 has been shown to be conducive to improving outcomes (Chanen & Thompson, 2014).

Service provision to this group is an issue. In our recently published paper in the Australian & New Zealand Journal of Psychiatry we have argued:

> The NHMRC clinical practice guidelines (National Health and Medical Research Council, 2012) makes two pertinent recommendations; first young people with emerging symptoms should be assessed for possible BPD; and second, adolescents should receive structured psychological therapies. Yet despite this clear guidance, there is ongoing reluctance from health professionals in diagnosing individuals with BPD prior to the age of 18 years. This has potential to not only limit the types of services individuals can access but also delays access to effective treatment. Primary care that is well connected to schools and families provide good opportunities to identify, intervene, and source additional support for individuals with these emerging problems (Project Air Strategy for Personality Disorders, 2015). Mental health staff working with adolescents similarly have the skills to assess and treat young people with emerging symptoms if they are trained in contemporary personality disorder treatment. (Grenyer, Ng, Townsend, & Rao, 2017).

There are some clear and evidence based steps that need to be taken for young people with personality disorder and there are examples of such work including the Project Air Strategy working collaboratively with NSW Health and NSW Department of Education to support this work.

- Recommendation 3: there is a need to focus on specific groups, including Aboriginal and Torres Strait Islander children and young people

The second group of young people that require a stronger response in relation to suicide prevention are **Aboriginal and Torres Strait Islander children** and young people. Service provision to this groups must to be informed by Indigenous communities and acknowledge that Indigenous views of mental health and social and emotional wellbeing can be different to those of non-Indigenous Australians: this affects the way in which policies, programs, early prevention and intervention initiatives need to be framed, formulated, implemented, measured and evaluated (Dudgeon et al., 2014, p. 2).

A 2013 systematic review of suicide prevention interventions for Indigenous populations recommended a range of individual prevention strategies, including training for general practitioners to recognise and treat suicidal behaviours, improving access to mental health care for those at risk, including young people and those with a history of self -harm, utilising cognitive behavioural approaches, gatekeeper training for community leaders and restricting access to means (Clifford et al., 2013). These strategies need to be part of community suicide prevention program tailored to specific communities by working collaboratively with communities (Clifford et al., 2013). Likewise, Dudgeon et al. (2014) found that promising programs for Indigenous populations are those that encourage self-determination and community governance, reconnection and community life, and restoration and community resilience.

e. Data collection about the incidence of youth suicide and attempted suicide

- Recommendation 4: there is a need for uniform data aggregation

Data is currently collected by a range of sources including nationally, the National Health and Welfare Institute and the Australia Bureau of Statistics, and in NSW through the NSW Department of Education, NSW Family and Community Services, NSW Health and the NSW Child Death Review Team. A key issue is that no one agency has the responsibility to pull together data on suicide attempts and deaths by suicide to fully understand the scope of the data and the underlying trends. In our recently published paper in the Australian & New Zealand Journal of Psychiatry we have argued for a national suicide registry:

> Rates of suicide for people with personality disorder have been established through examining longitudinal studies of individuals who have sought treatment and have been estimated to be at approximately 10%. The national calls for suicide prevention in Australia are silent on personality disorder, despite this diagnosis being associated with a higher risk of self-harm and suicidal behaviours (National Health and Medical Research Council, 2012). Where they exist, studies have predominately been based within North America and no data is available for Australia. Also, the data reflects individuals who have received treatment and it is unknown how this translates to individuals who are not engaging in treatment. The establishment of a national suicide registry may assist to understand mortality rates in Australia - if mental health diagnoses that include personality disorder are linked (Grenyer et al., 2017).

The Child Death Review Team also note the need to further examine suicide deaths to understand why the suicide mortality of children with a child protection history has declined to a greater extent that children without a history. The Child Death Review Team also noted that living in more disadvantaged areas *decreased* the odds of death from suicide (NSW Child Death Review Team, 2014). They argue for the need to: "take a closer look at youth suicide prevention strategies and progress; examine comparative interstate and national data; and consider the potential need for a 10-year review of suicide deaths to inform the targeting of prevention strategies" (NSW Child Death Review Team, 2014, p. 54).

f. Provision of high quality information and training to service providers
e. Approaches taken by primary and high schools

- Recommendation 5: there is a need to focus on emerging problems in primary school children and through the transition to high school

Our experience and work with schools has confirmed that although the management issues brought to our attention are from young people in later years of high school (15 - 18 years of age), all staff have identified that emotional dysregulation and interpersonal difficulties, including self-harm problems, generally can be detected in years 4 to 6 of primary school and through the transition to high school (e.g. ages 8-14).

Increasingly NSW high schools have had a student die by suicide. It is difficult to know the exact numbers, with at a minimum 264 young people dying by suicide in the last 15 years (NSW Child Death Review Team, 2016); it is likely many high schools will have been touched by this. This is significantly concerning due to an identified link between perception of peer

suicidal behaviour and actual suicidal behaviour, indicating a contagion effect (Zimmerman, Rees, Posick, & Zimmerman, 2016). This data is known to the Department of Education but not publicly available. In the 2015 Child Death Review Team report, 89% of the young people who died by suicide were enrolled in school or TAFE. Therefore, schools provide a great option to intervene universally and in a targeted way (Grenyer et al., 2016).

Project Air Strategy for Schools (www.projectairstrategy.org) is an example of an important NSW initiative providing high quality training and education in NSW secondary schools. Research shows that **half of all mental health disorders manifest before the age of 14**. Schools are recognised as important locations for addressing student wellbeing, because of the reach and familiarity to students and families, the opportunities they afford for mental health promotion and prevention and the link between wellbeing and learning outcomes.

Education staff have established relationships with students and are therefore in a pivotal position to notice changes in students' behaviour and provide appropriate action to support young people. To achieve this, the education environment needs to be equipped with appropriate knowledge and skills to identify and respond to young people with complex mental health problems, emerging personality disorder symptoms and challenging behaviours including self-harm. Project Air Strategy for Schools aims to upskill teachers, school counsellors and health staff to better recognise and respond to *young people with complex mental health problems, including self-harm, suicide, trauma and emerging borderline personality disorder*.

In addition to the Project Air Strategy for Schools, the authors have been involved in the Department of Education professional development workshops 'Exploring Strategies to Prevent and Respond to Youth Suicide across in NSW Department of Education schools'. This is an excellent initiative and would be of benefit to all NSW schools regardless of whether they are a government or non-government school.

In our observations of working with schools and education staff, we have identified the following areas in regards to the provision of high quality training and education, as well as approaches taken by primary and high schools:

1. Training and professional development for education staff in *primary schools* is required as there is an increase of self-harm and suicidal behaviours occurring in primary schools identified by staff

2. An increased focus on the *transition from primary school to high school* is needed for students at risk. This will require better communication, further student welfare resources and school counsellor services for students at risk.

3. There remains a need to *increase resources for student well-being*. This includes ensuring sufficient school psychologists are available at all schools, but also the availability of social workers to respond to situational issues and access to more intensive and complex support through partnerships with health professionals.

Children and young people who have had a non-fatal attempt at suicide are at very high risk of subsequently dying by suicide. Supportive treatment following a suicide attempt should include all interventions known to prevent future suicide attempts including:

- 24 hour crisis care (Lopez-Castroman & Blasco-Fontecilla, 2016; While et al., 2012)
- Follow-up continuity in days following (Christiansen & Jensen, 2007; Lopez-Castroman & Blasco-Fontecilla, 2016)
- Control of potential suicide means (Lopez-Castroman & Blasco-Fontecilla, 2016; While et al., 2012)
- A thorough psychiatric evaluation after suicide risk has been identified should include assessing for personality disorders (Lopez-Castroman & Blasco-Fontecilla, 2016)
- Treatment of co-morbid disorders and substance abuse (Lopez-Castroman & Blasco-Fontecilla, 2016)
- Assertive follow-up and outreach (Lopez-Castroman & Blasco-Fontecilla, 2016; NSW Child Death Review Team, 2015; While et al., 2012)
- Co-ordination of support (NSW Child Death Review Team, 2015)
- Ensuring school counsellor refers appropriately to specialist mental health services (NSW Child Death Review Team, 2015)
- Effective identification and response to possible contagion (NSW Child Death Review Team, 2015)

Conclusion

Despite the challenges of this work, there are many messages of hope. The recently released Australian Public Health Research and Practice paper on strategies to prevent suicide and suicidal behaviour suggest that improving service interventions including: general practitioner training, coordinated aftercare, brief contact intervention and school based programs would result in a 11.9% reduction in suicide deaths (Page, Atkinson, Heffernan, McDonnell, & Hickie, 2017). The authors also suggest that it is important to assess other potentially effective interventions including improving educational achievement, reducing unemployment and early intervention for mental health (Page et al., 2017).

There are many chances to intervene across childhood and adolescence and we need to build on these opportunities. Reducing the number of children and young people who die by suicide or attempt to end their life will require universal measures across childhood and adolescence as well as targeted interventions for young people most at risk. In particular, we highlight areas that have not had so much focus, including the needs of children in primary school, a focus on self-harm and emerging personality disorder, indigenous groups and better data to inform practice.

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