Submission No 54

PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

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Date Received: 15 September 2017

The Royal Australian & New Zealand College of Psychiatrists

New South Wales Branch

Parliament of NSW Committee on Children and Young People

Inquiry into the Prevention of Youth Suicide

Royal Australian and New Zealand College of Psychiatrists (NSW Branch) Submission

September 2017

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide input into the NSW Government inquiry on the current approaches aimed at preventing youth suicide in NSW. The RANZCP commends the Parliament of NSW Committee on Children and Young People for initiating this inquiry, particularly in view of recent statistics showing that suicide continues to be a leading cause of death among children and young people across Australia, especially in NSW.[1]

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand providing access to Fellowship of the College to medical practitioners. The NSW Branch (NSW Branch) represents 1,100 NSW members of the 5,500 College Fellows across Australia and New Zealand.

The NSW Branch offers a substantial resource of distinguished experts – academics, researchers, clinicians and leaders dedicated to developing expertise in understanding the risk factors, treating individuals and families, developing models of care and promoting public health measures that will reduce the personal suffering, loss of potential and huge economic costs caused by mental disorders in our community.

The following submission is presented in two parts. In the first section, the NSW Branch sets the scene around youth suicide in NSW and provides a set of comments relating to the inquiry, which do not fall under the prescribed Terms of Reference. In the second section, each separate element of the Terms of Reference is addressed.

SECTION ONE - General comments

What do the statistics tell us?

Suicide is a prominent public health concern in Australia. In 2015, there were 3,027 Australian suicides, a rate of 12.7 per 100,000. [2]

In 2015 more young people aged 15-24 years died in Australia by suicide than by any other means including transport accidents and accidental poisonings. For both young men and women aged between 15 and 24 years suicide rates are at their highest in 10 years. While

[1] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010

[2] http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats

still rare, rates have also increased in young people under the age of 14 years.[3] There were 360 deaths in NSW due to suicides of young people under 24 years between 2009-2013, representing 17% of suicides in Australia across this age group.[4]

It is important to note that many more young people think about attempting suicide, with 7.5% of Australian 12-17 year olds reporting having considered suicide over the previous year and 2.4% having made an attempt in the 2015 Australian Child and Adolescent Wellbeing Survey. This equates to approximately 41,000 Australian adolescents.[5]

Along with the devastating personal and community impacts of suicide and suicide related behaviours, there is also significant economic impact. A 2009 report estimated the cost of suicide in Australia to be $17.58b (equating to $795 per person per year)[6] and found that suicide and self-inflicted injuries accounted for the leading burden of disease in young males in Australia aged 15-24 years.

Over the past decade, rather than making inroads into reducing the number of young lives lost to suicide in Australia, there have instead been small but gradual increases in suicide rates. This has mirrored increasing rates of self-harm among young people, especially for young women.[7]

In 2016, the RANZCP published its updated clinical practice guideline (CPG) for the management of deliberate self-harm (DSH).[8] This guideline aims to provide guidance for the organisation and delivery of clinical services and the clinical management of patients who deliberately self-harm. These recommendations are based on scientific evidence supplemented by expert clinical consensus.

The need for a specific approach to suicide prevention for young people

The NSW Branch supports a targeted approach to address youth suicide prevention compared to other age groups. The reasons for this position include:

[3] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010

[4] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010

[5] Lawrence D, Johnson S & Hakefost J (2015) The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health

[6] Connetica Consulting (2016) Suicide prevention – a call to action. Available http://www.connetica.com.au/

[7] Robinson J, Bailey E, Browne V, Cox, G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health.

[8] Carter G, Page A, Large M, Hetrick S, Milner A. J, Bendit N, ... & Burns J (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. *Australian & New Zealand Journal of Psychiatry50*(10): 939-1000.

- ***The very high rates of onset of mental disorder during childhood, adolescent and young adult years and the well-documented elevated risk of suicide and suicide attempt among those experiencing mental disorder***

  Many mental disorders (e.g. mood disorders, substance misuse, conduct disorders and antisocial behaviour, eating disorders and psychotic disorders) are associated with an increased risk of suicide and suicide attempt, which also rises with the number of disorders.[9]

  Whilst young people with severe and complex mental disorder and psychosocial adversity are at most risk of suicide, many struggle to access the youth-focused subspecialist and youth-friendly specialist mental health support and healthcare services that will best meet their specific needs and provide the best health outcomes.

- ***Rates of self-harm are high among young people***

  This is an indicator for service providers and policy makers that many young people are distressed, coping poorly with their distress or disorder and would benefit from primary, specialist and subspecialist assessment and quality healthcare for early intervention to prevent development of a mental disorder or escalation of an underlying mental disorder that will increase suicide risk.

- ***The misuse of alcohol contributes to the three leading causes of death among adolescents: suicide, unintentional injury and homicide***[10]

  Alcohol misuse plays an important role in predisposing, precipitating, facilitating and sometimes disguising suicidal behaviour.[11] In developing both national and jurisdictional suicide prevention policies and strategies, it is critical to recognise the role and contribution to suicidal ideation, deliberate self-harm, unintentional injury, physical and sexual assault, homicide and completed suicide from drug and alcohol hazardous use and substance disorder (abuse and dependence) and substance-induced secondary mental and physical disorders.

  The NSW Branch believes that policy responses are required on a number of levels to address the role of alcohol in youth suicide.

  Firstly, a commitment is necessary to provide early intervention and access to drug and alcohol treatment services. That should include access to specialist and subspecialist healthcare, including addiction psychiatrists, for young persons within policy, program and service development. At the same time, there is a need to better

[9] Bridge J, Goldstein T, Brent D (2006) Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry* 47: 372-394.

[10] Australian Drug Foundation (2013) Young people and alcohol: Fact Sheet

[11] Giner L, Carballo J, Guija J, Sperling D, Oquendo M, Garcia-Parajua P, Sher L, Giner J (2007) Psychological autopsy studies: the role of alcohol use in adolescent and young adult suicides. *International Journal of Adolescent Medical Health* 19(1): 99-113.

understand and address the personal and contextual factors that contribute to the young person's problematic use of substances.

Secondly, it is crucial when considering the role of alcohol in youth suicide to recognise the marketing and lobbying sophistication of the alcohol manufacturing and distribution industries in contributing to the prominent part that alcohol plays in Australia's culture.[12] In 2016, the RANZCP partnered with the Royal Australasian College of Physicians (RACP) to develop an Alcohol Policy Paper.[13] In particular, this paper focused on the urgent need to address the frequency and impact of alcohol advertising, particularly on younger people. The NSW Branch endorses the broader advocacy position of the RACP regarding alcohol misuse, that as for evidence-based campaigns to reduce smoking, key public health interventions are required to reduce the harmful use of alcohol, such as reductions in advertising and imposition of taxes to reduce affordability.

- ***There are social and cultural factors (sometimes called 'determinants') that contribute to the youth suicide rate such as poverty, criminality, family disharmony, domestic violence, lack of secure housing, homelessness, poor educational outcomes, migration and family exposure to natural and man-made disasters***

  The NSW Branch believes that a public health framework approach that considers the social determinants of health outcomes is needed to address all the contributors to youth suicide and develop meaningful responses, including sectors outside of health, such as education, business, industry, community and the arts.

- ***Rates of suicide clustering is particularly high in the youth population[14]***

  Healthcare and education institutions and facilities and public media institutions all have a role in contributing to dissemination of information about a completed youth suicide which has been shown to increase the risk of triggering further suicides amongst vulnerable youth.

  These organisations therefore have a role in preventing cluster youth suicides through awareness, regulations and controls over the dissemination of information and details about suicides. We must be aware of and work towards better understanding and responding to contagion effects in relation to suicide, self-harm and other behaviours of concern.

[12] Global strategy to reduce the harmful use of alcohol (2010) Geneva: World Health Organization (http://www.who.int/substanceabuse/acti vities/gsrhua/en/, accessed 23 April 2014).

[13] https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf?sfvrsn=4

[14] Cheng Q, Li H, Silenzio, V & Caine E (2014) Suicide contagion: A systematic review of definitions and research utility. *PloS One, 9*(9), e108724. doi:10.1371/journal.pone.0108724

- ***Developmental factors in early life contribute to suicide and deliberate self-harm in young people***

  Relationships have been documented between childhood abuse and neglect and non-suicidal self-injury (NSSI) in adolescence,[15] and childhood adversity and suicide risk in adolescence and young adulthood[16].There is a significant association between bullying & victimisation and self-harm[17] with a well-documented relationship between childhood experiences of abuse and neglect and NSSI and attachment.[18] Parental mental disorder, discord, and low parental care and high control are all associated with suicidal behaviours in offspring[19]. These findings of multifactorial influences on suicidal behaviour in children and adolescents (e.g. parental, familial, relational and temperamental or personality-based factors) highlight the role for perinatal, infant, early childhood and childhood interventions to target suicide and self-harm in young people.

- ***Suicide prevention in youth with identified mental health problems requires evidence-based, young-person appropriate, accessible and acceptable clinical healthcare approaches***

  Suicide and deliberate self-harm should be considered a symptom of distress, helplessness and hopelessness in youth with mental health problems as much as a symptom of mental disorder. A commitment to good clinical care that draws on evidence, is person-centred and is responsive to the social and cultural context of all young persons (regardless of the presence of current suicidality) needs to be the foundation of specific efforts to prevent suicide in young persons with mental health problems.

The need for a targeted approach to address youth suicide compared to other age groups is supported by the Australian Institute for Suicide Research and Prevention that states, *Children and adolescents differ in terms of physical, sexual, cognitive and social development and warrant separate consideration*.[20]

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[15] Wan Y, Chen J, Sun Y, Tao F (2015) Impact of childhood abuse on the risk of non-suicidal self injury in mainland Chinese Adolescents. PLoS ONE 10(6): e0131239. doi:10.1371/journal.pone.0131239

[16] Bjorkenstam C, Kosidou K, Bjorkenstam E (2017) Childhood adversity and risk of suicide: cohort study of 548721 adolescents and young adults in Sweden. 357: j1334

[17] Fisher H, Moffitt T, Houts R, Belsky D, Arseneault L, Caspi A (2012) Bullying victimization and risk of self harm in early adolescence: longitudinal cohort study. *British Medical Journal* 344: e2683

[18] Martin K, Raby L, Madelyn H, Labella G & Roisman I (2017) Childhood abuse and neglect, attachment states of mind, and non-suicidal self-injury. *Attachment and Human Development* 19:5, 425-446, DOI: 10.1080/14616734.2017.1330832

[19] Bridge et al, 2006, op. cit.

[20] Australian Human Rights Commission (2014) Children's Rights Report Sydney: Australian Human Rights Commission.

This position also aligns to recommendations of the National Centre of Excellence in Youth National Health report (2016),[21] which calls for a youth-specific response due to the fact that despite 20 years of suicide prevention strategies and investment by all levels of government, suicide rates among young people are increasing.

This dedicated response should include consultation with adolescent and young adult consumers in the development of suicide prevention policies, the design of suicide prevention activities that would meet their needs and in evaluation and ongoing governance. Additionally, the voices of families and those who care for and support these young people need to be included.

Governments should support and resource crisis, acute and rehabilitation mental health care services. The NSW Branch recommends:

- The establishment of a Centre of Excellence in youth suicide research, led by academic child, adolescent and young adult psychiatrists to apply local and worldwide evidence to collaborate with stakeholders to define and test interventions, measure outcomes in a rapid-cycle, iterative process for improving programs, identify who benefits most and least, to allow cost-effective scaling and innovation to extend beyond programs and into systems.[22]

- Resources for child and adolescent psychiatrist training to address the current workforce shortfall below the recommended 4.0 FTE per 100,000 population. Shortfall in training opportunities in NSW are greatest in the treatment of under-12s children and their families, child psychiatry inpatient experience, vulnerable groups (as described in pp9-11 of this document) and in areas of need as prioritised by government and state and national Mental Health Commissions. Of immediate concern is that the funding for NSW Fellowships dedicated to the training of child and adolescent psychiatrists will be removed from 2018, which will immediately slow growth of this workforce. The impact will be in the areas most needed as these Fellowships provide training opportunities that do not exist in the Local Health District (LHD) training rotations. Notably, recent Fellows have, as part of their training, developed new collaborations, models of care and workforce training in child protection, children's court clinics, adolescent addiction and indigenous mental health. Furthermore, funding for the formal education course for the training of child psychiatrists remains unsecured.

- An adequate child and adolescent psychiatry subspecialty workforce thriving within well-designed state-wide, well-resourced Child and Adolescent Mental Health Services (CAMHSs) designed and led by child and adolescent psychiatrists in each LHD, where workplace peer-to-peer teaching and learning ensures rigorous clinical supervision and high standard of care.

- Child, adolescent and young adult inpatient beds determined by demographic service planning projections, adjusted for identified areas of need including rural communities with higher incidence of youth suicide.

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[21] Robinson J, Bailey E, Browne V, Cox G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health

[22] Center on the Developing Child at Harvard University (2016). From best practices to breakthrough impacts: A science-based approach to building a more promising future for young children and families. Retrieved from https://developingchild.harvard.edu/resources/from-best-practices-to-breakthrough-impacts/

- Architectural design of NSW child and adolescent inpatient units that optimises the therapeutic environment and redesign of Emergency Departments and Psychiatric Emergency Care Centres (PECCs) to support the best practice care of children, adolescents and young adults presenting with emotional distress or acute mental disorders.

- Adequate and seamless aftercare and follow-up services in the community for young persons to ensure good outcomes, and to minimise acute crisis, inappropriate or prolonged admissions, with a particular focus on outreach services for areas-of-need including Aboriginal and Torres Strait Islander people and rural and remote communities.

- Assertive outreach and/or crisis CAMHSs commissioned in all LHDs with easily accessible referral platforms that are separate for consumers and clinicians. Quick access is essential for those young people who are most risk, which is known to be increased after a presentation to the Emergency Department, following hospital discharge and when they contact crisis services.

- Access to state-wide youth-friendly subspecialty programs such as Psychosis Early Intervention Programs, youth-specific drug and alcohol detoxification and rehabilitation programs, psychiatric rehabilitation programs and group therapy programs such as Dialectical Behaviour Therapy (DBT) for young adults with emerging personality disorders.

- Telehealth to supplement access to psychiatrists and other mental health professionals in rural and remote communities in particular but also to youth and their families in urban areas who suffer non-geographic hurdles to accessing psychiatrists face-to-face.

- A commitment to providing continuity in service provision that minimises disruption and number of transitions and is skilled in engaging the young person and the resources of the family and social network

Economic modelling on the impact of suicide and suicide related behaviours

- Although the cost of suicide in Australia has been estimated to be $17.58b (equating to $795 per person per year)[23] there are no specific breakdowns available on the economic impacts of suicide or suicide related behaviour on young people either across Australia or on an individual state or territory basis. This gap has impeded evaluations of youth suicide prevention activities. A methodology to quantify the economic impact of suicide on young people in NSW is necessary to underpin the evaluation of any suicide prevention modelling targeting this population.

The need for a robust and nationally consistent evaluation framework for Primary Health Networks

- The NSW Branch supports the development of an evaluation framework/toolkit for PHNs as they develop and implement youth suicide prevention policies and

[23] Connetica Consulting (2016) Suicide prevention – a call to action. Available http://www.connetica.com.au/

programs. Ideally, this would include a better practice register as an information/data repository. The framework should be developed in partnership with young people to ensure that youth-related outcomes are collected and the program's acceptability and appropriateness are determined.

SECTION TWO – Response to the Terms of Reference

Any gaps in the coordination and integration of suicide prevention activities and programs across all levels of government

Despite the significant efforts already made in Australia to prevent youth suicide, there have unfortunately been small but gradual increases in suicide rates over the previous decade.

We recommend that the following issues be urgently considered in the context of service and program redesign across all levels of government:

- ***The need for a coordinated national approach***

  Youth suicide is a serious issue across Australia. As NSW further develops a youth suicide prevention strategy, it is crucial that it forms part of an integrated and coordinated national framework. The NSW Branch acknowledges that the Australian Government is reinvigorating its suicide prevention strategy, including a significant role for the 31 PHNs to plan and commission regionally focused suicide prevention responses. This is an opportunity for the Commonwealth to have an active coordinating role (as opposed to a purely advisory function recently suggested in a draft guide for PHNs[24]) in supporting the PHNs to develop and implement regionally-specific suicide prevention programs. A coordinated strategy in NSW must also engage and collaborate with services provided by NSW Health.

- ***The need for improved evaluation***

  Successive national and state/territory suicide prevention strategies have been released in Australia since 1995 although available evaluations have been unable to link any of these to reductions in suicide-related behaviours. The NSW Branch believes that robust evaluation frameworks are critical to ensure that future government funded suicide prevention strategies and activities are determined to be of benefit, and if not, how they can be improved on the basis of objective and relevant evaluation evidence.

- ***The need for evidence-based, young-person appropriate, accessible and acceptable programs and services***

  A 2016 analysis[25] of current suicide prevention strategies across Australia identified gaps in evidence-based youth specific policies, programs and services. The NSW Branch believes that NSW (or any other state or territory for that matter) should not

[24] Regional Planning for Mental Health and Suicide Prevention (2017) A guide for Primary Health Networks Department of Health

[25] Robinson J, Bailey E, Browne V, Cox G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health

fund policies, programs or activities for which limited evidence exists unless there is collaboration with local clinicians and academics to identify gaps and conduct research into the effectiveness of pilot projects *before* widespread implementation. There is a need to identify potential areas in which interventions are under-researched. For example, research into approaches that address family function and trauma informed and guided interventions require further development.

- ***The need to extend and coordinate youth suicide prevention policy and programs across all levels of government and outside of health e.g. justice, education, family services, non-government organisations and PHNs***

Governance arrangements and accountabilities for suicide prevention

A key principle outlined in many of the submissions and reports published by the RANZCP is that addressing the incidence of child and adolescent deliberate self-harm and suicide in Australia requires strategies to address the factors that contribute to and perpetuate such behaviours. There is consistent evidence to demonstrate that people who self-harm or die by suicide have a much higher prevalence of mental disorder and illness than the general population.

The NSW Branch believes that prevention and early intervention of mental disorder and illness in childhood and adolescence are key to addressing youth suicide and self-harm. To be effective, these approaches require adequate mental health service planning, resourcing and integration as well as sound clinical governance across functional networks. In particular specialist mental health care for inpatient care requires integration with early intervention services to ensure Stepped Care access into the youth mental health system on discharge from hospital or emergency care. Integration between different treatment settings (public and private, hospital and community, specialist and general) needs to be addressed to minimise disruptions to continuity of care for the young person and family and optimise responsiveness to the young person and their family, social, educative and occupational networks.

Provision of services in local communities, particularly in regional and rural areas

Suicide prevention policy should include the provision of accessible, timely and evidence-based mental health care that is sensitive and responsive to the person's and the family's context, as a core component regardless of address.[26] For young people, this means access to youth-specific mental health care.

State-wide access is required together with clear pathways into services for young people who have presented to hospital or Emergency Departments after deliberate self-harm or a suicide attempt. The NSW Branch believes that more local and coordinated follow up is required across the state, but particularly in rural and remote areas. Acute teams in CAMHSs are effective in managing intensively for weeks to months, to avoid including new services at every stage.

While the NSW Branch supports the use of telehealth in augmenting the delivery of mental health services in rural areas, it cannot be seen as a stand-alone solution. There are complex and often regionally-specific issues in rural areas that need to be carefully

[26] Jones H & Cipriani A (2016) Improving access to treatment for mental health problems as a major component of suicide prevention strategy. *Australian and New Zealand Journal of Psychiatry* 50: 176-8.

considered with regards to the particular needs of the community. 'Oversight responses' often involving metropolitan services such as telehealth or fly-in specialist services, while being valuable to address gaps in some cases, can disrupt networks and deskill local clinicians in others. Planning to provide local resources is of primary importance in providing crisis as well as routine input.

There is evidence that providing effective youth mental health care early following the onset of mental disorder or illness, in particular in the case of first episode psychosis, leads to better outcomes for young people and their families, including a reduction in future suicide-related behaviours.[27] The NSW Branch supports the further implementation of these treatment and prevention initiatives across NSW, with particular enhancement in regional, rural and remote areas many of which are experiencing disproportionate increases in youth suicide rates.

To address increasing suicide rates in regional, rural and remote areas, the Australian Government identified further funding for suicide prevention research and evaluation and additional regional suicide prevention trial sites as part of its 2016 election campaign. The NSW Branch supports including the role for the 31 Primary Health Networks to plan and commission regionally focused youth mental health services and suicide prevention programs.

We recommend an active coordinating role by the Commonwealth, to engage with the state workforce in order to access local knowledge of existing perinatal, infant, child and adolescent and young adult mental health services to encourage innovation, develop coordinated and effective evaluation frameworks, and standardise data collection across Australia.

Recognising that family and social factors play a significant role in suicide and deliberate self-harm in young persons, the NSW Branch also supports the development of approaches and collaborations that harness the strengths of a community and the social network of the young person.

Provision of services for vulnerable and at-risk groups

- ***Aboriginal and Torres Strait Islander people and communities***

  Suicide rates for Aboriginal and Torres Strait Islander children and young people (aged 5-17 years) are five times that of non-Aboriginal and Torres Strait Islander young people.[28] It has been suggested that many mainstream risk factors are less applicable to this group. The consequences of transgenerational trauma may be more applicable to these communities such as family disintegration, domestic violence, community politics, poor role models, poor literacy, unemployment, poor physical health and reduced lifespan, a lack of sense of purpose and grief, as well as widespread abuse of alcohol and other drugs, and need to be considered in developing suicide prevention strategies for Aboriginal and Torres Strait Islander young people.

[27] Harris M, Burgess P, Chant, D, Pirkis J & McGorry, P (2008) Impact of a specialised early psychosis treatment program on suicide. A retrospective cohort study. *Early Intervention in Psychiatry* 2: 11-21

[28] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010

Specific initiatives that have been found to be constructive in this area include;

- indigenous-led community initiatives, research and success stories
- effective postvention responses to enduring grief in communities impacted by suicide, violence and self-harm, especially children and young people who are witnesses or directly affected, utilising indigenous understandings and support models wherever possible
- indigenous health workforce training and development, including the provision of Social and Emotional Well-Being (SEWB) and related programs
- resourcing and evaluation for drug, alcohol and tobacco programs, and for maternal and child health
- national developments such as the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.[29]

The RANZCP recommends that Emergency Departments and hospitals should ask all patients whether they identify as Aboriginal or Torres Strait Islander, to ensure that population-specific data can be collected for deliberate self-harm, suicidal ideation or attempts and other presenting problems. [30]

Other young people at risk who need specifically targeted suicide prevention strategies include;

- ***Young people who have experienced developmental trauma***

  Young persons who have experienced abuse or neglect or loss of a parent or other close attachment figure, especially prior to the age of 12 years, are at increased risk of deliberate self-harm and suicide. Services need to be able to identify and attend to the specific and complex needs of this group of young persons, their families and social, educational and occupational networks.

- ***Young persons who have experienced out-of-home care***

  Children in out-of-home care are at substantially increased risk of suicide and deliberate self-harm.

- ***Children of parents with a mental illness***

  Children of parents with a mental illness have a higher risk of developing mental health problems or mental illness themselves (during childhood or adulthood). This is thought to be a combination of genetic predisposition as well as difficult life experience. [31] There are a number of protective factors that can reduce the impact of mental illness on these children and their daily lives, including access to effective and

[29] http://www.atsispep.sis.uwa.edu.au/

[30] Carter, G., Page, A., Large, M., Hetrick, S., Milner, A. J., Bendit, N., ... & Burns, J. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. *Australian & New Zealand Journal of Psychiatry*, *50*(10), 939-1000.

[31] Bridge J, Goldstein T & Brent D (2006) Adolescent suicide and suicidal behaviour, Journal of Child Psychology and Psychiatry 47: 372–394.

supportive services and networks for both themselves and their parents, and creating an education or care environment that reduces stigma and invites conversations about mental illness. [32]

- ***Young people recently in contact with the justice system***

  Suicide has been associated with having been involved in a forensic event (e.g. being arrested, charged or sentenced) in the previous three months and in particular the last week.[33]

- ***Young people who live in rural and remote areas***

  Suicide rates among young males living in regional, rural and remote areas are higher than those in major cities and have been shown to increase with remoteness.[34] Allocation of mental health clinicians to rural areas should not just be made on the basis of population numbers. Other factors need to be considered, such as the distance clinicians need to travel to reach families and the level of existing services in the public and private health sectors, availability of NGOs and resources across other sectors such as education, the juvenile justice system and family services. The high presentation of clinically complex cases reflecting social disparity and complex trauma in rural areas also needs to be factored into allocation of resources to rural and remote areas.

- ***Young people in current or recent contact with statutory care***

  Twelve months after leaving care, more than one in two young people report suicidal thoughts and more than one in three had attempted suicide.[35]

- ***Young people who have been exposed to suicide or suicide related behaviour***

  These young people are eight times more likely to report engaging in deliberate self-harm than those who have not been exposed.[36]

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[32] http://www.responseability.org/__data/assets/pdf_file/0015/13209/Children-of-parents-with-a-mental-illness.pdf

[33] Cooper J, Appleby L & T (2002) Life events preceding suicide by young people. *Social Psychology and Psychiatric Epidemiology* 37: 271-275.

[34] http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010

[35] Cashmore, J & Paxman M (2007) Wards leaving care: four to five years on. A longitudinal study. NSW Department of Community Services.

[36] McMahon E, Corcoran P, Keeley H, Perry I & Arensman E (2013) Adolescents exposed to suicidal behaviours of others: prevalence of self-harm and associated psychological, lifestyle and life event factors. *Suicide and Life Threatening Behaviours* 43: 634-45.

- ***LGBTIQ young people***

  A recent survey of 860 transgender and gender diverse young people showed that 80% of transgender young people in the 12-17 year age group have deliberately self-harmed compared to 11% in the general population. It also showed that almost 1 in 2 have attempted suicide, which is 20 times higher than adolescents in the general population and 14.6 times higher than for Australian adults.[37] In December 2016, the NSW Branch and the RACP submitted a co-signed proposal to the NSW Government to fund a multidisciplinary gender dysphoria assessment service for children through to young adults at the Westmead Hospital campus. To date, there has been no response to this submission. The NSW Branch emphasises that the issue of LGBTIQ young persons is broader than the scope of this essential service and that there needs to be strategies that identify the vulnerabilities of these young persons and support them. This is particularly relevant as Australia prepares to debate the issue of same sex marriage.

- ***Young people with learning difficulties***

  There is a well-established relationship between acute and/or chronic academic difficulties and suicide[38]. School responses and programs are mentioned below. It is also important to consider Australian and international experience of how to reach high-risk young people who are not at school[39].

- ***Refugees***

  Children and adolescents who are or have been in immigration detention show a high prevalence of suicidal ideation and self-harm[40]. Much more research is required to gain information about suicidal behaviour, ideation and deliberate self-harm among child and adolescent refugees and asylum-seekers. Young asylum-seekers may be suicidal in relation to lack of protections in their country of origin (such as LGBTIQ

[37] Strauss P, Cook A, Winter, S, Watson V, Wright-Toussaint D, Lin A. (2017). Trans Pathways: the mental health experiences and care pathways of trans young people. Summary of results. Telethon Kids Institute, Perth, Australia.

[38] Zalsman G, Siman Tov Y, Tzuriel D, Shoval G, Barzilay R, Tiech Fire N, Sherf M, John-Mann J (2016) Psychological autopsy of seventy high school suicides: Combined qualitative/quantitative approach. *European Psychiatry*. 38:8-14. doi: 10.1016/j.eurpsy.2016.05.005. Epub 2016 Sep 6

[39] Knight A, Havard A, Shakeshaft A, Maple M, Snijder M & Shakeshaft B (2017) The feasibility of embedding data collection into the routine service delivery of a multi-component program for high-risk young people. *International Journal of Environmental Research and Public Health*. 20:14(2). pii: E208. doi: 10.3390/ijerph14020208.

[40] Dudley M, Steel Z, Mares S & Newman L (2012) Children and young people in immigration detention. *Current Opinion in Psychiatry* 25: 285-292.

asylum-seekers)[41] or in their host country, as for example with bullying and victimisation, though other factors may also mitigate suicidality[42].

Data collection about the incidence of youth suicide and attempted suicide

In the RANZCP clinical practice guideline for the management of deliberate self-harm several consensus and evidence-based recommendations are made regarding data collection and management, that could be extended to include suicide, suicidal ideation and attempts among young people.[43] These include;

- Better information systems to collect data on rates of deliberate self-harm and suicidal ideation or attempts among young people presenting to acute care services.
- Sentinel surveillance units in general hospitals to collect regional data on deliberate self-harm and suicidal ideation or attempt rates among young people, to enable more accurate estimates of prevalence, incidence and trends.
- National surveys should be designed to collect data on hospital treated and community deliberate self-harm and suicidal ideation and attempts among young people.

The NSW Branch believes that as part of building an evidence-base to address increasing rates of youth suicide and self-harm, NSW needs to participate in a national better practice register and evaluation framework to share information and collect and analyse youth-related outcomes.

We note that 'Promoting CARE' is the only systematically evaluated comprehensive suicide prevention program delivered to young people who were assessed initially as 'at risk' of suicide. The program is based on behaviour change by enhancing coping skills, social support, motivation and self-efficacy. Follow-up done at 2.5 to 8 years after early intervention when the participants were in grades 9-12 (with a mean age of 15.9 years old) found that the program was successful in promoting and maintaining lower-risk status for individuals from adolescence to young adulthood; some high-risk behaviours indicated a need for additional intervention to gain earlier effects[44].

We strongly advocate for the establishment of a strategic research agenda in NSW, in partnership with the Commonwealth Government, to focus on the prevention of youth suicide

[41] Alessi E, Kahn S, Chatterji S (2016) 'The darkest times of my life': Recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity. *Child Abuse and Neglect* 51:93-105. doi: 10.1016/j.chiabu.2015.10.030. Epub 2015 Nov 24.

[42] Pottie K, Dahal G, Georgiades K, Premji K & Hassan G (2015) Do first generation immigrant adolescents face higher rates of bullying, violence and suicidal behaviours than do third generation and native born? *Journal of Immigration Minor Health* 17(5):1557-66. doi: 10.1007/s10903-014-0108-6. Review

[43] Carter G, Page A, Large M, Hetrick S, Milner A. J, Bendit N, ... & Burns J (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. *Australian & New Zealand Journal of Psychiatry 50*(10): 939-1000.

[44] Hooven C, Herting J & Snedker K (2010) Long-term outcomes for the promoting the CARE suicide prevention program. *American Journal of Health Behaviour* 34(6): 721–736.

and deliberate self-harm. There is an opportunity for the research funding promised as part of the 2016 election as well as future National Health and Medical Research Council (NHMRC)/Australian Research Council (ARC) research priorities to focus on addressing gaps that exist in the conduct of youth-focused and youth-friendly suicide prevention research.

The NSW Branch supports an alignment of national and state/territory data items and collection processes related to youth suicide and deliberate self-harm to understand the prevalence and impact of suicide related behaviours and to evaluate suicide prevention strategies. We also support the development of policies and processes to improve data aggregation and sharing.

The RANZCP recommends that Emergency Departments and hospitals should ask all patients whether they identify as Aboriginal or Torres Strait Islander, to ensure that population-specific data can be collected for deliberate self-harm, suicidal ideation or attempts and other presenting problems. [45]

Provision of high-quality information and training to service providers

As described above, the NSW Branch supports the development of a better practice register to enable ready access to existing evidence that identifies youth appropriate, acceptable and effective strategies and that this information is made available to training and service planners and providers.

The NSW Branch recognises that clinicians and service providers charged with supporting young persons at risk of suicide will also bear considerable anxiety and concern. Continuous development of expertise in mental health care and mental health first aid in other service providers is needed so that they can effectively respond to the complex issues associated with concerns about suicide. Access to professional support and supervision should be incorporated into the role of service providers.

Further, it should be recognised that many children and adolescents are being treated in settings that are not specifically designated for their care. The NSW Branch recommends ongoing capacity building in other services (e.g. adult mental health, consultation-liaison settings, schools and community) to respond to the needs of young people according to principles of good clinical care.

Approaches taken by primary and secondary providers

It is estimated that up to 90% of people who make suicide attempts have co-existing mental health conditions. It is also estimated that 80% of these people will not have received early, or indeed any treatment for their mental illness.[46]

At the moment, for young people experiencing severe mental illness in NSW, there is a lack of mental health services providing the full spectrum of integrated and evidence-based care from early intervention to specialised inpatient care. There is a need for improved coordination between private and public sectors and for clear referral and communication

[45] Carter, G., Page, A., Large, M., Hetrick, S., Milner, A. J., Bendit, N., ... & Burns, J. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. *Australian & New Zealand Journal of Psychiatry*, *50*(10), 939-1000.

[46] Robinson J, Bailey E, Browne V, Cox G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health

pathways to link the complex myriad of mental health service providers: General Practitioners, psychiatrists, other specialists, allied health clinicians, Emergency Departments, PECCs, CAMHSs, adult wards accommodating young people, young adult units and non-government organisations.

Also, the multidisciplinary shared-care models of care need to be seriously considered for more complex needs and high-risk patients, such as those at risk of suicide. A diversity of treatment modalities, clinicians, settings and models is required, so that the best fit is provided for individual patients and their families rather than a one-size-fits-all approach. The NSW Branch supports the ongoing implementation of Stepped Care to personalise the approach to individual needs.

Suicide in young people should take into consideration the developmental context and the associated vulnerability in terms of the developing brain and emotional maturity with attention also given to family, school and other systems that are relevant for the young person. In addition to preventative strategies and building resilience it is important to provide opportunities for short-term youth-specific or youth-friendly hospitalisation especially in the 12-72 hours following a suicidal attempt for immediate containment and also to evaluate the biopsychosocial risk and stressors as well as strength, resilience and support systems.

There are frequent consumer reports of young people falling through cracks in the mental health system, which in some cases have had devastating consequences. These 'cracks' are particularly common in the period following discharge from an Emergency Department or hospital following a suicide attempt or self-harm. The NSW Branch believes there is an urgent need to improve follow-up care after a suicide attempt or after discharge from inpatient care and/or emergency departments as there is considerable evidence that in the period following discharge from hospital, there is an elevated risk of suicide[47]. The developing liaison role of the Primary Health Networks could facilitate this.

There is also a need to explore the role of technology in better supporting young people who have attempted suicide on release from hospital. Many young people seek information and support for their health and mental health from the internet. In particular those considering suicide may wish to remain anonymous, hence the importance of online prevention programs. Online services can provide clinical support at all stages of mental disorder at all times of the day, particularly at night, when young people are often vulnerable and experiencing suicidal ideation.

Improved online services are also required to support the move towards Stepped Care in NSW and could be of particular value when young people are discharged from inpatient care. While online delivery of resources to young people is an attractive option, it is important to acknowledge that many rural and remote areas experience poor network connectivity and that the majority of mobile app mental health interventions remains unsupported by evidence. Online platforms should add value to young people in their engagement with support and services and not be an additional barrier to accessing support.

Improving skills among General Practitioners in screening and referral of young people at risk has been shown to increase the numbers who access help before they consider or

[47] Fedyszyn I, Erlangsen A, Hjorthoj C, Madsen T & Nordentoft M (2016) Repeated suicide attempts and suicide among individuals with a first emergency department contact for attempted suicide; A prospective, nationwide, Danish register-based study. *Journal of Clinical Psychiatry* 77: 832-40.

engage in suicidal related thoughts or behaviours.[48] Training primary care providers to understand youth suicide risk and feel comfortable making outpatient referrals has also been associated with a reduction in referrals to Emergency Departments.[49] However evidence also shows that young people are less likely to seek help from a General Practitioner for their mental health than any other age group.[50] Strategies are therefore required that address the barriers to primary care for young people. One example in this space is the safeTALK, which is a half-day alertness workshop that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide-alert helper.[51]

Another important Australian Government policy and program response to reduce suicide has been the Access to Allied Psychological Services (ATAPS) Suicide Prevention Program. This program provides psychological services as needed for two months for people who present to a General Practitioner with suicide-related behaviours, including suicidal ideation, self-harm or who are at increased risk due to the impact of another's suicide. Generally the ATAPS program has been deemed an appropriate and effective suicide prevention intervention involving primary care in the short term. However it has not yet been tested for economic efficiency nor for data on suicide related outcomes in the longer term. Its specific impact on young people is not clear from evaluations to date.[52] The NSW Branch suggests that further evaluation related to the ATAPS program in relation to suicide prevention in young people should be explored.

To support PHNs and LHDs to establish suicide prevention networks to suit local contexts, stakeholder engagement frameworks including youth mental health organisations, schools and tertiary education providers, primary care, police, community services, Aboriginal Torres Strait Islander organisations, parents and young people have been shown to be beneficial.[53]

Importantly we believe that the role of crisis support services should be protected, ensuring they can be accessed quickly and simply. Some existing models, including the Assertive CAMHS approach, have shown promise in initial evaluations and there is potential to develop teams based on these models.[54]

In the RANZCP clinical practice guideline (CPG) for the management of deliberate self-harm several consensus and evidence-based recommendations are made regarding the organisation of services to provide improved care for people who deliberately self-harm.

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[48] Jones H & Cipriani A (2016) Improving access to treatment for mental health problems as a major component of suicide prevention strategy. *Australia NZ Journal of Psychiatry* 50: 176-8.

[49] Winstersteen M & Diamond G (2013) Youth suicide prevention in primary care: A model program and its impact on psychiatric emergency referrals. *Clinical Practice in Paediatric Psychology* 1: 295-305.

[50] Robinson J, Bailey E, Browne V, Cox G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health

[51] www.livingworks.com.au/programs/safetalk/

[52] Australian Healthcare Associates (2014) Evaluation of Suicide Prevention Activities. Final Report.

[53] Robinson J, Bailey E, Browne V, Cox G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health

[54] https://www.sprc.unsw.edu.au/media/SPRCFile/Evaluation_of_the_Assertive_CAHMS_Pilot_in_NSW.pdf

The NSW Branch believes these recommendations are applicable to suicidal ideation and attempts among young people.[55] For service improvement they include;

- Minimising waiting times for young people who present to Emergency Departments after deliberate self-harm or suicidal ideation or attempts and monitor the reception area closely to ensure patients do not leave before psychosocial assessment is completed.

- For young people who attend frequently for deliberate self-harm or suicidal ideation or attempts, identify primary and specialist care providers who can work with hospital staff and, where appropriate, the service user (patient), to create an active management plan for future presentations. This should be linked to a hospital alert so the management plan is available early in each episode of care.

Approaches taken by primary and secondary schools

Schools, TAFE colleges and universities provide an appropriate and effective setting within which to deliver evidence-based suicide prevention activities to young people. While there have been numerous studies on these activities, the quality of evidence has been variable.

To date, school-based suicide prevention activities in Australia have consisted of gatekeeper training for staff, mental health awareness raising among students and teachers, whole-of school student wellbeing policies to address risk factors and to promote help-seeking, and postvention programs. To date they have not typically featured components that facilitate discussions about suicide or suicide-related behaviours directly with students. There is general consensus in the literature that while there is not sufficient evidence that school-based programs that focus on raising awareness about suicide are beneficial and not harmful, they should be avoided to minimise the risk of suicide clustering.[56] However screening programs as well as gatekeeper training show particular promise according to one recent systematic review[57]; and specific U.S. programs have successfully used screening, case-finding and referral, sometimes in conjunction with psychoeducation that underscores the relationship of suicide with mental illness[58] [59] [60]. A whole of school student health and wellbeing approach is required to build protective factors among school students such as

[55] Carter G, Page A, Large M, Hetrick S, Milner A. J, Bendit N, ... & Burns J (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. *Australian & New Zealand Journal of Psychiatry 50*(10): 939-1000.

[56] Robinson J, Bailey E, Browne V, Cox G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health

[57] Robinson J, Cox G, Malone A, Williamson M, Baldwin G, Fletcher K et al. (2013) A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide-related behaviour in young people. *Crisis* 34(3):164-182. DOI: 10.1027/0227-5910/a000168

[58] Miller D, Eckert T, Mazza J (2009) Suicide prevention programs in the schools: a review and a public health perspective. *School Psychology Review* 38 (2): 168-188.

[59] Aseltine R, James A, Schilling E, Glanovsky J (2007) Evaluating the SOS suicide prevention program: a replication and extension. *BMC Public Health* 7: 161.

[60] Bridge J, Goldstein T & Brent D (2006) Adolescent suicide and suicidal behaviour, Journal of Child Psychology and Psychiatry 47: 372–394.

self-esteem, social skills, looking after each other, anti-bullying and creating safe and supportive educational environments. One example of such a program is the Hunter New England LHD early intervention and planning tool, *Responding to Mental Health Complexities – a Resource for Schools*.[61]

The NSW Branch believes that an 'end to end' school-based mental health program to be delivered from early childhood education to the end of secondary school is required for all states and territories to build resilience and support promotion and prevention activities.

Given that youth suicides occur more commonly in clusters than adult suicides, postvention activities in school settings provided to students impacted by suicide or self-harm are important to reduce the risk of subsequent deaths. Currently the Australian Government funds headspace School Support to provide postvention services across Australian secondary schools. However, there are gaps in the program including a lack of services in tertiary education settings and primary schools and limited evaluation. The NSW Branch believes that given the Australian Government has recently released funding to support future postvention services, it is important that these gaps are addressed in any NSW policy developments.

The NSW Branch believes that government funded mental health and suicide prevention education should be extended into tertiary education and vocational training settings. They are currently not included in State or Commonwealth mental health and suicide prevention program funding and delivery.[62]

Any related matters

Please refer to Section One

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https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf?sfvrsn=4

http://www.responseability.org/__data/assets/pdf_file/0015/13209/Children-of-parents-with-a-mental-illness.pdf

[61] http://www.hnekidshealth.nsw.gov.au/client_images/1923886.pdf

[62] Robinson J, Bailey E, Browne V, Cox G & Hooper C (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, National Centre of Excellence in Youth Mental Health

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