6 Suicide

Youth suicide is a deeply tragic and complex issue that continues to affect families, schools, and communities across Australia. Twenty-four children and young people died from suicide in 2024–25 in Queensland. Addressing youth suicide requires compassion, awareness, and a commitment to creating safe, supportive environments where every young person feels seen, heard, and valued.

The Commission is committed to supporting the Queensland Government's *Every life: The Queensland Suicide Prevention Plan 2019–2029*. This whole-of-government strategy aims to reduce suicide and its impact across the state by promoting early intervention, improving access to care, and fostering community-led solutions.

The Commission analyses data on childhood suicide to identify at-risk populations and improve mental health outcomes for all children. We also provide opportunities for others to share research insights to support responsive interventions and prevent suicide trajectories.

We engaged keynote speakers to present their research findings and insights on youth suicide at the 2025 Australian and New Zealand Child Death Review and Prevention Conference. Our discussions with the Australian Institute for Suicide Research and Prevention led to a partnership agreement to collaborate on a multi-year research project exploring help-seeking pathways by Aboriginal and Torres Strait Islander children who died by suicide in Queensland.

Our information sharing arrangement with the Department of Education helps them provide postvention supports in schools affected by suicide. We are in discussion with Be You, a national mental health in education service, to support their outreach to schools affected by suicide.

We continue to invite researchers to contact us to explore the data within the Register and discuss how it can be used to advance suicide prevention efforts. By collaborating with researchers, we aim to translate data-driven insights into meaningful strategies that reduce suicide risk and improve outcomes for individuals and communities.

When communicating about suicide, particularly involving children and young people, we are mindful of the importance of following evidence-informed guidelines to ensure safe and respectful language use. The Commission supports the use of the *Mindframe guidelines* on responsible, accurate and safe reporting on suicide, mental ill-health and alcohol and other drugs. We recommend referring to these guidelines when reporting on statistics in our reports and publications, available at www.mindframe.org.au.

Reader advisory

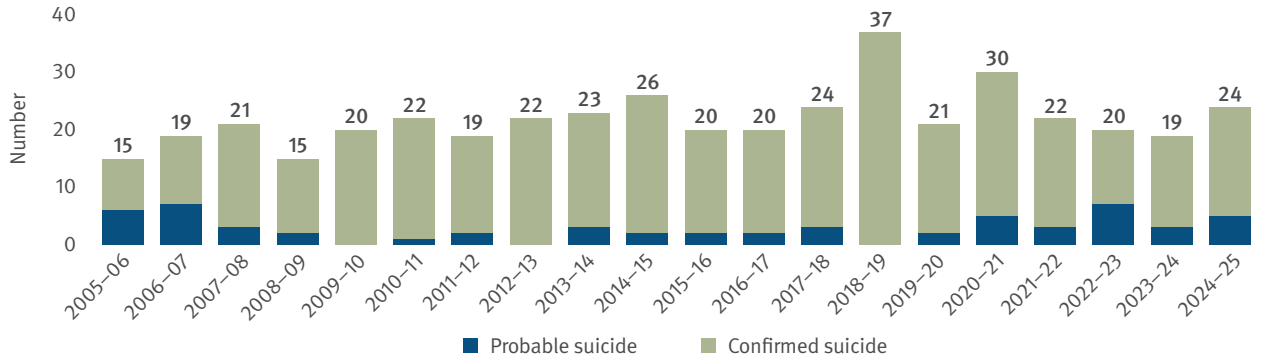
This chapter contains information about suicide among children and young people, which may be distressing. Readers are encouraged to seek support if affected by the content.

If you or someone you know is struggling, help is available:

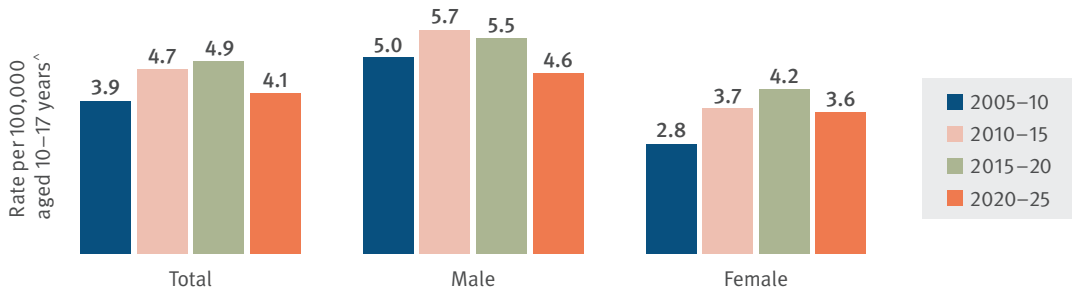
- **Lifeline:** 13 11 14 www.lifeline.org.au/gethelp
- **Kids Helpline (for young people aged 5 to 25 years):** 1800 551 800 www.kidshelpline.com.au
- **Suicide Call Back Service:** 1300 659 467 www.suicidecallbackservice.org.au
- **StandBy – Support After Suicide:** 1300 727 247 www.standbysupport.com.au

Key facts on child deaths from suicide

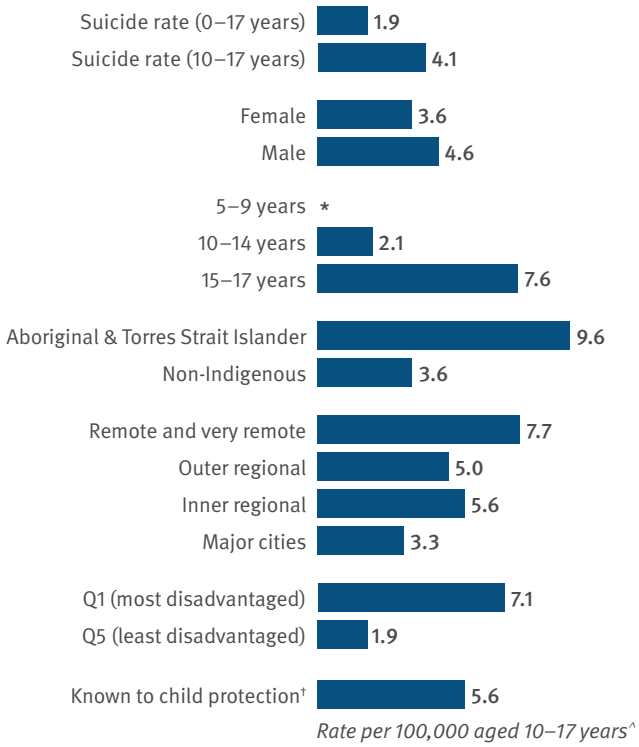
2005 to 2025



5-year summary (2020–2025) | Sex



Demographics



Risk factors

46% adverse childhood experiences

41% diagnosed mental health condition

77% self-harm and suicidal behaviours

34% history of alcohol and/or substance misuse

45% history of behaviour problems and/or offending

17% neurodivergent

Notes: Counting is by date of death registration.
** rate not calculated for numbers less than 4.*
^ deaths in 5–9 age group are included in 10–17 year rates, with exception of age group rates.
† in the 12 months prior to death.

Key findings

Defining and classifying suicide

Suspected suicide cases are assessed and categorised using a suicide classification model that considers factors such as: whether the incident was more consistent with death by suicide than any other cause; whether intent was communicated; any prior suicide attempts; and mental health history. Suicide classifications are made based on information held by the Commission at the time of reporting. Deaths are classified as possible suicides where there is insufficient information to determine fatal intent—these deaths will be reported under another applicable category. Where the fatal outcome was most likely not intended, such as the consequences of risk-taking behaviour, these deaths will be classified as 'other non-intentional injury'. Where the cause of the injury cannot be determined as either accidental or intentional the death will be classified as 'unexplained'.

Further information on the classification model can be found in **Appendix F** available at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

Twenty-four children and young people died by suicide in 2024–25, an increase from 19 deaths in the previous reporting period.

Nineteen deaths in the 2024–25 period were classified as confirmed suicides and 5 deaths were probable suicides (i.e. more consistent with suicide than any other means).

A total of 115 young people died by suicide over the last 5 years, with an average of 23 deaths per year.[63] The suicide mortality rate has slowly increased across most of the periods (trend line up 1.2% per year on average). High numbers of suicides recorded in 2018–19 and 2020–21 (37 and 30 respectively) contributed to an increase in rates, but with lower numbers in the last 4 years the suicide rate has decreased in the most recent periods.[64]

Data from the Interim Queensland Suicide Register, published by the Australian Institute of Health and Welfare (AIHW), shows that in 2024, children and young people accounted for 2.7% of all suicide deaths in Queensland. While suicide among this age group is relatively uncommon compared to adults, it remains the leading cause of death for young people aged 10–14 years and 15–17 years.[65]

Table A.8 in **Appendix A** provides summary data and key characteristics for suicide deaths in the last 5 years.

Coronial findings

At the time of reporting, coronial findings had been finalised for 12 of the 24 suicides from 2024–25. Coroners made clear statements that suicide was the cause of death in all 12 cases.

Intent stated or implied (orally or written)

There was evidence of suicidal intent in 15 of the 24 suicide deaths during 2024–25. Five young people stated or implied their intent to a friend or parent. Intent was stated or implied either by text or instant message or in person.[66] Suicide notes were left by 11 young people.

63 Tables with data for 2004–2025 are available online at **www.qfcc.qld.gov.au/about-us/publications/child-death-reports-and-data**

64 Suicide rates in this chapter are per 100,000 population aged 10–17 years and, with the exception of age specific rates, include the small number of suicides of children aged 5–9 years.

65 AIHW (2025) *Monthly suicide registers – Suicide & self-harm monitoring*, **www.aihw.gov.au/suicide-self-harm-monitoring/geography/states-territories/monthly-suicide-registers**

66 Each young person may have stated or implied their intent using more than one communication method.

Age

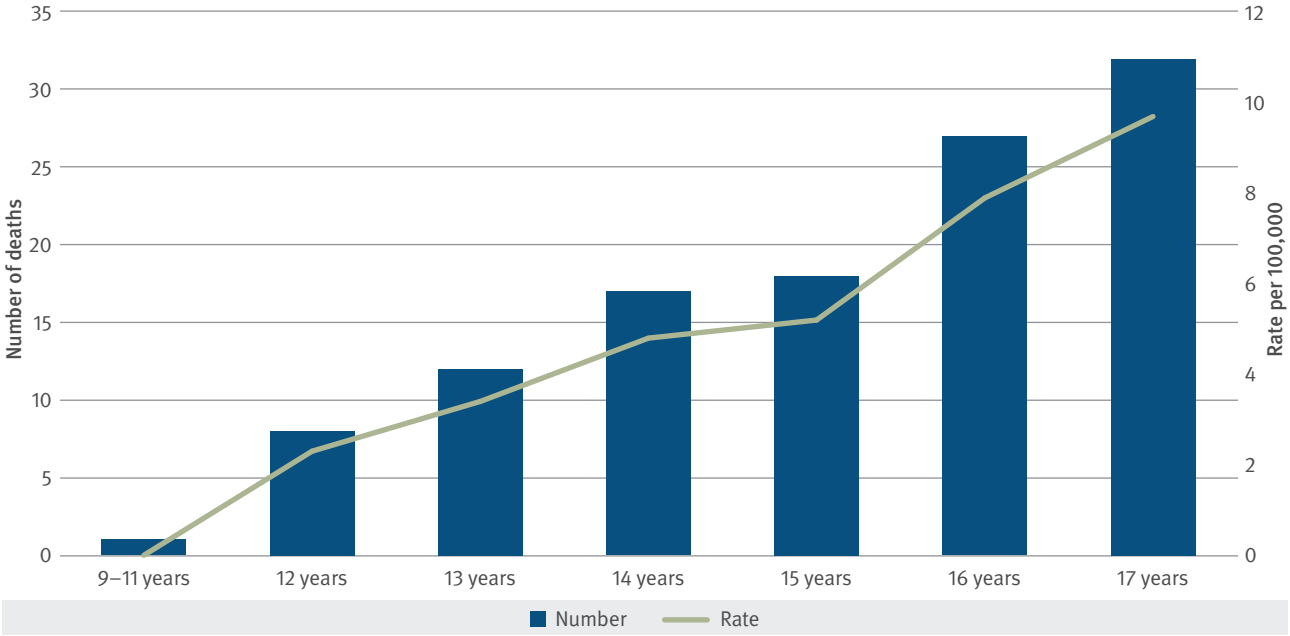
Of the 24 suicide deaths during 2024–25, 8 were aged 10–14 years and 16 were young people aged 15–17 years.

The 5-year suicide rate for young people aged 15–17 years was 3.5 times the rate for young people aged 10–14 years (7.6 deaths per 100,000 aged 15–17 years, compared with 2.1 deaths per 100,000 aged 10–14 years).

Recent research into suicidal behaviours among very young children remains minimal, reflecting longstanding assumptions about their cognitive capacity to understand and act on suicidal thoughts. However, emerging evidence reveals that children as young as 6 years old can and do engage in suicidal behaviour, underscoring the need for earlier recognition and targeted interventions. A national study in the United States identified 78 suicide deaths among children aged 6 to 9 years over a 15-year period, with most occurring at age 9.[67] The study highlights the need for early identification and intervention strategies, as well as further research into the developmental and environmental factors contributing to suicidality in this age group. Complementing these international findings, the Queensland child death register holds data dating back to 2004, including the suicide deaths of children as young as 9 years of age.

Numbers and rates of suicide deaths among young people generally increase with increasing age, as illustrated in Figure 6.1. For example, the rate of suicide for 12-year olds was 2.3 deaths per 100,000 while the rate for 17-year-olds was 9.7 deaths per 100,000 (5-year averages).

Figure 6.1: Numbers and rates of youth suicides in Queensland by single year of age, 2020–21 to 2024–25



Sex

Of the 24 young people who died by suicide in 2024–25, 12 were female and 12 were male. Over the last 5 years, the average suicide rate for males was 1.3 times the rate for females (4.6 deaths per 100,000 males aged 10–17 years, compared with 3.6 deaths per 100,000 females aged 10–17 years). While male youth suicide numbers have historically been higher than those of females, there have been 2 previous reporting periods over the past 20 years in which the number of female suicides exceeded that of males.

67 Mintz S, Dykstra H, Cornette M, Wilson RF, Blair JM, Pilkey D, and Collier A (2024) 'Characteristics and Circumstances of Suicide Among Children Aged 6 to 9 Years — United States, 2006–2021', *Pediatrics*, 154 (Supplement 3) e2024067043L, doi.org/10.1542/peds.2024-067043L

Figure 6.2 illustrates the trends in the male and female suicide rates since 2004. It reflects a slow increasing trend in the suicide rate for females, however the change did not reach statistical significance.

Figure 6.2: Youth suicide by sex (5-year rolling rate), 2004–09 to 2020–25

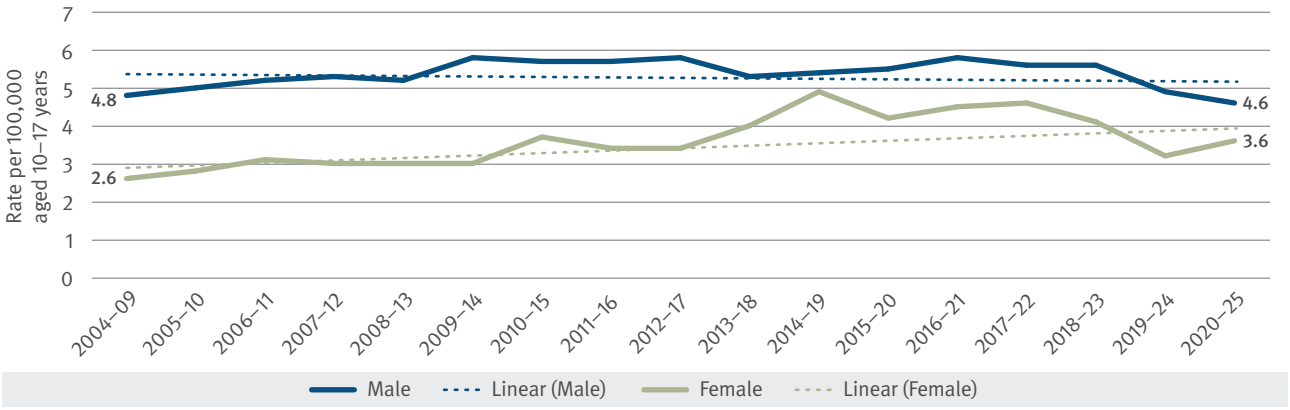
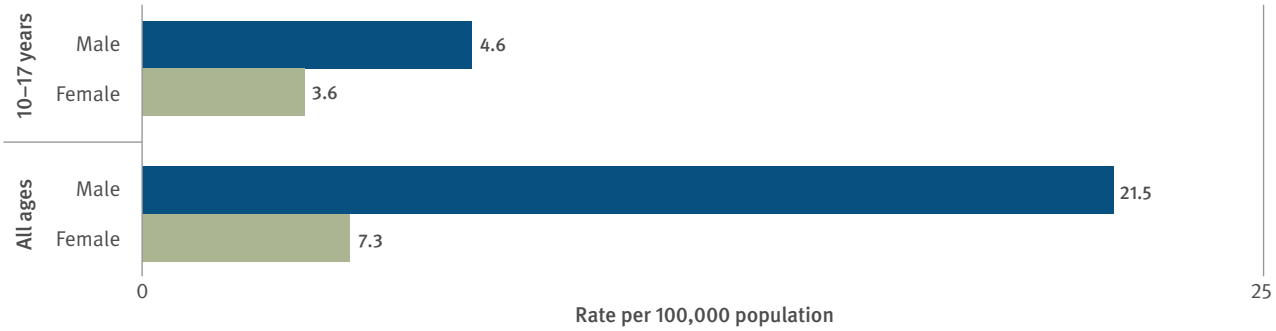


Figure 6.3 presents the male and female suicide rates in the youth population in contrast to the population level suicide rates by sex (age-standardised). It illustrates the much higher rate of male suicide in the 'all ages' data compared with the much closer male and female rates for 10–17-year-olds.

Figure 6.3: Male and female youth suicide rates (2020–25) and Queensland total suicide rates(2023, age-standardised)



Sources: QFCC Queendland Child Death Register; ABS (2024) Causes of Death, Queensland, 2023, 'Table 4.1: Underlying cause of death, All causes, Queensland, 2023', www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#data-downloads

Risk factors

Child maltreatment and adverse childhood experiences

Recent data from the AIHW indicates that one in 32 children in Australia came into contact with the child protection system in 2023–24. Of those, approximately one in 4 (7.3 per 1,000 children) resulted in findings of substantiated maltreatment. Emotional abuse was the most frequently substantiated type of abuse (57%), followed by neglect (21%), physical abuse (12%) and sexual abuse (9.1%).[68]

The National Health and Medical Research Council 2023 report, *The prevalence and impact of child maltreatment in Australia: Findings from the Australian child maltreatment study*, found that one in 4 16–24 year olds reported experiencing child maltreatment and that the abuse often occurred over a number of years. The report identified that young people aged 16–24 years who had experienced child maltreatment were at increased risk of developing cannabis dependence, attempting suicide, non-suicidal self-injury or developing a mental disorder.

68 AIHW (2024) *Family, domestic and sexual violence*, www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/child-protection

Other literature on suicide provides a relatively consistent account of the factors and life circumstances that are associated with youth suicide.[69] The *Adverse childhood experiences study* has led research showing strong relationships between adverse experiences in childhood (child maltreatment and household dysfunction, including substance abuse, parent mental illness, exposure to domestic violence and parent criminal behaviour) and health and social problems across the lifespan, with a link to depressive disorders.[70]

Information available indicated 11 of the 24 young people who suicided in 2024–25 had a history of alleged childhood abuse and neglect, with similar numbers of identification across the maltreatment types.

Household dysfunction was identified in 7 of the 24 suicide deaths of young people in 2024–25, with exposure to domestic violence identified as the most common.

Complex behaviours

Young people can engage in complex behaviours that go beyond what is developmentally appropriate. These behaviours may interfere with development and daily functioning, pose serious risks to the young person's health and safety, and impair healthy functioning. The behaviours often include self-harm and suicidal behaviours, verbal and physical assaults on others, destruction of property, engaging with adults who are considered exploitative, criminal behaviour, high-risk sexual behaviour, engaging in dangerous physical activities and substance dependency.

Self-harm and suicidal behaviour

Research into youth suicide shows that a history of self-harming behaviour, suicidal ideation and previous suicide attempts are associated with future suicidality. In relation to the 24 young people who died by suicide in 2024–25:

- At least one risk factor was present for 16 of the 24 young people who suicided.
- Eleven young people had previously engaged in self-harming behaviour, such as cutting.
- Fifteen had previously expressed suicidal thoughts (ideation).[71]
- Five had previously attempted suicide, with 2 young people attempting suicide on more than one occasion.
- There was no evidence of previous self-harm or suicidal behaviour for 8 young people.

Contact data from the 2024 Kids Helpline Impact Report indicated that one in 6 contacts made to the helpline were suicide-related and one in 13 involved concerns about self-injury and self-harm.[72]

Behavioural problems and offending

Thirteen of the young people who suicided in 2024–25 were identified as having exhibited behavioural problems or alleged offending, with aggression identified the most frequently followed by rule breaking, disciplinary problems with teachers and/or school, and alleged offending behaviour.

69 McDermott B (2021) *Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide*, Queensland Child Death Review Board, https://www.qfcc.qld.gov.au/board/publications

70 Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, and Anda RF (2004) 'Adverse childhood experiences and the risk of depressive disorders in adulthood', *Journal of Affective Disorders*, 82(2):217–225, doi.org/10.1016/j.jad.2003.12.013

71 Each young person with identified self-harm or suicidal behaviour may have exhibited more than one type of behaviour.

72 Kids Helpline (2023) *Kids Helpline impact report 2023*, www.kidshelpline.com.au/about/impact-report-2023

Alcohol and substance misuse

Eight of the 24 young people who suicided during 2024–25 was reported as having a history of alcohol, tobacco and/or substance use with the most commonly identified being with alcohol, cannabis and illicit stimulants.[73]

Mental health

A high proportion of mental illness has been found among young people who die by suicide. While mental health issues are prevalent among young people who suicide, many young people are treated for these conditions and only a very small number may go on to suicide.

Seven of the 24 young people who suicided during 2024–25 had a diagnosed mental health condition before their death. All 7 young people were known to have engaged with a healthcare professional and 6 had been prescribed medication for their condition/s. In 4 instances, there was information indicating that the young person had ceased taking their prescribed medication.

The range of mental health diagnoses included depressive disorders, anxiety disorders (including obsessive compulsive disorder), post traumatic stress disorder, oppositional defiant disorder, adjustment disorders and eating disorders. The most common diagnosed conditions were depressive and anxiety disorders. Five of the 7 young people were identified to have multiple mental health conditions (co-occurring conditions).

A further 10 young people were suspected to have a mental health issue. Two of those young people had engaged with a healthcare professional.

Neurodivergence

Neurodivergence refers to the natural variation in how people's brains function, particularly in areas such as thinking, learning, attention, and social interaction. The term is often used to describe individuals whose cognitive profiles differ from what is considered 'neurotypical', including autism, attention deficit hyperactivity disorder, Tourette's syndrome, dyspraxia, dyslexia, dyscalculia and other learning disabilities.

In 2022, an estimated 4.3% of Australian children aged 5–14 years were identified as autistic, reflecting a continued increase in prevalence from 3.2% in 2018, with rates notably higher among males (6.1%) than females (2.3%).[74]

Autistic children and adolescents face a significantly higher risk of suicidal thoughts and behaviours compared to their neurotypical peers. A recent review found that over a quarter of autistic youth report suicidal ideation, with a notable proportion also attempting suicide.[75] This heightened risk is linked to co-occurring mental health conditions, social isolation, and interpersonal challenges. The vulnerability is even greater among autistic youth who are also gender diverse.

Six of the 24 young people who suicided during 2024–25 were described as neurodivergent.

Over the 5-year period from 2020–25, 20 of the 115 children who died by suicide were neurodivergent, representing 17% of cases. Attention deficit hyperactivity disorder (ADHD) and autism were the most commonly identified neurotypes, and 6 of these children were reported to have co-occurring neurodevelopmental differences.

73 Previous or current use of alcohol or drugs identified by friends, family members or in toxicology findings.

74 ABS (Australian Bureau of Statistics) (2023) *Autism in Australia, 2022*, www.abs.gov.au/articles/autism-australia-2022

75 Brown CM, Newell V, Sahin E, and Hedley D (2024) 'Updated Systematic Review of Suicide in Autism: 2018–2024', *Current Developmental Disorders Reports*, 11, 225–256, doi.org/10.1007/s40474-024-00308-9

Cohorts in youth suicide

The *Adverse childhood experiences study* and the *Australian child maltreatment study* both highlight the risks to future health outcomes for those who have a history of adverse childhood experiences, including the increased risk of suicidal behaviour. While the cohort of young people who experience these adversities accounts for a significant proportion (46%), it appears that there are a number of other distinct groups within youth suicides.

Figure 6.4 provides a summary of the adverse childhood experiences, mental health diagnoses and complex behaviours identified for the 115 young people who suicided in Queensland in the last 5 years. This overview is based on information available to the Commission and may therefore under-represent the actual circumstances for the children and young people.

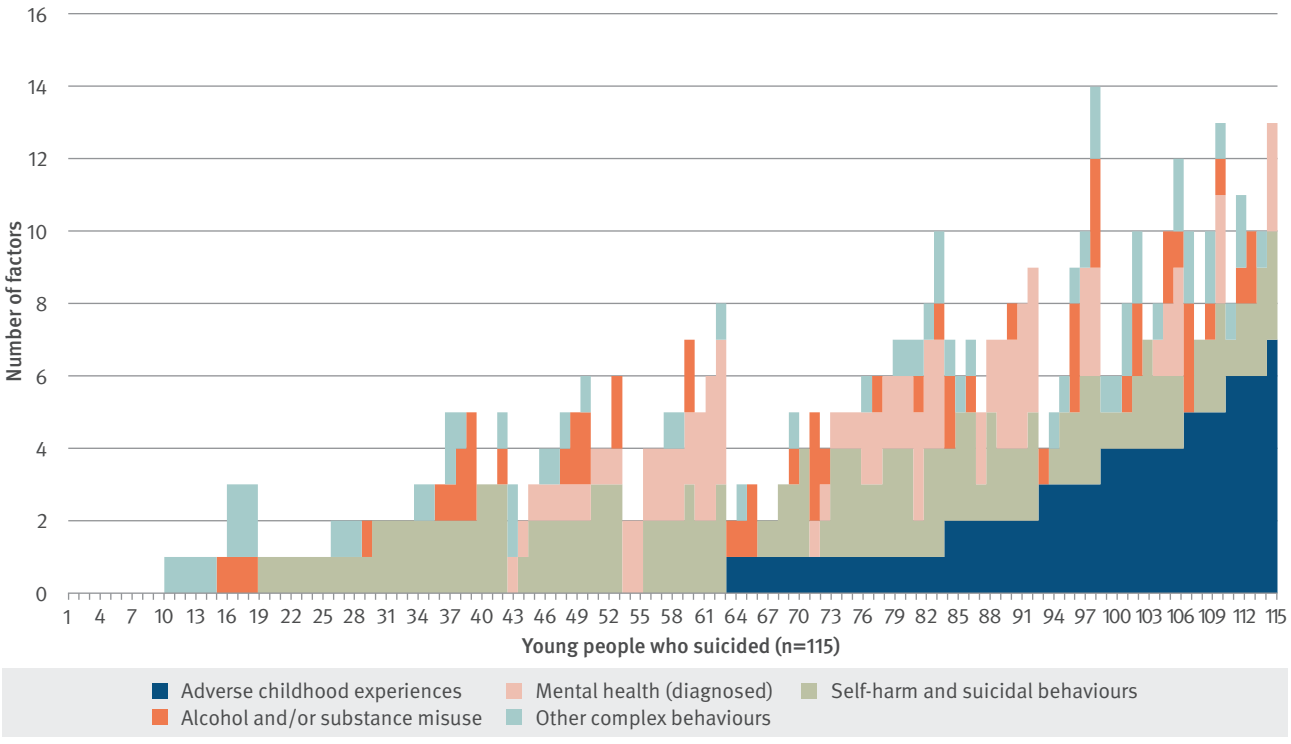
Across the cohort, 41% had a diagnosed mental health condition, 77% had a history of self-harm, suicidal ideation and/or prior suicide attempts, 34% had a history of alcohol and/or substance misuse, and 45% had other complex behaviours.

The data in Figure 6.4 shows a number of groups, based on the experiences of those young peoples' lives:

- Young people who have a history of adverse childhood experiences with, for most, co-occurring diagnosed mental health conditions and/or complex behaviours (46%).
- Young people with diagnosed mental health conditions with, for most, co-occurring complex behaviours (18%).
- Young people who demonstrate complex behaviours (29%) without other risk factors.
- Young people without any identified risk factors (7%).

The data highlights the importance of intervention and prevention strategies tailored to the life experiences of children and young people.

Figure 6.4: Adverse childhood experiences, diagnosed mental health conditions and complex behaviours in youth suicides (number), 2020–21 to 2024–25



Stressful life events and precipitating incidents

Life stressors are events or experiences which produce significant strain on an individual; they can occur at any stage over the course of a person's lifetime and vary in severity and duration. Life stressors differ from precipitating incidents as they are more likely to occur in the background with strain accumulating over a period of time.

Precipitating incidents refer to events or stressors which occur prior to a suicide and which appear to have influenced the decision for a person to end their life. Most precipitating incidents will occur in the hours, days or weeks prior to death. Bereavement can be considered a precipitating incident, with an arbitrary timeframe of up to 6 months between the death of the family member or friend and the suicide of the young person.

School-related stressors and signs of psychological distress

Fifteen of the 24 young people who suicided during 2024–25 had documented experiences of school-related stressors, including transitions in education, disciplinary action by teachers or schools and academic or achievement-related stress. Further, 6 of the 24 young people were noted to have been experiencing difficulties with school engagement; with chronic absenteeism, non-participation and truancy identified.

The Australian Institute of Family Studies' research snapshot on *Suicidal Thoughts and Behaviours in Adolescence* highlights several school-related stressors and indicators of disengagement that are associated with youth suicide risk.[76] Drawing on data from *Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC)*, the report identifies that suicidal behaviours tend to increase during adolescence—a period marked by significant social, emotional, and educational transitions. Among young people who reported suicidal thoughts and behaviours, many also experienced complex life challenges, including academic pressure, school disengagement, and bullying. These findings suggest that difficulties within the school environment—such as feeling disconnected, struggling academically, or being targeted by peers—may co-occur with suicidal distress and should be considered in prevention and early intervention strategies.

Digital psychosocial stressors

Understanding the influence of a digital world on children's relationships, connections, wellbeing and functioning is complex. Research suggests that underlying social and psychological challenges like low self-esteem, social isolation, or identity struggles can be worsened by harmful online experiences for children. When used positively, digital platforms can offer children connection, support, and resources. They can be used by children experiencing mental health concerns to seek help, support, understanding and information about their worries and symptoms.[77]

Increasingly more research is emerging on the study of children's social and mobile media use, in particular 'digital stress', and its association with adolescent socioemotional and psychosocial wellbeing and functioning. Digital stress includes, approval anxiety, availability stress, fear of missing out, connection overload and online vigilance.[78]

76 Australian Institute of Family Studies (2023) *Research snapshot: Suicidal thoughts and behaviours in adolescence*, https://aifs.gov.au/growing-australia/research/research-snapshots/suicidal-thoughts-and-behaviours-adolescence

77 Christensen H, Slade A, and Whitton AE (2024) 'Social media: the root cause of rising youth self-harm or a convenient scapegoat?', *Medical Journal of Australia*, Volume 221 (10), pp. 524-526, doi.org/10.5694/mja2.52503

78 Khetawat D and Steele RG (2024) 'Examining the association between digital stress components and psychological wellbeing: A meta-analysis', *Clinical child and family psychology review*, Volume 26, pp. 957-974, doi.org/10.5694/mja2.52503

Digital psychosocial stressors have been identified for 8 of the 24 young people who died by suicide, with documented experiences involving high levels of digital content consumption, use of digital platforms without parental consent, exposure to illicit content, involvement in sending or receiving sexually explicit material, experiences of cyberbullying, or being victims of sextortion.

According to the *Kids Helpline Impact Report 2024*, one in 7 contacts from children aged 10 to 14 seeking support for bullying (including cyber-bullying) also reported suicidal thoughts.[79]

Sextortion is an increasingly prevalent digital threat in Australia, with offenders primarily targeting teenage boys by coercing them into sending sexual images and threatening to share them unless payment is made. In 2024, Kids Helpline received 432 contacts related to sextortion—up from 367 in 2023—with young males aged 13 to 25 accounting for 85% of all sextortion-related counselling contacts.[80]

These findings highlight the importance of coordinated policy, education, and platform accountability to protect children from digital harms.[81]

In December 2025, Australia will implement a world-first social media age restriction law, *Online Safety (Age-Restricted Social Media Platforms) Rules 2025*, prohibiting children under 16 from holding accounts on platforms such as Facebook, Instagram, TikTok, Snapchat, X, and YouTube, in an effort to reduce exposure to harmful online content and improve youth wellbeing.

Clinicians working with children should be encouraged to assess digital media use in the context of a child's overall psychological and social functioning, and in consideration of a child's specific uses of digital media.[82]

Contagion

Contagion refers to the process by which a prior suicide or attempted suicide of a family member or friend facilitates or influences suicidal behaviour in another person. Contagion was identified in 2 youth suicides during 2024–25.

Other factors

Outside of adverse childhood experiences, the most common stressors and precipitating incidents evident for young people who suicided in 2024–25 included: parental separation (13); arguments with family members, intimate partners or friends (7); poor intra-familial relationships (7); relationship breakdowns (6); and social isolation (6).

79 Yourtown (2024) *Kids Helpline Impact Report 2024*, https://ytn-p-001.sitecorecontenthub.cloud/api/public/content/61b0c5d568434b1a9fa9881bc4a12884?v=b2a569f9

80 Yourtown (2024) *Kids Helpline Impact Report 2024*, https://ytn-p-001.sitecorecontenthub.cloud/api/public/content/61b0c5d568434b1a9fa9881bc4a12884?v=b2a569f9

81 Australian Policy Observatory (2025) *A precautionary approach to social media: protecting young minds in an evolving digital world*. https://apo.org.au/sites/default/files/resource-files/2025-08/apo-nid331769.pdf

82 Steele RG, Hall JA, and Christofferson JL (2020) 'Conceptualizing digital stress in adolescents and young adults: Toward the development of an empirically based model', *Clinical child and family psychology review*, Volume 23, pp. 15-26, doi.org/10.5694/mja2.52722

Queensland Ambulance Service data

This year, a new and improved methodology was introduced by QAS to identify suicidal behaviour and self-harm related incidents. The updated approach is more accurate, rigorous, and robust, resulting in a higher number of identified cases than reported in previous years across. Queensland Ambulance Service (QAS) data indicates in the last year over 11,000 ambulance responses occurred for suicidal behaviour and self-harm-related incidents involving children, including both fatal and non-fatal injuries (see Table 6.1). Female patients accounted for 65% of responses.

Table 6.1: Queensland Ambulance Service responses to self-harm and suicidal behaviour incidents (number), 2024–25

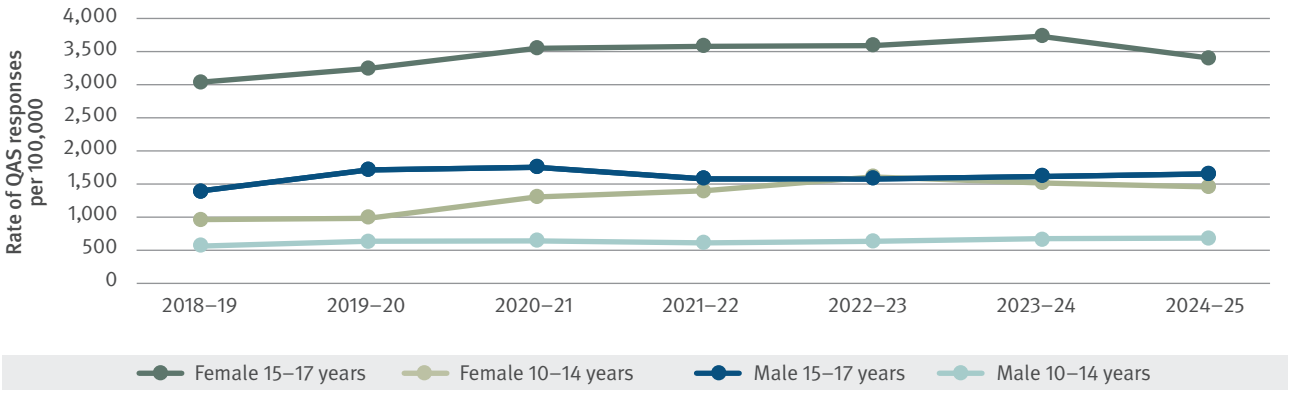
Age	Female	Male	Not specified	Total
5–9 years	149	242	0	391
10–14 years	2,891	1,359	46	4,296
15–17 years	4,395	2,206	64	6,665
Total	**7,435**	**3,807**	**64**	**11,352**

Data source: Queensland Ambulance Service (Aug 2025)

Notes: Not specified includes cases where gender was recorded as indeterminate or missing.

Figure 6.5 presents the rate of Queensland Ambulance Service (QAS) responses for self-harm and suicidal behaviours over the past 7 years. To enable accurate trend analysis, the data shown is based on the previous methodology reported on in past annual child death reports. The rate for females aged 15–17 years has consistently remained substantially higher than all other demographic groups. While rates for males in both age groups have remained relatively stable over this time period, rates for females have shown more variability. In particular, rising rates were observed in females aged 15–17 years in earlier years, followed by a slight decline in the most recent reporting period.

Figure 6.5: Queensland Ambulance Services responses to self-harm and suicidal behaviour incidents (rate per 100,000), 2018–19 to 2024–25



Data source: Queensland Ambulance Service (Aug 2025)

Notes: Excludes cases where gender was recorded as indeterminate or missing. Rates are calculated for each financial year per 100,000 children in each age/sex category.

Learnings

2025 Australian and New Zealand Child Death Review and Prevention Conference

Beyond Band-Aid Solutions: Multifactorial approaches to understanding and addressing youth suicidality

Grace Sholl
Suicidologist and lived experience advocate

Grace Sholl opened the 2025 Australian and New Zealand Child Death Review and Prevention Conference, hosted by the Commission in May, with *Beyond Band-Aid Solutions: Multifactorial approaches to understanding and addressing youth suicidality*. Grace proposed that suicide prevention must be designed by and for young people. She anchored her case in stark national figures—3.3 million Australians over 16 years of age will experience serious suicidal thoughts, 1.5 million will plan to suicide and 970,000 will attempt suicide. Grace noted that sexually diverse youth and those diagnosed with depression or attention deficit hyperactivity disorder (ADHD) face earlier onset and faster progression of suicidal behaviour.

The presentation highlighted how critical data gaps and inconsistent reporting across Australian jurisdictions mask the true numbers for repeated suicide attempts, non-fatal crises and probable suicides. Consequently, limitations in data can impede policy evaluation and targeted intervention. For Queensland, the Commission provides a robust breakdown by age, gender, intent and risk factors for children who have died by suicide, whereas, other jurisdictions tend to publish basic demographics.

Service delivery systemic shortcomings, where featured and included, pooled mental-health budgets that favour "marketable" programs over dedicated suicide support; almost non-existent crisis services for children under 16 years of age; and a lack of youth-specific training resulting in some clinicians who then tend to over-hospitalise young people often resulting in further traumatisation. In addition, ethical and funding barriers stifle life-saving research, sensationalist media deepens the stigma associated with mental health, and standard clinical tools fail to capture the complex, fluctuating nature of youth suicidality.

Grace proposed a multifactorial prevention model—combining universal upstream strategies, targeted interventions and ongoing lived-experience research, alongside an expansion of peer-led, community-based supports. She spotlighted the STARS framework (Systematic Tailored Assessment for Responding to Suicidality), a semi-structured, person-centred tool co-designed with young people to map psychosocial stressors, co-create safety plans and address long-term risk factors.

The presentation concluded with Grace recommending embedding youth co-design in all service development, a national standardisation of suicide reporting metrics, dedicated funding and specialist training for youth suicide prevention, and promotion of community-centred interventions alongside clinical care. By centring young people's expertise and autonomy, stakeholders can replace temporary fixes with sustainable, effective solutions.

View the presentation: www.qfcc.qld.gov.au/2025/ANZCDRPG-Conference

Learnings

2025 Australian and New Zealand Child Death Review and Prevention Conference

Understanding the links between childhood domestic and family violence exposure and youth suicide risk

Professor Silke Meyer
Leneen Forde Chair in Child and Family Research

Maria Atienzar
School of Health Sciences and Social Work, Griffith University

Professor Silke Meyer and Maria Atienzar-Prieto presented at the 2025 Australian and New Zealand Child Death Review and Prevention Conference on a research study funded by the Queensland Mental Health Commission. The study delved into the lived experiences of young people who were exposed to domestic and family violence (DFV) during childhood and later died by suicide. Conducted by Griffith University, the study aimed to understand the long-term psychological consequences of early trauma, particularly how DFV impacts mental health, coping capacity, and overall life outcomes.

By analysing detailed case data, the study uncovered recurring patterns that revealed heightened vulnerability among children exposed to DFV—manifesting in emotional dysregulation, impaired stress response, and increased isolation. These factors, when left unaddressed, significantly elevated suicide risk. The research highlighted DFV as not merely a momentary disruption but a chronic condition with lasting developmental consequences.

The presentation concluded with a call for trauma-informed frameworks within healthcare, education and social services, in conjunction with proactive, integrated support systems that prioritise early intervention, mental health care, and community-based resources to help build resilience. In addition, policymakers were urged to adopt reforms that acknowledge the intersection of childhood trauma and suicide, with particular attention to improving data-sharing mechanisms and tailoring services to the needs of vulnerable youth populations.

View the presentation: www.qfcc.qld.gov.au/2025/ANZCDRPG-Conference

Publication of the full report is still in progress and will be launched by the Queensland Mental Health Commission in the future. In the meantime, an earlier report which informed this study can be accessed at https://research-repository.griffith.edu.au/items/cb3d3321-519f-4449-bdb1-75440427adf5