CHILD DEATH REGISTER
KEY FINDINGS 2017–18
Youth suicide in Queensland

Queensland
Family & Child
Commission

During 2017–18, 24 young people aged under 18 years died of suicide in Queensland. Suicide was the equal leading external (non-natural) cause, with transport incidents, of child death. The annual suicide rate averaged over the 14-year period since 2004 was 1.9 deaths per 100 000 aged 0–17 years.

Key findings 2015–16 to 2017–18

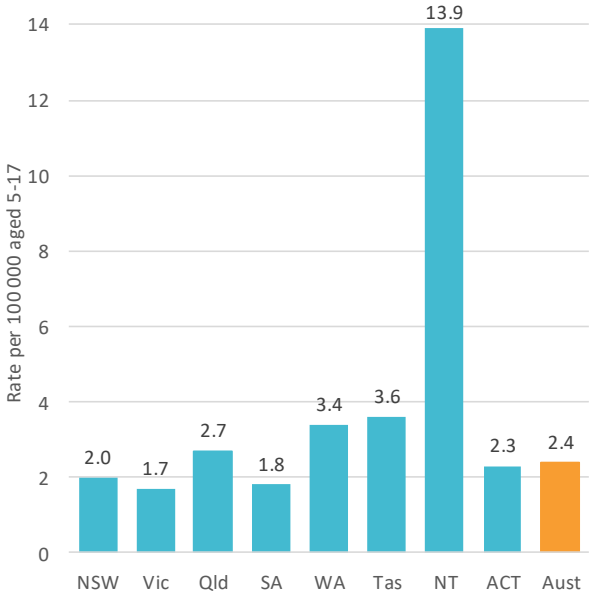
Over the three years to June 2018, data from the Queensland Child Death Register showed that 64 young people died of suspected or confirmed suicide:

- 37 **males** and 27 **females** took their own lives. The suicide rate for males was 1.3 times the rate for females (respectively 4.9 and 3.8 deaths per 100 000 aged 10–17 years).
- 73% (47 of 64) were **aged 15–17 years** while 25% (16 of 64) were **aged 10–14 years** (respectively rates of 8.5 and 1.7 deaths per 100 000 in age group).
- The suicide mortality rate for **Indigenous** young people was 2.8 times higher than **non-Indigenous** young people (respectively 10.8 and 3.8 deaths per 100 000 aged 10–17 years).
- The suicide mortality rate for children **known to the child protection system** was three times the Queensland average (respectively 5.9 and 1.9 deaths per 100 000 aged 0–17 years).

National comparison

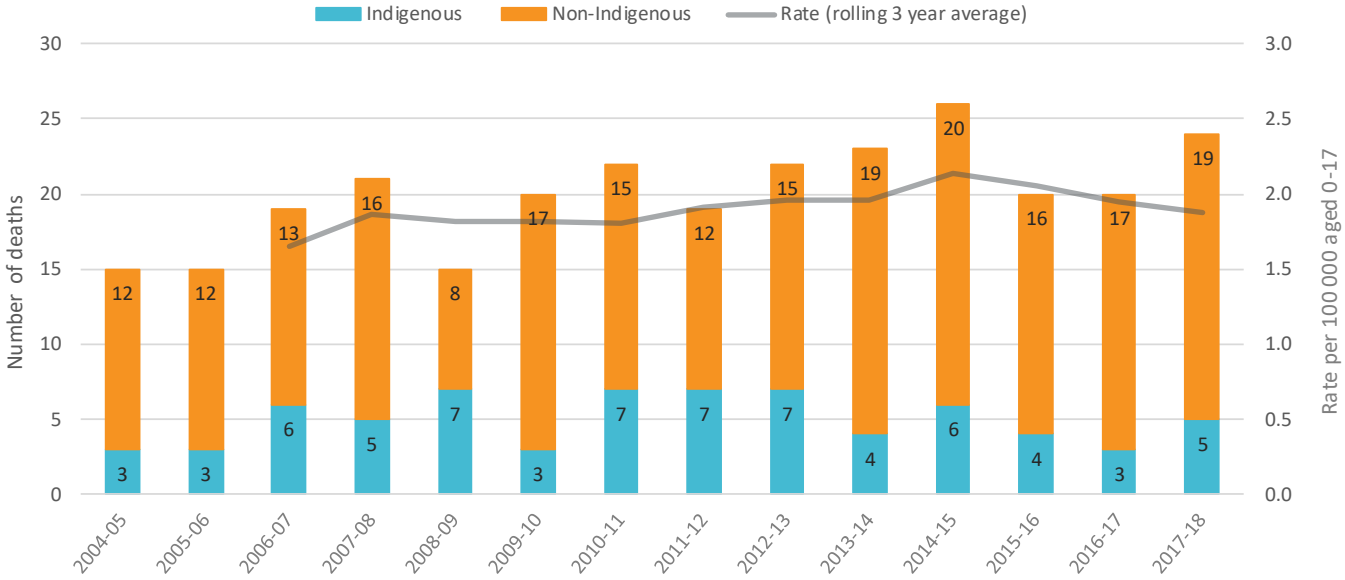
Queensland had the fourth-highest rate of youth suicide deaths nationally and was above the nation average rate of youth suicide in the period 2013–2017.

Figure 2. Intentional self-harm death rate, children aged 5–17 years, by state and territory 2013–2017



Source: Australian Bureau of Statistics, 3303.0 *Cause of Death, Australia, 2017*

Figure 1. Suicide deaths of children and young people by Indigenous status, 2004–05 to 2017–18



Source: Queensland Child Death Register

1. Rates (deaths per 100 000 population aged 0–17 years) are averaged over three-year periods (reference year and two preceding years).

Risk factors – five years to June 2018

The literature on suicide provides a relatively consistent account of the factors and life circumstances that are associated with youth suicide.[1,2]

- Research into youth suicide shows that a history of self-harming behaviour, suicidal ideation and previous suicide attempts are associated with future suicidality.
- A high proportion of mental illness has been found among young people who die by suicide.
- Childhood abuse and exposure to domestic violence have been found to be potential risk factors for future youth suicides.

Suicidal behaviours in young people are often not the result of a single cause, and multiple stressors and adverse life experiences may be present. Most suicides; however, cannot be predicted.[3] While mental health issues are prevalent amongst young people who suicide, many young people are treated for these conditions and only a very small number may go on to suicide.

The Queensland Family and Child Commission (QFCC) collects information from coronial reports and other sources on the risk factors and life circumstances present for young people who died by suicide. The following sections outline the analysis of these factors and other adverse life circumstances for the 113 young people who suicided in the five years to June 2018.

Self-harm, suicidal ideation and previous suicide attempts

The Child Death Register shows that 58% (66 of 113) of young people who died by suicide expressed thoughts of suicide (suicidal ideation) prior to death. Further, 41% (46) of young people had a history of self-harming behaviour, and 30% (34) had previously attempted suicide. Young people may have one or more of the factors present.

Mental health

Of young people who died by suicide 74% (84 of 113) had a diagnosed and/or a suspected mental health disorder (both a known and a suspected mental health disorder may be present). Thirty-nine per cent (44) of the young people had a diagnosed mental health disorder, while 40 young people were suspected to have a mental health disorder which had not been diagnosed.

Children known to the child protection system

Of the 113 suicides, 35% (40) of children and young people were known to the Queensland child protection system within the year[4] before their death. An increased risk of suicide has been identified among children and young people known to child protection agencies.

Precipitating incidents and stressful life events – five years to June 2018

Precipitating incidents and stressful life events were often found to be present in young people who died by suicide. Analysis of the circumstances of the 113 youth suicides found:

- 64% (72) experienced **conflict** in personal relationships with intimate partners, family or friends
- 65% (73) experienced **personal loss** of someone or something
- 43% (49) experienced **family stress** such as domestic or family violence, homelessness, or familial alcohol or substance abuse
- 40% (45) experienced **social stress**, such as illness or disability, school stress, sexual identity or gender issues.

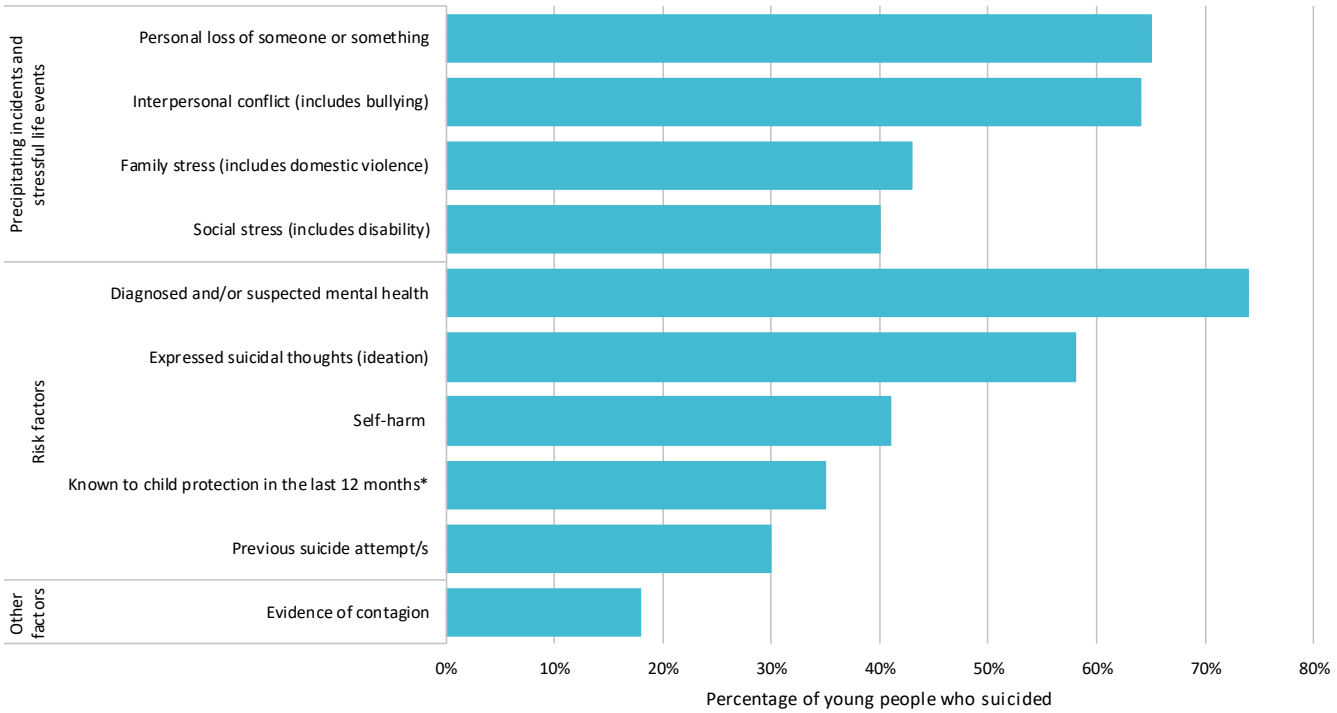
Of young people who suicided, 8% (9 of 113) were identified as having a **disability**. The most common disability noted was being on the autism spectrum.

Bullying (recent or historical) was noted as a possible factor for 16% (18 of the 113 deaths) of youth suicides.[5] Experiencing bullying can significantly exacerbate suicide risk factors already present, such as mental health issues, while reducing help-seeking behaviours and the influence of protective factors.

Evidence of **contagion** influences, where a family member or peer had suicided, was found for approximately 18% (20 of the 113 deaths) of suicide deaths of children and young people in Queensland over the last five years.

[1] Commission for Children and Young People and Child Guardian (2009) *Reducing Youth Suicide in Queensland discussion paper*.
[2] Robinson, J & Rice, S. (2015) *Suicide and self-harm in young people.*
[3] Scott J, Ryan A, Hielscher E, & Thomas H (2018) *Suicide in children and adolescents in Queensland 2004-2015*, QFCC Research Summary.
[4] For 2013–14, the child was known to child protection in the 3 years before death (i.e. the statutory review period applicable at the time).
[5] Bullying is also counted as experiencing personal conflict.

Figure 3. Youth suicide deaths by presence of risk factors and adverse life circumstances, 5 years to June 2018



Source: Queensland Child Death Register (2013–14 to 2017–18)
* For the first year, 2013–14, this category includes children known to child protection in the 3 years before death, as this was the statutory review period applicable at the time.
1. Young people may experience more than one risk factor or life circumstance.
2. Evidence of contagion may also be represented in interpersonal loss due to the death of a family member or friend.

Prevention strategies

Mental health services are a key focus for prevention. Youth-oriented or specialist mental health services are needed by young people who experience anxiety, depression and other mental health issues in their teenage years, including:

- services that are affordable and acceptable to young people
- counsellors trained and experienced to connect with young people
- services that are easily accessible, particularly for young people who lack parental support
- emergency responses that do not involve police and avoid hospitalisation as much as possible.

Approaches need to be multifaceted and tailored to address different life stages, settings and risk groups.

Intervening early with young people who experience trauma, such as childhood maltreatment, or who disengage from school or other supports, may help to reduce risk factors for the young person while also helping them to overcome early adversity.

Prevention and intervention activities need to specifically consider the different needs and resources available for Aboriginal and Torres Strait Islander young people living in regional and remote areas.

Schools play a key role in supporting young people, including through programs that build mental wellbeing and resilience and address bullying behaviours. Parents, teachers and young people need to be provided with information on warning signs and how to help a young person if they are concerned.

We also know that young people at risk of suicide may have had adverse experiences and multiple stresses in their lives. These may bring them into touch with government services notably: police, ambulance, youth justice, domestic and family violence, drug and alcohol, housing and, very commonly, child protection services.

Frontline staff need to be equipped with ‘mental health first aid’ skills to identify and respond to young people in distress. Communication within and between government agencies and community services needs to be strong to ensure the coordination of resources provided to young people, especially for those who lack parental support.

Building the evidence base of suicide and intentional self-harm and continued research and investigation will extend our understanding of risk factors and any underlying barriers to effective suicide prevention.

Government focus on suicide prevention

The Queensland Government's *Our Future State - Advancing Queensland's Priorities*, sets out the key areas for action to 2026. Our Future State includes a strong focus on mental health, and one of the major priorities is to reduce suicide rates.

The whole-of-government work is being driven through the *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023*, led by the Queensland Mental Health Commission.

Notes and definitions

More detailed definitions and methodology can be found in the latest of the QFCC's annual reports on child deaths at www.qfcc.qld.gov.au/kids/preventing-child-injury-death/child-death-reports-data

Bullying – repeated hurtful behaviour which involves a power imbalance (includes physical, verbal, cyber, or covert i.e. spreading rumours, gossiping).

Contagion – where a prior suicide or attempted suicide of a family member or peer may have influenced suicidal behaviour in another person.

Data – analysis in this paper are based on data extracted from the Child Death Register in March 2019.

Family stress – stressors that put real or perceived demands on, or cause interpersonal conflict for, an individual. Examples include poor intra-familial relationships, parental abandonment, familial alcohol or substance use or psychopathology, or financial problems, or domestic and intimate partner violence.

Interpersonal conflict – conflict in personal relationships, including issues with intimate partners, family, friends or acquaintances, and bullying.

Known to the child protection system – a child for whom, in the year before their death (if after June 2014), the Department of Child Safety, Youth and Women was notified of and/or took action about concerns or risk of harm to the child, or the child was in the custody or guardianship of the department. The statutory period of review was changed from three years to one year in July 2014. In the analysis of risk factors and adverse circumstances, deaths in the year 2013–14 were counted as 'known' if contact with protection services was in the three years before death.

Personal loss – loss or perceived loss of something, someone or a number of individuals and includes the death of a loved one (including pets), loss of social supports (often due to transitions), and parental divorce or separation.

Self-harm – deliberate destruction of one's own body tissue and can be suicidal or non-suicidal in intent. It does not include self-harm done for religious or cultural purposes, such as rites of passage.

Social stress – any stressors that may have impacted on the young person, such as illness or disability, unemployment, school stress, body image issues, sexual identity or gender issues, or pregnancy.

Stressful life event – an event that occurred over the course of the child's life, with the stressor first occurring more than six months before death, and usually of a more chronic or longstanding nature.

Suicide – deaths resulting from a voluntary and deliberate act against oneself, where death is a reasonably expected outcome of such act. This includes confirmed suicide and suspected suicide (where the available information is not conclusive on intent, but is more consistent with death by suicide than by any other means).

Suicidal ideation – the explicit communication of having thoughts of suicide.

Suspected mental health disorder – symptoms displayed by a person that may relate to a mental health disorder, but there is no evidence a diagnosis has been given.

Postvention – provision of crisis intervention, support and assistance for those affected by suicide.

Suicide rates – based on the most up-to-date population data available and are calculated per 100 000 children (in the sex/age/Indigenous status) in Queensland each year.

Sources

The Queensland Child Death Register contains information sourced from: Queensland Registry of Births, Deaths and Marriages; the Office of the State Coroner; the Queensland Police Service; Queensland Health; the Department of Child Safety, Youth and Women (DCSYW); the National Coronial Information System; and the Australian Bureau of Statistics (ABS).

Data for prevention activities

The QFCC contributes to child death prevention by providing detailed data to researchers. The QFCC also has a formal arrangement with the Department of Education to provide alerts of suspected suicide deaths, supporting postvention and management of contagion influences in school settings.

QFCC can provide detailed child death data to researchers and organisations, at no cost. Please email child_death_prevention@qfcc.qld.gov.au

Reports on child deaths and 14-year data tables can be found at www.qfcc.qld.gov.au/kids/preventing-child-injury-death/child-death-reports-data