

# CHILD DEATH REGISTER

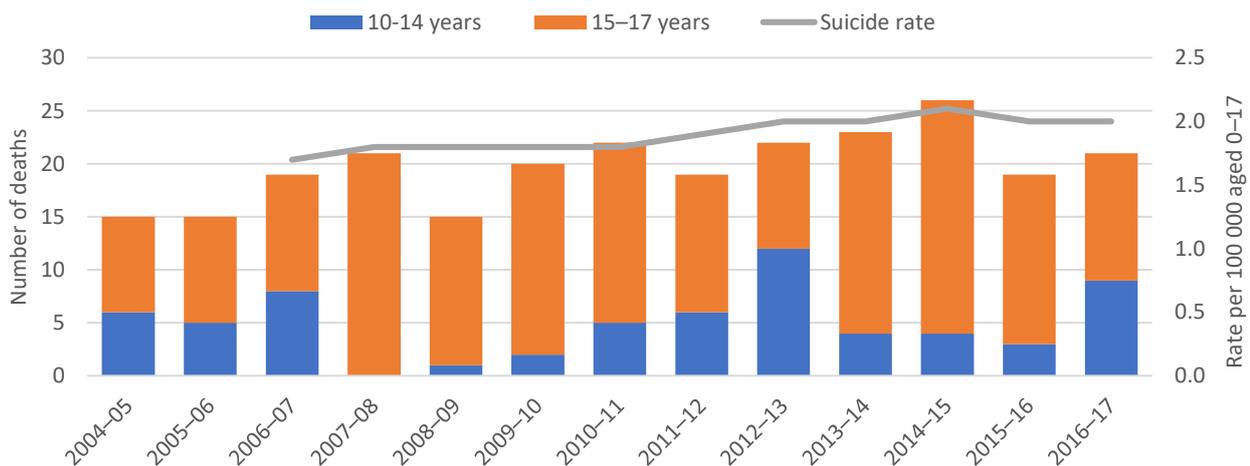
## KEY FINDINGS

### Youth suicide in Queensland

Queensland  
Family & Child  
Commission

The Queensland Child Death Register recorded 257 suicide deaths of children and young people aged 9–17 years between July 2004 and June 2017. During 2016–17 there were 21 suicides of young people, making suicide the leading external (non-natural) cause of death in 2016–17, ahead of drowning and transport (19 and 14 deaths respectively). The annual suicide rate averaged over the 13 year period was 1.9 deaths per 100 000 aged 0–17 years.

**Figure 1. Suicide deaths of children and young people by age, 2004–05 to 2016–17**



Source: Queensland Child Death Register (2004–2017)

1. The 10–14 years age group includes one death in 2010–11 of a child aged under 10 years.

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

### Key findings 2012–13 to 2016–17

Over the five years to June 2017, data from the Queensland Child Death Register showed that 112 young people died of suspected or confirmed suicide:

- 72 **males** and 40 **females** took their own lives. The suicide rate for males was 1.7 times the rate for females (respectively 6.0 and 3.5 deaths per 100 000 aged 10–17 years).
- 71% (79 of 112) were **aged 15–17 years** while 29% (33 of 112) were **aged 10–14 years** (respectively rates of 8.8 and 2.3 deaths per 100 000 in age group).
- The suicide mortality rate for **Indigenous** young people was 3.3 times higher than **non-Indigenous** young people (respectively 13.3 and 4.0 deaths per 100 000 aged 10–17 years).
- The suicide mortality rate for children **known to the child protection system** was more than five times the Queensland average (respectively 11.5 and 2.0 deaths per 100 000 aged 0–17 years, based on deaths in the three years to June 2017).

### Risk factors

The literature on suicide provides a relatively consistent account of the risk factors and adverse life circumstances that are associated with youth suicide.<sup>1,2</sup>

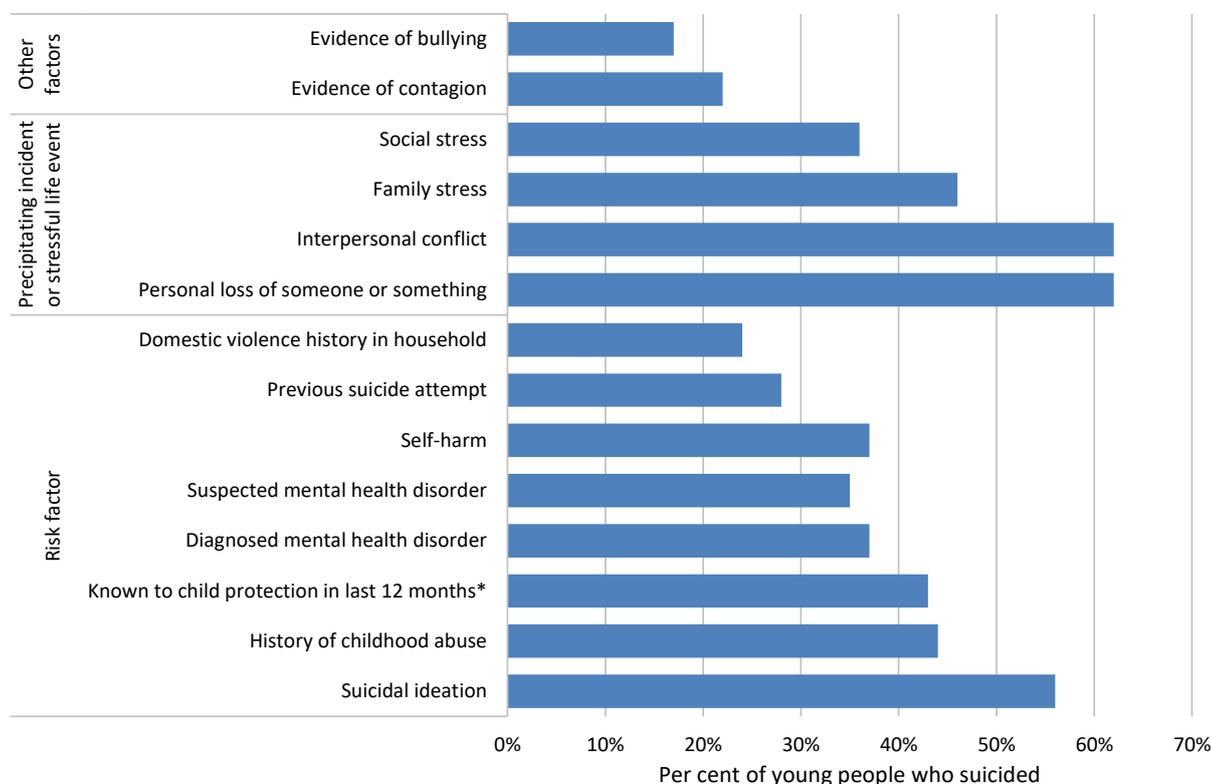
- Research into youth suicide shows that a history of self-harming behaviour, suicidal ideation and previous suicide attempts are strong predictors of future suicidality.
- A high frequency of mental illness has been found among young people who die by suicide.
- Childhood abuse and exposure to domestic 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, but are multiplicative and interact with each other. The Queensland Family and Child Commission (QFCC) collects information from coronial reports and other sources on the risk factors and life circumstances present in young people who die by suicide. The following sections outline the analysis of these factors and other adverse life circumstances in young people who suicided in the five years to June 2017.

<sup>1</sup> Commission for Children and Young People and Child Guardian (2009) *Reducing Youth Suicide in Queensland discussion paper*

<sup>2</sup> Robinson, J & Rice, S. (2015) *Suicide and self-harm in young people*

**Figure 2. Youth suicide deaths by presence of risk factors and adverse life circumstances, July 2012 to June 2017**



Source: Queensland Child Death Register (2012–13 to 2016–17)

\* This category relates to suicide deaths in the period from July 2014 to June 2017.

1. Young people may experience more than one factor. Factors are not exclusive, in that individual circumstances may be represented under multiple factors (e.g. the suicide death of a parent may be included as personal loss, family stress and evidence of contagion).

### Self-harm, suicidal ideation and previous suicide attempts

The Child Death Register shows that 56% (63 of 112) of young people who died by suicide expressed thoughts of suicide (suicidal ideation) prior to death. Further, 37% (41) had a history of self-harming behaviour.

Of the 112 suicides, 28% (31) of young people had previously attempted suicide.

### Mental health

Of young people who died by suicide 37% (41 of 112) had a diagnosed mental health disorder and 35% (39) had a suspected mental disorder.<sup>3</sup>

### Childhood abuse and domestic violence

A history of childhood abuse was present for 44% (49 of 112) of young people who died by suicide and 24% (27) had experienced domestic violence in their household.

### Precipitating incidents and stressful life events

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 112 youth suicides found:

- 62% (69) experienced personal loss of someone or something
- 62% (69) experienced conflict in personal relationships with intimate partners, family or friends
- 46% (51) experienced family stress such as domestic or family violence, homelessness, or alcohol or substance abuse
- 36% (40) experienced social stress, such as illness or disability, school stress, sexual identity or gender issues.

<sup>3</sup> Young people may have both a known and a suspected mental health disorder.

## Bullying

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.

Bullying (recent or historical) was noted as a possible factor for 17% (19 of the 112) of youth suicides.

A multifaceted approach is needed in response to bullying, including educating children, young people, care givers and the community about bullying and its consequences, and emphasising that the behaviour is unacceptable and should not be tolerated.

## Contagion

One of the key findings in global youth suicide research is that suicides can occur in clusters.<sup>4</sup> One of the suggested causes of suicide clusters is contagion. Suicide clusters and contagion are most commonly observed in young people.<sup>4</sup>

Evidence of contagion influences, where a family member or peer had suicided, was found for approximately 22% (25 of the 112 deaths) of suicide deaths of children and young people in Queensland over the last five years.

## Prevention strategies

Prevention strategies need a focus on:

- reducing suicide risk and enhancing protective factors for the child through intervention frameworks that recognise and engage with the different environments of a child's life
- school programs that improve mental health, build resilience and address bullying behaviours
- providing children and young people who are feeling suicidal with access to a range of support from family and the community, the workplace, professional carers and health services
- providing parents, teachers and young people with information on warning signs and how to help a young person if they are concerned
- developing and delivering prevention and intervention activities that are tailored to specifically consider the different needs and resources available for Aboriginal and Torres Strait Islander young people living in regional and remote areas
- strengthening collaboration within and between government agencies and community services to improve the coordination of resources, information and activities

- improving community understanding of the needs of people with a mental illness by educating and providing information to immediate family, friends, social networks, work colleagues, and local health and community service professionals
- extending our understanding of risk factors and any underlying barriers to effective suicide prevention through continued research and investigation
- building the evidence base of suicide and intentional self-harm through data sharing activities to ensure the accurate and timely reporting of these events.

## Data for prevention activities

The QFCC contributes to suicide prevention by providing detailed data to researchers, including to recent projects with Queensland Health and the University of Queensland. 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](mailto:child_death_prevention@qfcc.qld.gov.au)

Reports on child deaths and 13-year data tables can be found at [www.qfcc.qld.gov.au/child-death-reports-and-data-0](http://www.qfcc.qld.gov.au/child-death-reports-and-data-0)

## 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/child-death-reports-and-data-0](http://www.qfcc.qld.gov.au/child-death-reports-and-data-0)

**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** – analyses in this paper are based on data extracted from the Child Death Register in January 2017.

**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.

<sup>4</sup> Cox, G., Robinson, J., Williamson, M., Lockley, A., Cheung, D. & Pirkis, J. (2012) *Suicide clusters in young people: Evidence of the effectiveness of postvention strategies*



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

**Known to the child protection system** – a child for whom, in the year before their death, the Department of Child Safety 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 analysis has been limited to the three year period to June 2017, as the statutory period of review was changed from three years to one year in July 2014.

**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).

**Suicide cluster** – a group of suicides or suicide attempts that occur closer together in time and space than would normally be expected.

**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.