

## **Part IV: Intentional injury-related deaths**

### **Chapters 10–11**

Includes child deaths due to suicide and fatal assault.

## Chapter 10

# Suicide

*“That a child or adolescent would find himself or herself in a situation where the only perceived option is to take their own life is tragic but not uncommon” (Shaw, Fernandes & Rao 2005:309)*

### Key issues

- Of the 15 children who are suspected of taking their own lives between 1 July 2005 and 30 June 2006, 3 identified as Aboriginal and 5 were known to the Department of Child Safety in the last 3 years. Five were aged 10–14 years and 10 were aged 15–17 years.
- Forty percent of children and young people stated their intent to suicide before taking their own lives. This highlights the importance of taking threats or talk of suicide seriously. Parents, caregivers and others need to recognise that children know enough to attempt suicide, regardless of whether they appreciate the finality and permanence of death.
- The Commission has identified a number of issues which impact upon the classification of childhood suicide and the subsequent under-reporting of these deaths in official statistics. The Commission has made recommendations to the Australian Bureau of Statistics and the Registry of Births, Deaths and Marriages in relation to the capturing and reporting of data to more accurately reflect childhood suicide in Queensland.

Fifteen children and young people died as the result of suspected suicide in the period from 1 July 2005 to 30 June 2006. This cause of death was responsible for 32.6% of external deaths among children aged 10–17 years. Suicide incidents equally accounted for the highest number of deaths for children aged 10–14 years,<sup>179 180</sup> and the second-highest for children aged 15–17 years, exceeded only by transport fatalities.

### Children and suicide

A common misconception about childhood is that it is a period in which children are immune to the risk of suicidal behaviour (Centre for Suicide Prevention 2000:1). According to Greene (1994:230), society is in denial about the prevalence of suicide among pre-adolescents. Reasons for the under-appreciation of this problem include the smaller numbers of suicides reported in children under 15 years, often because of misclassification and conservative cause-of-death coding, and the existence of widespread myths about children and suicide (Greene 1994:230; Wise & Spengler

1997:319). In particular, the myths include that children are incapable of suicide as they are unable to understand the finality and irreversibility of death and do not have the developmental maturity to think up, or act upon, suicidal thoughts (Centre for Suicide Prevention 2000:1; Greene 1994:230–31; Wise & Spengler 1997:319–20). These erroneous beliefs have resulted in a lack of awareness of childhood suicide (refer to the ‘Classification issues’ section of this chapter for a more detailed discussion of this topic).

Recent evidence suggests that the suicide rate among children has increased dramatically in the past few years (Beautrais 2001:649; Horsburgh & Fowler 2003; O’Leary et al. 2006:33; Pompili et al. 2005:63). In line with this, the Commission’s *Annual Report: Deaths of children and young people, Queensland, 2004–05* (Child Death Annual Report, 2004–05) found that suicide was the leading cause of death for children aged between 10 and 14 years, and the second leading cause for 15–17 year olds.<sup>181</sup>

179 Transport fatalities were equally the leading cause of death for children aged 10–14 years during this reporting period.

180 One additional suicide of an Indigenous child aged 10–14 years occurred in this period that is not accounted for in this chapter as the death has not been registered by the Registry of Births, Deaths and Marriages. Refer to Chapter 2.

181 For children aged 10–14 years, 9 suspected suicides were identified, compared with 10 suicides for 15–17 year olds.

This is again consistent with the findings of the current reporting period. Despite this, it is noted that data on suicide in children younger than 15 years are not easily available (Pompili et al. 2005:64) and are rarely reported in official statistics. The Commission has found that the young age at which children are intentionally taking their own lives in Queensland is a significant issue that requires further attention and consideration.

### Defining suicide

In the literature, there is limited agreement about definitions of suicide and suicidal behaviour. The Queensland Government's (2003:10) definition of suicide is "[a] self-inflicted injury that is accompanied by the intention of the individual to die from the result of the action taken".

In Queensland, a high standard of proof is generally needed for a suicide to be labelled as such. However, the substantial evidence necessary for suicide classifications means that deaths which would ordinarily be categorised as suicides in clinical or research situations may lack sufficient evidence to be considered suicide in a legal sense (De Leo & Evans 2002:19). As a result, in cases where a suicide is suspected, but intent is unclear (that is, the deceased did not leave a suicide note and did not make an oral statement of intent before their death), the cases are often coded as accidents. It is acknowledged throughout the literature that childhood suicides are under-reported in official statistics and a large proportion are mistakenly recorded as accidents (Mohler & Earls 2001:150; Pompili et al. 2005:63; Wise & Spengler 1997:319–20). The Commission has endeavoured to reduce the likelihood of suicides being undercounted among children and young people by taking into account in this chapter all cases where police have indicated that a death may be a suspected suicide.<sup>182</sup> In addition, to enable further categorisation of these deaths, the Commission has developed a suicide classification model (see Appendix 10.1), discussed below.<sup>183</sup>

### Suicide classification model

The Commission's suicide classification model is used to classify all cases of suspected suicide into one of three levels of certainty. In classifying these deaths, the Commission considers a number of factors, including whether intent was stated previously, the presence of a suicide note, witnesses to the event, prior suicide attempts and any significant precipitating factors. Information used to classify suicide certainty is based on data available to the Commission at the time of reporting. Information is gathered from numerous records, including the Police Report of Death to a Coroner (Form 1), autopsy and coronial findings, toxicology reports, Department of Child Safety (DChS) records<sup>184</sup> and, for finalised cases, police briefs of evidence to the coroner (which can include witness statements, supplementary Form 1s, additional police reports and suicide notes). Levels of classification are as follows:

- **Beyond reasonable doubt:** The available information refers to at least one significant factor which constitutes a virtually certain level of suicide classification, or coronial investigations have found that the death was a suicide.
- **Probable:** The available information is not sufficient for a judgement beyond reasonable doubt, but is more consistent with death by suicide than by any other means. Risk factors for suicide have been identified and/or the method and circumstances surrounding the death are such that intent may be inferred.
- **Possible/undetermined:** The police have indicated (on the Form 1) that the case is a suspected suicide but, because of a lack of information on the circumstances of the death, there is a substantial possibility that the death may be the result of another cause, or be of undetermined intent.

182 As indicated in the Police Report of Death to a Coroner (Form 1). In circumstances where the Commission is notified of cases where a child may have suicided, but this information was not recorded on the Form 1, these cases will also be included in this chapter. In this reporting period, no cases were included in the analysis that were not identified by police as suspected suicides.

183 The Commission's classification model is based on the Australian Institute for Suicide Research and Prevention's (AISRAP) suicide classification flow chart (De Leo & Evans 2002).

184 Where the child or young person has had contact with the DChS in the 3 years before their death.

In the reporting period, 9 deaths were classified by the Commission as ‘beyond reasonable doubt’ and 6 were categorised as ‘probable’. No deaths were classified as ‘possible/undetermined’. These classifications will be detailed further in the following ‘Suicide trends and patterns, 2005–06’ section of this chapter.

## Suicide trends and patterns, 2005–06

In the 12-month period between 1 July 2005 and 30 June 2006, 15 children (9 males and 6 females) died from suspected suicide. The majority of these children were aged between 15 and 17 years of age (66.7%). Table 10.1 illustrates the gender and age category breakdowns for all child suicides.

**Table 10.1:** Suicide by gender and age category at death

Age at death	Females <i>n</i>	Males <i>n</i>	Total <i>n</i>	Rate per 100,000
<b>10–14 years</b>				
12 years	0	2	2	
14 years	1	2	3	
<b>Subtotal 10–14 years</b>	<b>1</b>	<b>4</b>	<b>5</b>	<b>1.8</b>
<b>15–17 years</b>				
15 years	2	4	6	
16 years	3	0	3	
17 years	0	1	1	
<b>Subtotal 15–17 years</b>	<b>5</b>	<b>5</b>	<b>10</b>	<b>6.0</b>
<b>Total 10–17 years</b>	<b>6</b>	<b>9</b>	<b>15</b>	<b>3.3</b>
<b>Rate per 100,000</b>	<b>2.7</b>	<b>3.9</b>	<b>3.3</b>	

Data source: Queensland Child Death Register (2005–06)

- Notes:
1. Age categories were excluded where no children of that age died in the reporting period.
  2. Rates are calculated based on population data for children and young people aged between 10 and 17 years only.
  3. Rates are unable to be calculated for numbers less than four.

## Gender

Consistent with the 12-month data reported in the Commission’s 2004–05 analysis (see Chapter 3) and the national suicide findings, male children and young people were more likely to suicide compared with females (Beautrais 2001:647; De Leo & Evans 2002:35). Male suicides represented 60.0% of all suicides during the reporting period, a slightly lower proportion compared with that reported in the Child Death Annual Report, 2004–05.<sup>185</sup> The rate of suicide was also greater for males, with 3.9 males aged 10–17 years per 100,000 males aged 10–17 years in the population taking their own lives, compared with 2.7 females per 100,000.

It has been suggested that the gender differences in youth suicide are most likely due to the greater likelihood of males experiencing multiple risk factors, such as co-morbid mood and alcohol abuse disorders, and higher levels of aggression, as well as males choosing more lethal suicide methods compared with those chosen by females (Bridge, Goldstein & Brent 2006:373; Giskes 2004:14; Shaffer & Pfeffer 2001:25S–26S). This is in contrast with the higher suicidal ideation and attempt rates reported among adolescent females (Bridge, Goldstein & Brent 2006:377; Doshi et al. 2005:371; Elliott-Farrelly 2004:2).<sup>186</sup>

## Age

The majority of suicides occurred among adolescents aged between 15 and 17 years (10 deaths, 66.7%) compared with children aged 10–14 years (5 deaths, 33.3%). Suicide was identified as the leading cause of death for children aged 10–14 years, equalling transport fatalities, with 5 deaths each. Suicide was the second leading cause for adolescents aged 15–17 years, with the highest number of deaths for this age category occurring in transport accidents. These findings are similar to the Commission’s 12-month 2004–05 data (see Chapter 3), with only 1 fewer death occurring in the 10–14 year age category and 1 more death in the 15–17 year age group. The rate of suspected suicide for 10–14 year olds in the current reporting period is 1.8 per 100,000 children

185 Caution should be exercised when interpreting results because of the small number of deaths analysed. As a result, a change of 1 or 2 deaths over the course of a year may have a significant impact on findings.

186 Refer to the ‘Self-harming and suicide attempts’ section of this chapter.

in the population aged 10–14 years, compared with 6.0 young people aged 15–17 years per 100,000.

It is generally accepted that child and adolescent suicide figures are considerably lower in official statistics compared with the true numbers occurring (Beautrais 2001:651; Wise & Spengler 1997:319).<sup>187</sup> As a result, numerous studies have noted that childhood suicide is rare and “not clearly noticeable until the age of 15 years” (Cantor et al. 1999:34; Hawton & James 2005:891). Further, it is suggested that there is a paucity of information on the phenomenon of childhood suicide – in particular, on issues surrounding ideation and intent (Greene 1994:230; O’Leary et al. 2006:33). This lack of awareness and understanding of the issue of childhood suicide has resulted in suicide strategies neglecting children as an age group who require targeted prevention and intervention.

The Commission’s inaugural Child Death Annual Report, 2004–05 found that there appeared to be a rise in child suicides in Queensland. While the absolute numbers of children and young people taking their own lives may be small, the repetition of these trends in 2005–06 reinforces the importance of understanding the epidemiology and characteristics of children who suicide. Consequently, the Commission will be undertaking an in-depth research project into the circumstances surrounding the suicides of Queensland children and young people from 1 January 2004 to 31 December 2006, to be released in 2007.

### Aboriginal and Torres Strait Islander status

Three children who took their own lives during the reporting period (and whose deaths are registered with the Registry of Births, Deaths and Marriages) were identified as Aboriginal. No Torres Strait Islander children suicided during this time. Aboriginal youth accounted for 20.0% of all child suicides, despite only making up 6.3% of the youth population in Queensland (Commission for Children and Young People and Child Guardian 2006). Similarly, 3 Indigenous children were recorded to have suicided in the 12-month period between

1 July 2004 and 30 June 2005, also representing 20.0% of suicides during this time (see Chapter 3). In the reporting period, all of the Aboriginal suicides occurred among females (3 deaths), who were 14, 15 and 16 years of age. This finding contradicts the suicide literature, which suggests that Aboriginal male children and young people are at a significantly greater risk of suicide than Aboriginal female youth (Hunter 2001:3; Hunter & Milroy 2006:149).

Indigenous suicide was first considered a serious problem in the late 1980s, coinciding with the national inquiry into Aboriginal deaths in custody (Elliott-Farrelly 2004:4; Hunter 2001:3). Research found that the national media focus on the Royal Commission into Aboriginal Deaths in Custody<sup>188</sup> was the stimulus for development of political understandings of hanging that echoed the effects of colonisation and oppression (Hunter 2001:3; Hunter & Milroy 2006:144). The contemporary ‘meaningfulness’ of hanging by Indigenous youth is believed to derive from the disadvantage they experience by comparison with wider society (Hunter 2001:3). It is suggested that the predominance of hanging as a method is a political and poignant symbolic statement of oppression and injustice (Reser 1991 & Hunter 2001, cited in Elliott-Farrelly 2004:4).

Although the reasons for the over-representation of Indigenous deaths are not entirely clear, a number of factors have been suggested to explain the increasing suicide numbers among Indigenous people, including the ongoing experience of dispossession, social and economic disadvantage, elevated rates of substance abuse, modernisation, lack of services and the general low status and wellbeing of Indigenous people (Beautrais 1999:240; Department for Community Development 2005:14; Elliott-Farrelly 2004:5).

The increasing rate of Indigenous youth suicides, in particular, is of significant concern. In terms of prevention, of critical importance is the need to differentiate between the distinct aetiologies associated with Indigenous compared with non-Indigenous suicides, as many mainstream risk

187 Reasons for under-reporting of child and adolescent suicides will be discussed in detail in the ‘Classification issues’ section of this chapter.

188 The Royal Commission into Aboriginal Deaths in Custody was convened to investigate Indigenous deaths in police and prison custody, a significant proportion of which were the result of suicide by hanging (Hunter 2001:3).

factors for suicide do not apply to Indigenous people and their communities (Elliott-Farrelly 2004:3,7). In particular, the reported infrequency of mental illness in Aboriginal suicides and the strong link with alcohol and other drug use need further exploration (Elliott-Farrelly 2004:7; Ogilvie 1994:31). The existence of such important differences indicates the need for Indigenous suicide to be addressed under a separate framework from that targeting the general population (Elliott-Farrelly 2004:7). Consequently, there is a requirement for the development of evidenced-based approaches addressing Indigenous suicide prevention and culturally informed screening tools (Hunter & Milroy 2006:153).

### Geographical distribution (ARIA+)

Eight suicides of children and young people occurred in regional areas (4.5 deaths per 100,000 young people aged 10–17 years living in regional areas), compared with 5 in metropolitan areas (2.0 deaths per 100,000 young people in metropolitan areas) and 2 in remote areas.<sup>189</sup> These figures are consistent with the findings from the 12-month period in 2004–05 (see Chapter 3), which were that suicide rates were greatest in regional areas, followed by metropolitan regions. Suicide rates are reported to be consistently higher in rural compared with metropolitan areas (Beautrais 1999:237; Caldwell, Jorm & Dear 2004:S10). The findings for the reporting period are in line with this literature.

It is noted that, while adolescent males living in rural and remote areas have particularly high suicide rates (Cantor et al. 1999:50; De Leo & Heller 2004:53), those in metropolitan regions have higher suicide numbers overall (Cantor et al. 1999:51). The Commission found that male suicide numbers were highest in regional areas, with 5 deaths, compared with 4 deaths in metropolitan areas. Females also experienced a greater number of suicides in regional areas, with 3 deaths, followed by 2 deaths in remote areas and 1 in metropolitan areas.<sup>190</sup>

Research suggests that the higher suicide rate among male youth in rural areas may be attributed to a lower likelihood of contacting health professionals for mental health or related problems, restricted access to mental health services (Caldwell, Jorm & Dear 2004:S12), factors relating to rural economic downturn and greater access to firearms (Beautrais 1999:237–38).

### Socio-economic status (SEIFA)

Between 1 July 2005 and 30 June 2006, 8 children and young people who died from suicide were living in a low or very low socio-economic region<sup>191</sup> (53.3%); 2 suicides occurred in high or very high socio-economic areas and 5 were in a moderate area. In contrast, data for the 2004–05 12-month period showed that deaths occurred almost equally in low and high socio-economic regions. Suicide rates are highest in moderate socio-economic areas (5.3 suicides per 100,000 young people aged 10–17 years in the population), followed by low and very low socio-economic regions (4.3 suicides per 100,000).

Research has found that risks of suicidal behaviour are increased for individuals from socially disadvantaged backgrounds, characterised by low socio-economic status and low income (Beautrais 1999:143; Cantor & Neulinger 2000:378). A few Australian studies examining this area have found a relationship between socio-economic disadvantage and youth suicide (Cantor et al. 1999:56–57).

### Child protection population

Of the 15 children and young people who took their own life between 1 July 2005 and 30 June 2006, 5 were known to the DChS (33.3%). The Department's involvement with those children will be reviewed by the Queensland Child Death Case Review Committee.<sup>192</sup> This is an increase on the 2 deaths reported in the 12-month 2004–05 period. The number and rate of suspected suicide for children known to the DChS compared with all children in Queensland are illustrated in Table 10.2.

189 Rates are unable to be calculated for numbers less than 4.

190 Rates were unable to be calculated and compared with gender as a number of the categories had fewer than 4 deaths. Calculating rates for some regions and not others would be inaccurate.

191 Five of these children were classified as residing in very low socio-economic regions.

192 Since 1 August 2004, the DChS has been required to conduct a review of its involvement with a child if the child was known to the Department within 3 years before their death. The Child Death Case Review Committee is an independent committee responsible for considering the Department's review. The committee is multi-disciplinary and is chaired by the Commissioner.

**Table 10.2:** Suicide of children known to the DChS compared with all children in the Queensland population by age category at death

Age at death	Total <i>n</i>	Rate per 100,000
<b>Known to the Department</b>		
10–14 years	2	*
15–17 years	3	*
<b>Total 10–17 years</b>	<b>5</b>	<b>23.3</b>
<b>All Queensland children</b>		
10–14 years	5	1.8
15–17 years	10	6.0
<b>Total 10–17 years</b>	<b>15</b>	<b>3.3</b>

Data source: Queensland Child Death Register (2005–06)

\* Rates are unable to be calculated for numbers less than 4.

Notes: 1. Rates are calculated based on population data for children and young people aged between 10 and 17 years only.

2. The DChS population data supplied to the Commission included 90 children of unknown age. This is because the age and sex of the child were unknown. These children have not been included in the calculation of rates in this table.

As demonstrated in Table 10.2, the rate of suicide for children known to the DChS is greater compared with the suicide rate for all children in Queensland. For children known to the DChS aged 10–17 years, the rate of suicide was 23.3 deaths per 100,000 children in the child protection population, compared with 3.3 suicides per 100,000 Queensland children aged 10–17 years.<sup>193</sup>

An increased risk of suicide has been identified among children and young people known to child protection agencies. This is because children known to these agencies often may be living in circumstances that are characterised by substance abuse, mental health problems, lack of attachment to significant others, conduct disorder or a history of abuse (Department of Child Youth and Family Services 2000:6). Even more problematic is the fact that many of these children do not receive help until their problems become so severe that they come to the attention of the authorities as a result of their behaviour (Department of Child Youth and Family Services 2000:6).

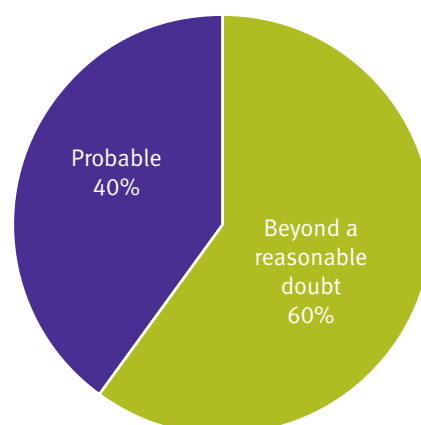
In New Zealand, it has been estimated that about a quarter of suicides occur among children in the child protection population (Department of Child Youth and Family Services 2000:8). In this reporting period, the Commission found that a third of Queensland children who took their own life were known to the DChS in the 3 years before their death. This finding is higher than the proportion of suicides identified among children known to the Department in the Child Death Annual Report, 2004–05, when just over 20% of children were known. In addition, 2 of the 5 young people known to the Department in the current period had a previous suicide alert flagged on their file.<sup>194</sup>

For people working with these children, detection of suicidal thoughts, actions and risk factors as early as possible is an essential component of early intervention that may prevent later suicidal behaviour. The Commission has raised the over-representation of suicide deaths in the child protection population with the DChS. This issue will be investigated further in the Commission’s Suicide Prevention Project due to be released in mid-2007.

### Suicide classification model

Figure 10.1 shows the percentages of suspected suicide deaths in the three classifications described earlier in this chapter.

**Figure 10.1:** Percentages of suspected suicide deaths by classification



Data source: Queensland Child Death Register (2005–06)

193 Caution needs to be taken when interpreting these figures due to the small numbers being considered.

194 One of these alerts was created by the Department of Communities and the other by the DChS.

As identified above, the vast majority of cases were classified by the Commission as beyond reasonable doubt (9 deaths), 6 were classified as being of probable likelihood and no cases were classified as being of possible or undetermined intent.

## Coronial findings

Post-mortem examinations and toxicological investigations were conducted for 7 of the 15 cases in the 12-month reporting period. Coronial findings were available for 7 of the children and young people suspected of suiciding. Table 10.3 shows the coroner's findings for each of these cases, and the classification assigned by the Commission using the suicide classification model.

**Table 10.3:** Coronial findings and classifications of suspected suicides

Coronial finding	Intent clearly stated in findings	Suicide classification
Hypoxic-ischaemic encephalopathy due to hanging	Yes	Beyond reasonable doubt
Ligature compression of the neck due to hanging	No	Probable
Colchicine toxicology	Yes	Beyond reasonable doubt
Neck compression	Yes	Beyond reasonable doubt
Hypoxic brain injury due to hanging	No	Beyond reasonable doubt
Cerebral hypoxia due to hanging	No	Probable
Neck compression	No	Probable

Data source: Queensland Child Death Register (2005–06)

In all 3 cases where the coroner clearly identified intent, the cases were classified by the Commission as being beyond reasonable doubt. In 1 other case where the intent of the child or young person was unclear, but the finding was 'hanging', the case was classified as beyond reasonable doubt. The remaining 3 cases where no comment was made in relation to intent were classified as probable suicides. This classification is based on available information as discussed.

### Inquests

Under section 28(2) of the *Coroners Act 2003* an inquest may be held into a reportable<sup>195</sup> death if the coroner considers it desirable to hold an inquest to draw attention to the circumstances of the death, to assist in the prevention of similar deaths. The purpose of an inquest is to gather information

to establish facts surrounding a death. Inquests are an inquisitorial process and not a method of apportioning guilt. Coroners will often comment on issues associated with the circumstances surrounding the death and make recommendations that relate to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future (s. 46, *Coroners Act 2003*).

The State Coroner has issued a Notice of Inquest into 1 case of suspected suicide that occurred during this reporting period. In addition, it is noted that an inquest was carried out for 1 death reported in the Child Death Annual Report, 2004–05.<sup>196</sup>

Of the 15 suspected suicide deaths between 1 July 2005 and 30 June 2006, there are coronial findings available for 7 deaths and 1 inquest has begun.<sup>197</sup>

<sup>195</sup> Refer to Chapter 2, 'Methodology', for the definition of a reportable death.

<sup>196</sup> Refer to the 'Prevention and intervention' section of this chapter for further details of this inquest.

<sup>197</sup> This inquest has been adjourned.

## Circumstances of death

### Method of death

Table 10.4 presents the methods of suicide used by children and young people by gender. Hanging was the most frequently used method of suicide for both males and females, accounting for 86.7% of all suicides (13 deaths). Other suicide methods in the reporting period included a gunshot wound and poisoning (2 deaths).

**Table 10.4:** Method of suicide deaths by gender

Method	Females		Males		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Hanging	5	83.3	8	88.9	13	86.7
Gunshot wound	0	0.0	1	11.1	1	6.7
Poisoning	1	16.7	0	0.0	1	6.7
<b>Total</b>	<b>6</b>	<b>100.0</b>	<b>9</b>	<b>100.0</b>	<b>15</b>	<b>100.1</b>

Data source: Queensland Child Death Register (2005–06)

Notes: 1. Percentages are calculated for each column.  
2. Total percentage columns may not sum to 100% because of rounding.

The findings in Table 10.4 are consistent with the Child Death Annual Report, 2004–05, which found that most suicides occurred by hanging. In Queensland the number of suicides by hanging has increased over the past decade (De Leo & Heller 2004:46). The data for the current period also demonstrate the increased frequency of hanging as the chosen method of suicide.

### Hanging

Despite the fact that hanging is currently the single most common mode of suicide for children and young people in Queensland, there are currently no clear interventions to reduce the use of this method (Beautrais 1999:236). Hanging is a mode of suicide to which it is virtually impossible to restrict access. Consequently, the method which accounts for the greatest number of youth suicides is also the least amenable to change (Beautrais 1999:236). The easy availability of hanging ligatures is demonstrated in Table 10.5.

**Table 10.5:** Hanging ligatures

Ligature description	Total <i>n</i>	Total %
Rope	6	46.2
Electrical cord	2	15.4
Garden hose	1	7.7
Webbing belt	1	7.7
Bicycle chain lock	1	7.7
Hay baling twine	1	7.7
Belt	1	7.7
<b>Total</b>	<b>13</b>	<b>100.1</b>

Data source: Queensland Child Death Register (2005–06)

Note: 1. Total percentage columns may not sum to 100% because of rounding.

With the rising numbers of hangings in Queensland, there is a need to gain a better insight into this method of suicide. Researchers have suggested that availability and socio-cultural acceptability are both important influences on an individual's choice of suicide method and that particular suicide methods may be more acceptable to certain subgroups of individuals (De Leo, Evans & Neulinger 2001:186). More specifically, a number of studies have shown that hanging suicides are concentrated in the younger age groups (De Leo, Evans & Neulinger 2001:186; Shaw, Fernandes & Rao 2005:314). Although the reasons for this are unclear, it may be that hanging is becoming more acceptable and the preferred method in adolescent culture, or it may be related to access to hanging points and materials (Cantor & Neulinger 2000:380; Shaw, Fernandes & Rao 2005:315). This highlights the importance of targeting suicide prevention strategies towards early intervention and identification of at-risk children and young people.

### Situational circumstances and risk factors

This section outlines the factors that may have triggered suicidal behaviour in Queensland youth in the 2005–06 reporting period. The analysis contained in this section is based on information recorded in Police Form 1s, autopsy and toxicology reports, coronial findings, DChS records<sup>198</sup> and,

198 Where the child or young person has had contact with the DChS in the 3 years before their death.

for finalised cases, police briefs of evidence to the coroner. The numbers may therefore under-represent the true number of circumstances and risk factors for some of the children and young people who took their own lives during the reporting period.<sup>199</sup>

Factors commonly linked to youth suicide are often complex and may involve a combination of biological, psychological and social elements. Suicidal behaviours in young people are often not the result of a single cause but are multiplicative and frequently occur at the end point of adverse life sequences in which several interacting risk factors combine (Beautrais 1999:245; Department for Community Development 2005:4), resulting in feelings of hopelessness and a desire to ‘make it all go away’ (Souter & Kraemer 2004:261). Research has identified a number of common risk factors and adverse life circumstances that may lead to suicidal behaviours in children and young people. Key factors are outlined below.

### ***Mental health and behavioural problems***

Five children and young people who suicided in the reporting period experienced some form of mental health or behavioural problem before their death (representing 33.3% of suicides during this period).<sup>200</sup> Problems identified include alcohol and drug dependency (2 cases), depression (2 cases), behavioural issues/conduct disorder (1 case) and attention deficit hyperactivity disorder (1 case). Three of these children were known to have been assessed by a mental health service provider or general practitioner in relation to their mental health and/or behavioural problems. One young person was noted to have been receiving counselling in the days prior to death and in 2 cases the young people were noted to have been taking prescribed medication for their condition/s. One child was identified to have co-morbid conditions.

The proportion of children and young people identified as having mental health and/or behavioural problems during this reporting period

is consistent with the findings from the Child Death Annual Report, 2004–05, with just over a third of children recorded as having a mental health or behavioural problem before their death. Conditions identified were very similar across the two periods.

Research suggests that mental health issues play a major role in youth suicidality. Studies have estimated that up to 90% of young people who die by suicide have at least one mental health disorder at the time of attempt (Bridge, Goldstein & Brent 2006:375; Shaffer & Pfeffer 2001:255). Mental health issues most frequently associated with youth suicide include affective disorders, substance dependence and antisocial behaviour (Beautrais 1999:188; Shaffer & Pfeffer 2001:355). Further, it has been observed that many young people dying by suicide have multiple or co-morbid psychiatric conditions (Beautrais 1999:211; Bridge, Goldstein & Brent 2006:375) and are likely to have had a history of contact with psychiatric services (Beautrais 1999:211). Consequently, earlier identification, recognition and treatment of mental health and behavioural issues are essential in preventing child and adolescent suicides (Bridge, Goldstein & Brent 2006:385; Pompili et al. 2005:66).

### ***Previous suicidal behaviour***

Previous suicidal behaviour and/or thoughts were identified for 4 children and young people in the reporting period (26.7%). All 4 children were recorded to have experienced suicidal ideation.

Further, 2 young people had previously attempted suicide. One child previously attempted suicide by overdosing on prescription medication and, in a separate incident, attempted hanging. Another child was also recorded to have attempted suicide by drug overdose. Two children were also reported to have engaged in self-harming behaviour, including cutting and burning.

Of these 4 children, 3 were known to have been assessed by a mental health service provider or general practitioner previously.

199 Section 89ZG of the *Commission for Children and Young People and Child Guardian Act* provides that a government entity may provide the Commissioner with information reasonably required to perform Part 4A child death research functions. As the identification of suicide risk factors requires full case records from a number of government agencies, the Commission is currently working with a number of departments to develop memorandums of understanding to gain access to further information, including education and health records.

200 Each child and/or young person may have experienced more than one mental health problem (co-morbid disorders). Therefore numbers may not sum accurately.

Findings for this year are similar to those reported in the Child Death Annual Report, 2004–05. Specifically, previous suicidal behaviour identified for the current period indicates that the percentage of children and young people who engaged in self-harm and had previously attempted suicide was almost the same compared with last year (26.7% and 26.3% respectively).

The literature suggests that a previous suicide attempt is the single most potent risk factor predicting youth suicide (Bridge, Goldstein & Brent 2006:374; Fritz n.d.). Prior suicidal behaviour is considered one of the strongest predictors of future suicidal behaviour, with estimates that the suicide rate is almost 20 times higher for people with previous attempts than for those with no history of attempts (Beautrais 1999:211).

The most common methods of self-harm reported in the literature are cutting, followed by burning (Muehlenkamp & Gutierrez 2004:18; Ross & Health 2002:67). In this reporting period, the findings for the 2 young people identified as having previously self-harmed before suiciding are consistent with this literature. It is noted that self-harm is often a highly impulsive act and that many individuals report thinking about the act just minutes before doing it (Hawton & James 2005:892). Alcohol and drug consumption is suggested to increase the likelihood of impulsive acts. It is unknown whether the young people identified in the reporting period were affected by substances at the time of their previous self-harming/suicide attempts.

### ***History of childhood abuse***

Four children reported a history of childhood abuse (26.7%). Three young people were victims of physical abuse (20.0%)<sup>201</sup> and 1 child had allegedly been sexually abused (6.7%). Perpetrators of physical abuse were all immediate family members.

In addition, 3 children were noted to have family histories of domestic violence.

Four children noted to have a history of physical or sexual abuse and/or domestic violence in their families were known to the DChS either at the time of death or within 3 years before their death.

The Child Death Annual Report, 2004–05 recorded that 26.3% of children had a previous history of physical and/or sexual abuse. The findings from the current period are similar to the proportion of cases identified last year.

A number of studies have shown that children and young people who were physically or sexually abused in childhood are at a significantly greater risk of suiciding than children with no history of abuse. Many studies have found a direct link between abuse and suicidal behaviour (Evans, Hawton & Rodham 2004:45; Queensland Health 2005:31; Ystgaard et al. 2004:863; Zametkin, Alter & Yemini 2001:3121). Likewise, research indicates that family violence may also influence childhood suicidal behaviours (Wise & Spengler 1997:324).

### ***Precipitating incidents and stressful life events***

#### ***Precipitating incidents***

Precipitating incidents were identified in 12 of the suicides (80.0%).<sup>202</sup> For 8 of the children and young people, an argument with a significant other preceded the suicide. This included arguments with the children's parents (6 cases), another family member (2 cases), school authorities (2 cases), boyfriend/girlfriend (1 case) and the community (1 case). In all 8 cases, arguments occurred up to the day before, or immediately before, the suicide. Three young people had arguments with more than one person in the days leading up to the suicide.

Four children endured a recent relationship breakdown with a significant other, 3 with a parent and the other with a girlfriend/boyfriend. Other significant precipitating incidents reported included family transition, bullying, possible intoxication, sickness/illness, police contact, fear of abuse, and loss of a close friend to suicide. An immediate

201 All 3 recordings of physical abuse have been substantiated.

202 Each child and/or young person may have experienced more than one precipitating incident or life stressor. Therefore numbers may not sum accurately to the number of suicides which occurred in the 2005–06 period examined.

trigger for the suicide of 3 young people was unable to be identified or was not recorded.

Similar numbers and types of precipitating incidents were identified this year as compared with those identified in the Child Death Annual Report, 2004–05. The most noteworthy incident identified for both reporting periods appears to be the occurrence of an argument with a significant other in the days leading up to, and in most cases on, the day of the suicide. These findings are consistent with the literature, which identifies that precipitating incidents most commonly associated with suicide are arguments with partners, family or friends, relationship breakdowns, bereavement as a result of a death and disciplinary troubles in school or with police (Beautrais 1999:218; Gould & Kramer 2001:9; Shaffer & Pfeffer 2001:25S).

#### *Other stressful life events*

A number of long-term stressors were also identified for 6 children who took their own life during the current reporting period. In addition to the other risk factors mentioned,<sup>203</sup> young people who suicided were also noted to have had parents with mental health problems (2 cases) and/or alcoholism (2 cases), had significant police contact (3 cases), had been suspended/expelled or were not attending school (2 cases), and had experienced the death of a parent some years before the child's suicide, resided in and out of foster care, suffered from a long-term sickness and/or were unemployed (1 case each). Previous police contact for 3 of the children involved offences including unlicensed driving, property damage and stealing.

Studies have found that young people who suicide have experienced a higher rate of adverse or stressful life events in the period preceding the suicide, compared with other people of the same age (Beautrais 1999:227). Further, evidence suggests that stressful events are particularly likely to provoke suicidal behaviour in vulnerable individuals.

#### *Alcohol, drug and substance use*

Nine of the children and young people who suicided were reported to have been known alcohol, drug or substance users (60.0%).<sup>204</sup> Consistent with the findings from the Child Death Annual Report, 2004–05, marijuana/cannabis was the most frequently reported substance used, with 5 children identified as having been users. Other substances used included alcohol (4 cases), volatiles (1 case), benzodiazepines (1 case) and ecstasy (1 case), and 1 child reportedly injected anti-psychotic medication not prescribed to them.<sup>205</sup> In a further case, the child was reported to have taken a significant number of pain relief tablets before their death.

Of the 9 children identified as alcohol, drug or substance users, 4 children were noted to have been heavy drug users, 2 of whom were suggested to have been dependent on drugs. Three children were recorded to have possibly used on the night before they suicided. Overall, the proportion of cases where children used substances is higher in the current reporting period compared with last year's findings.

Research suggests that alcohol and other drug use increases the risk of suicide (Department for Community Development 2005:14). This increased risk was often attributed, in the short term, to the indirect effects of intoxication on behaviour.

#### *Contagion*<sup>206</sup>

In a third of cases, the child or young person was identified as having a family member or close friend who had either taken their own life or attempted to take their own life (5 deaths, 33.3%). In 2 cases the method of suicide used by the family member/friend was the same method used by the child. In 1 case, the young person had previously attempted suicide using the same method as his family member. In 1 case it is unknown how the relative suicided. Contagion-related suicides for the current report period were three times higher than the number reported in the Child Death Annual Report, 2004–05 (28.9% versus 10.5%).

203 That is, stressors mentioned here do not include other risk factors already examined, such as domestic violence and mental health problems. This section considers only those stressors that are not mentioned elsewhere.

204 This figure does not include the substance used by 1 child to suicide by drug overdose. For another child, it is not recorded what type of substance was used.

205 Some children were noted to have used more than one type of substance.

206 Contagion is defined as the process by which a prior suicide facilitates the occurrence of subsequent suicides (Beautrais 1999:232).

There is considerable evidence to suggest that the suicide of one person may trigger suicidal behaviour in those associated with that person, or in vulnerable people who become aware of the suicide (Beautrais 1999:241; Department for Community Development 2005:5). This can occur in a number of ways, including:

- seeing the person who completed suicide and being involved in the aftermath
- having talked with or seen the person on the day of the suicide
- belonging to the family of the person
- being a close friend of the person or of the family
- being in the same class or group
- learning of the attempted or completed suicide of a role model, and
- reading or hearing about the death in the media.

#### *Familial contagion*

There is consistent and strong evidence that a family history of suicide is a significant risk factor for suicidal behaviour in children (Pompili et al. 2005:65), with studies suggesting a two- to six-fold increase in suicide rates among adolescent suicide victims and attempters (Bridge, Goldstein & Brent 2006:379). The onset of suicidality in children is suggested to be particularly high after the suicide of a relative (Pompili et al. 2005:65). The reasons for this familial aggregation are not clear. However, research has indicated the presence of genetic influences, as the association with familial suicidal behaviour has been shown to increase suicide risk even after studies have controlled for psychopathology and poor parent–child relationships (Beautrais 1999:153; Bridge, Goldstein & Brent 2006:379; Gould & Kramer 2001:9). Three of the suicides in the current period occurred in circumstances where an immediate family member had previously attempted or completed suicide. It is therefore essential that careful analysis of the impact of a close relative’s suicide on children should be part of preventative intervention to reduce contagion effects (Pompili et al. 2005:65; refer to the ‘Prevention and intervention’ section later in this chapter for information on the National Suicide Bereavement Project).

#### *Imitative contagion*

One feature of suicidal behaviours, and particularly suicide, is the tendency for contagion and clustering (Beautrais 1999:231). There are numerous reports in contemporary suicide literature on the occurrence of suicide clusters in prisons, psychiatric institutions, schools and colleges, religious sects and geographically defined communities (cited in Beautrais 1999:231). Specifically, Gould, Wallenstein and Kleinman (1990:71) have demonstrated that a small but statistically significant number of adolescent suicides occur in time-space clusters, consistent with mechanisms of contagion and imitation. These effects have been identified for clusters of both completed and attempted suicide, and appear to be limited to adolescents and young adults (Gould, Wallenstein & Kleinman 1990:71). Consequently, one completed suicide may provide the model for subsequent suicides by means of imitation and identification (Gostelow 1990:92).

During the reporting period, 2 of the children who took their own lives had a close friend suicide in the preceding 7 months. Both children suicided using the same method as their friends. Two suicides occurred in the same school in the space of a month (representing one contagion effect). The contagion process which leads to suicide clusters is something all schools need to be aware of (Gostelow 1990:92), as research has shown that a small number of students, especially those who may already be experiencing difficulties, might identify with the destructive solutions adopted by the suicide victim, thus raising the notion of suicide as an option (World Health Organisation 2000:15). It is therefore essential that, in any postvention response, schools involve not only those children who were directly known to the suicide victim, but also those who may not have known the student but who may have heard about the suicide ‘through the grapevine’ (World Health Organisation 2000:16). These deaths reinforce the need for, and importance of, having detailed suicide prevention, intervention and postvention guidelines available to schools (see the ‘Prevention and intervention’ section of this chapter for information on Education Queensland’s guidelines).

Table 10.6 illustrates a number of circumstances and risk factors common for children and young people who suicided in Queensland. As shown, many of the children experienced multiple factors that place individuals at a higher risk of suicidal behaviours (Beautrais 1999:245).

**Table 10.6:** Summary of risk factors/selected characteristics of all 15 children who were suspected of suiciding in 2005–06

Gender*	Age**	ATSI <sup>a</sup>	Regional/ remote	Low SES	Mental health issues	Previous suicidal behaviour	History of childhood abuse	Precipitating incident	Child protection history	Alcohol/ drug use	Contagion
F	10–14	✓	✓	✓			✓		✓	✓	✓
M	10–14		✓					✓		✓	
M	10–14				✓	✓	✓	✓	✓	✓	✓
M	10–14			✓	✓			✓			✓
M	10–14		✓	✓				✓			
<b>Subtotal</b>	<b>5</b>	<b>1</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>4</b>	<b>2</b>	<b>3</b>	<b>3</b>
M	15–17		✓							✓	
F	15–17		✓					✓			
F	15–17		✓	✓	✓	✓	✓	✓	✓	✓	
F	15–17		✓	✓		✓	✓	✓	✓	✓	✓
M	15–17				✓			✓		✓	
F	15–17	✓	✓	✓				✓		✓	
M	15–17		✓		✓						
M	15–17							✓			
F	15–17	✓		✓				✓	✓	✓	
M	15–17		✓	✓		✓		✓			✓
<b>Subtotal</b>	<b>10</b>	<b>2</b>	<b>7</b>	<b>5</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>8</b>	<b>3</b>	<b>6</b>	<b>2</b>
<b>Total</b>	<b>15</b>	<b>3</b>	<b>10</b>	<b>8</b>	<b>5</b>	<b>4</b>	<b>4</b>	<b>12</b>	<b>5</b>	<b>9</b>	<b>5</b>

Data source: Queensland Child Death Register (2005–06)

✓ = Yes, the child has this risk factor

\* M = Male; F = Female

\*\* 10–14 = 10 to 14 years; 15–17 = 15 to 17 years

<sup>a</sup> Aboriginal and/or Torres Strait Islander

Note: 1. Low SES refers to children and young people who have been classified as residing in either a low or a very low socio-economic region.

The following case study illustrates the presences of multiple factors which may have acted as triggers for this young person's suicide.

### Case study

Matthew<sup>207</sup> was 14 years of age when he took his own life. Matthew experienced a multitude of stressful life events and precipitating factors before his death. These included:

- a history of domestic violence and substantiated childhood abuse
- problems at school
- previous police contact
- alcohol/drug abuse
- the suicide of an immediate family member some years before his death, and
- prior suicidal behaviours – ideation, threats, self-harm and attempts.

In addition, the young person had a significant history with a number of children's services (including the DChS and mental health) and had been placed in out-of-home care on a number of occasions over the course of his life.

207 Matthew is a pseudonym.

## Other significant factors

### *Place of incident*

During the 12-month period examined, 73.3% of suicides occurred at the child or young person's place of residence (11 deaths), with 5 of the incidents taking place inside the house and 6 outside in the back yard, carport, veranda or other structure on the property. Other places included at a friend/boyfriend's house (2 deaths), in bushland (1 death) and at school (1 death). The findings for the current reporting period indicate that a higher proportion of children suicided in their own homes compared with last year's analysis (73.3% versus 63.2%), supporting the notion that a child's residence is consistently the most likely place of incident.

### *Intent stated (orally or written)*

In 40.0% of suicides, young people orally stated or implied their intent to a family member, friend or health professional before their suicide (3 deaths). Suicide notes were found in another 3 cases.<sup>208</sup> This is slightly lower than reported in the Child Death Annual Report, 2004–05 (47.4%). The fact that these children and young people stated their intent before suiciding highlights the importance of taking threats or talk of suicide seriously. Parents, caregivers and others need to recognise that children know enough to attempt suicide, regardless of whether or not they appreciate the finality and permanence of death (Beautrais 2001:652).

Studies estimate that approximately 80% of young people who complete suicide communicated suicidal thoughts and feelings and their intent to kill themselves to someone before their death (Department for Community Development 2005:2). The problem is that it is often difficult to tell what some of the signs may mean, or that the indications are so subtle that they go recognised. However, what can be identified are significant changes in behaviour. Knowledge of risk factors for suicide may help parents, friends and families to intervene and take appropriate action (Department for Community Development 2005:2).

Unfortunately, cases do occur where there are no clues before the suicide or the warning signs go unrecognised. In other cases the desire to die may be so strong that even when interventions are initiated they are unsuccessful (Shaw, Fernandes & Rao 2005:312). Documented interventions by friends, family or physicians were noted in 2 cases<sup>209</sup> and yet the individuals still suicided only days later.

It is important to remember that, in the majority of cases, few people are intent on dying and it is more that they want the pain they are experiencing, or have experienced, to end (Department for Community Development 2005:2). Consequently, a young person's suicide may be seen as a way of getting back a degree of control over their life, including making people close to them aware of their pain (Department for Community Development 2005:2). Family and workers sometimes see this as manipulative or attention seeking. This is a dangerous view, as it is likely to result in the underlying pain of the person being ignored. In circumstances where this belief is expressed or implied to the young person, this may make it even more difficult for a person to communicate their need directly and openly to the people who are able to help them (Department for Community Development 2005:2). It is therefore essential to recognise the potential for suicide among children and to take all threats of suicide seriously.

### *Media and technology influences*

There is a growing body of evidence that media publicity may encourage suicidal behaviour in vulnerable children (Beautrais 1999:233). Specifically, evidence suggests that there is an association between non-fictional portrayal of suicide in film, television and newspaper articles and actual suicides, and that this may represent a causal relationship (Pirkis & Blood 2001:81). The magnitude of the relationship is suggested to be proportional to the amount of publicity given to the story (Becker & Schmidt 2005:229; Pirkis et al. 2006:2881) and the prominence of the story's placement (Gould & Kramer 2001:10). Other media content was also associated with increases in

208 One young person had stated or implied their intent to a family member, friend or health professional before their suicide and also left a suicide note.

209 Interventions counted were specifically in relation to suicide risk and included counselling.

suicides, including opinion pieces about suicide, mass suicides (Pirkis et al. 2006:2883) and the notoriety of the victim (Bridge, Goldstein & Brent 2006:381). The impact of suicide stories on subsequent completed suicides is reported to be greatest for adolescents (Gould & Kramer 2001:10).

This finding has implications for the way suicide is represented in the media. Media depiction may increase suicide risk by encouraging imitation and by normalising suicide as a common and acceptable response to resolving problems (Beautrais 1999:233), particularly among emotionally vulnerable individuals (Commonwealth of Australia 2001:1). In contrast, presenting suicide in a factual light and discussing mental health issues openly, as opposed to romanticising suicide, has been associated with a lower risk of imitation (Stack 2005:121).

In particular, research findings suggest that certain ways of describing suicides in the news media contribute to suicide contagion and copycat suicide (Tully & Elsaka 2004:1). Australia has promoted and implemented guidelines, codes of practice, other resources and legislation to encourage responsible reporting of suicide (Tully & Elsaka 2004:1). Recommendations made to print and broadcasting authorities in relation to reporting suicide in the media include the following:

- do not give undue prominence to reports on suicide
- avoid repeated coverage of suicide stories
- avoid using the word ‘suicide’ as part of the headline
- avoid using photographs and television footage relating to the suicide
- do not portray suicide as a romantic or glamorous solution to problems
- treat the bereaved with sensitivity and respect their privacy
- avoid discussion of the method of self-harm used
- avoid using language which suggests that completed suicide is a desirable outcome, and
- reinforce that suicide is often related to mental illness, and promote help-seeking behaviour

(Commonwealth Department of Health and Aged Care in Commonwealth of Australia 2001:10–11).

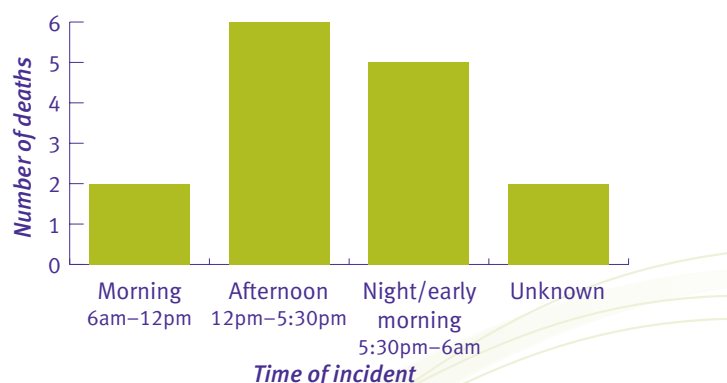
In addition, Queensland<sup>210</sup> has enacted legislative constraints on suicide reporting. Section 41(1) of the *Coroners Act 2003* allows coroners discretion in relation to the prohibition of the publication of information about self-inflicted deaths.

It is not known whether or not the media had an impact on the suicides of any of the young people in the current reporting period. However, research findings in this area highlight the importance of sensitive reporting of suicide in the news media. Consequently, depictions of suicide that do not glorify or romanticise it, and do not provide visual detail of the exact method, are preferable. Likewise, reporting that stresses the consequences for others, identifies the potential hazards of particular methods and refers to sources of help for vulnerable individuals is desirable (Pirkis et al. 2006:2885).

### Day and time of incident

Children and young people in this reporting period were more likely to suicide early in the week (Monday and Tuesday; 6 deaths).<sup>211</sup> Consistent with the findings of the Child Death Annual Report, 2004–05, suicides occurred most frequently in the afternoon between 12pm and 5.30pm, representing half of the known incident times (6 deaths).<sup>212</sup> Figure 10.2 illustrates the most frequent time of incidents for the reporting period.

Figure 10.2: Time of incident



Data source: Queensland Child Death Register (2005–06)

210 These legislative constraints also exist in New South Wales and the Northern Territory.

211 In one case, the day of incident is unknown.

212 Incident times are approximate. For 2 deaths, the approximate time of the incident was not known.

It is of note that, while no incidents occurred on the same day, 2 suicides occurred within 24 hours of each other. It is not known whether any of the children and young people were friends or associates. In addition, 2 incidents were recorded to have occurred on a public or school holiday<sup>213</sup> and most incidents occurred in the autumn months<sup>214</sup> (7 deaths, 46.7%).

## Classification issues

The Commission has identified a number of factors that influence the classification of suicide among children and young people, and the subsequent under-reporting of childhood suicide in official statistics. Issues suggested to have the greatest impact on under-recording and misclassification of suicides among youth are detailed below.

### Children and intent

While uncertainty of some degree is probable in most cases of suicide ordinarily, ambiguity surrounding the intention of children and younger adolescents is particularly problematic. For a death to be considered a suicide, a significantly high standard of proof and substantial evidence are necessary to support the classification of a death as intentionally self-inflicted. For children, it has been suggested that death is a psychologically difficult concept to comprehend until a certain age of maturity (Agritmis et al. 2004:25) and that the pattern of development for appropriate subconcepts of death<sup>215</sup> differs from child to child (Lazar & Torney-Purta 1991:1321). Consequently, how a child perceives their suicidal act and under what circumstances they take their own lives are almost always subject to debate.

In Queensland, a number of child and adolescent suicides are being coded as accidents.<sup>216</sup> This has been attributed to the belief that children do not understand the consequences of their actions and are therefore incapable of suiciding, even when their self-inflicted injuries result in death (Cantor et al.

1999:12–14; Greene 1994:231; Mishara 1999:106). The effect of this belief is that the misclassification of self-inflicted deaths among children and younger adolescents has resulted in childhood suicide being largely overlooked in Queensland.

A number of studies have investigated intent in children and younger adolescents. The capacity for, and prevalence of, children under 15 years taking their own life is increasingly documented in the suicide literature (Agritmis et al. 2004:25; Beautrais 2001:647; Fritz n.d.; Greene 1994:230; Horsburgh & Fowler 2003; Mishara 1999:105; Mishara 2003:128; O’Leary et al. 2006:33; Shaw, Fernandes & Rao 2005:309; Wise & Spengler 1997). More specifically, research has found that children between the ages of 8 and 10 years know that an intentional act of suicide will result in death and understand that death is permanent and final (Mishara 1999:114). The results from these studies, together with the increasing body of knowledge being produced on this issue, suggest that it is “naïve to think that children do not know about suicide” (Mishara 1999:114) or to think that children are incapable of taking their own lives. Consequently, there needs to be clear recognition among caregivers, teachers, counsellors and others that children do know enough about suicide to take their own lives (Beautrais 2001:652), regardless of whether their understanding is equivalent to an “adult understanding” (Mishara 1999:115). Hence, recognising the potential for suicide, even in very young children, is an essential prerequisite to providing effective prevention and early suicide intervention.

### Coroners

It is well documented that coroners may be reluctant to classify self-inflicted deaths in children as suicides (Cantor et al. 1999:12–14; Mishara 1999:106). In particular, Queensland coroners mostly confine their findings to a medical cause of death and rarely provide behavioural descriptions of fatality (Cantor & Neulinger 2000:370).

213 School holiday comparisons based on public school holidays.

214 Representing the months of March to May inclusive.

215 Made up of irreversibility, cessation, causality and inevitability.

216 In the absence of a clear statement of intent before the child’s death (e.g. a note or orally) and where coroners do not specify that the death was self-inflicted (e.g. cause of death is listed as ‘hanging’).

Australian states and territories in general take an inherently conservative approach to suggesting that deaths were intentionally self-inflicted, particularly in the case of child and youth suicides. This is consistent with the Commission's findings from the Child Death Annual Report, 2004–05, with updated findings for this period indicating that only 7 out of 17 coronial findings received in the reporting period clearly indicated the intent of the child or young person (41.2%).<sup>217</sup> For 8 deaths a coronial finding named 'hanging'<sup>218</sup> as the cause of death, with no clear statement made about whether the injury was self-inflicted, accidental or otherwise.

A number of reasons have been suggested for coroners' apparent reluctance to classify self-inflicted deaths in children as suicides, including:

- the general belief that children do not understand the finality and irreversibility of their actions (as detailed in the above section)
- the repealed *Coroners Act 1958* prohibiting coroners from making a finding of suicide and limiting coroners to a verdict on the medical cause of death only; in contrast, the new *Coroners Act* does not make any reference to deliberate self-harm resulting in death, and so there could be a 'follow-on' effect from the repealed *Coroners Act*
- the *Births, Deaths and Marriages Registration Act 2003* currently prohibiting entry of the word 'suicide' or similar words into the register, and
- a wish to avoid embarrassment and guilt in family members, or the influence of religious values and/or cultural attitudes (Australian Bureau of Statistics 2000:35; Tatz 1999:49).

In response, the Queensland State Coroner has indicated that, if a coroner considers a death to be accidental or undetermined, then this will be expressly stated in the coroner's findings (for example, 'accidental hanging'). In cases where the finding simply states the cause of death as, for example, 'hanging' (and the Form 1 indicates a suspected suicide), the absence of the term 'accidental' or 'undetermined' should be taken to imply that the death was intentional (Child Death Annual Report, 2004–05).

On 13 September 2005 the State Coroner issued guidelines (under section 14(1)(b) of the *Coroners Act 2003*) to all coroners in relation to a number of issues, including the findings of suicide. Specifically the State Coroner has instructed Queensland coroners to "find whether the deceased intended to kill him/herself". The State Coroner reports in this guideline that remaining silent on the issue of suicide is "likely to lead to an under estimate of the extent of the terrible public health problem suicide represents".

Non-specific reference to intentional self-harm in Queensland continues to have implications for the classification of childhood suicides (with many still being coded to accidents) and subsequently the undercounting of these deaths in official statistics (these issues will be discussed in more detail in the following section). Therefore the Commission suggests that, to reduce the undercounting and misclassification of suicide occurring among children and young people, individuals coding and classifying deaths should liaise with representatives from state and national coronial systems and relevant child death review teams to ensure that consistency in coding and classification of suicide is achieved. The Commission has liaised with the Australian Bureau of Statistics (ABS) to discuss this approach and ensure a consistency of coding for Queensland. (Refer to Appendix 10.2.)

It is noted that coroners are in the unique position to bring about awareness among parents, practitioners, policy makers and the community in relation to the occurrence of suicide in children, and to influence suicide prevention and intervention strategies to target children and young people. Currently, the under-reporting (and non-reporting) of childhood suicide in Queensland has resulted in a lack of attention to children in suicide prevention approaches. Although it is noted that coroners may not be experts in the suicide field, they can act as catalysts through inquisitorial and investigative processes by means of which specialist information can be converted to broad community use and understanding (Hallenstein 1990:175).

217 For 1 death, the coroner clearly indicated that the death was the result of the deceased's actions, but noted that the death was an 'accident'.

218 Or a similar or like term, including but not limited to 'asphyxia, hanging' and 'death by strangulation'.

Thus there is significant advantage which may be derived from effective use of the coronial processes to bring about awareness and understanding of the issue of suicide in children and young people.<sup>219</sup>

## Coding

Most official statistical bodies in Queensland use the International Classification of Diseases (ICD-10) to code underlying causes of death. However, it is noted that this classification system is based on a legal premise requiring a high threshold of proof in order for a death to be coded to a suicide. In cases where police indicate that a death is a suspected suicide, a clear statement of intent has not been made by the young person before their death (in the form of a suicide note or oral statement of intent) and where the coroner does not specify the intent of a person in coronial findings, deaths are coded to accidents (ABS 2005, pers. comm., 20 December; Cantor et al. 1999:14; National Centre for Classification in Health 2005, pers. comm., 18 May). This has resulted in the number of childhood suicides, in particular, being misclassified as accidents in official statistics, and contributes to the neglect of the issue of childhood suicide on the basis that the deaths do not appear to be occurring.

The Commission has sought to clarify this issue through the Health Information manager contracted by the Commission from the National Centre for Classification in Health (NCCH).

The Commission placed a query with both the Mortality Reference Group and the Australian Mortality Data Interest Group forums in an attempt to clarify the opinions of national and international coders in relation to assigning intent in circumstances where there is insufficient evidence to code the death as a suicide. The question placed with the forums stated the following:

*In cases of suspected suicide (as reported by police), coroners are notably silent when it comes to stating intent on their findings for young people. (Nor is intent stated on the death certificate.) Additional police or agency documentation may indicate that there was a precipitating incident (eg argument with parents)*

*or a history of self-harm or depression; however, the death certificate and findings tend to read as in the following example:*

*Death certificate: 1a) Hanging*

*Coroners findings: 15 year old female found hanging from belt tied to ceiling beam.*

*Both MMDS and the index (volume 3) default to accidental for hanging unless there is any further information available from the entity legally responsible for certifying the death (in this case the coroner). I would like to ask for your opinion on how you would code this or similar situations.*

Responses to this question varied across the board, with some coders indicating that they would code this death as a suicide and others as an accident. As a result of discussion on this question, several coders did identify the need for an ‘unspecified’ code to be created that is distinguishable from the ‘undetermined intent’ code. Further, the issues raised by the Commission, and the responses provided by coders, were discussed at the Mortality Reference Group meeting held on 5 May 2006. The comments made at this meeting in relation to the query were as follows:

*Accidents, so stated and accidents, unknown are very different. The legal systems in countries are very different. When data other than death certificates are used, each country has to develop its own instructions. In ICD-11, we need a block for unknown cause of injury and one for injuries of undetermined intent.*

*Action item: No change in ICD-10.*

In an attempt to overcome these problems the Commission, in consultation with the National Centre for Classification in Health (NCCH), has developed and implemented a new code for use in the Queensland Child Death Register. The new ‘Y20A – Hanging, strangulation and suffocation, unspecified intent’ code represents cases where police indicate that the death is a suspected suicide but the deceased had not made a statement of intent before death and the coroner is silent on this issue (for example, the cause of death is assigned

219 For an example of this, see the ‘Prevention and intervention’ section below for recommendations/comments made by a Queensland coroner in relation to a youth suicide last year.

to hanging with no behavioural descriptor).<sup>220</sup> The use of this additional character allows cases to be analysed as undetermined both as per the World Health Organisation definition and for the purposes of the Commission. In addition, consistency with other coding bodies, both nationally and internationally, is able to be maintained by rolling back the additional character to the original ‘undetermined cause’ code.

As the Commission’s child death functions are research functions, legal classifications of suicide are not required to be met. Consequently, the creation of this new ‘unspecified intent’ code allows the Commission to identify all cases of suspected suicide (where, on the basis of police information, the death is suggested to be a suicide) and reduces the under-reporting of childhood suicide occurring in the Queensland Child Death Register (as the majority of these deaths were previously coded as accidents). The following is an example of a case which would be classified as unspecified intent (but would ordinarily be coded as an accident).

#### **Case study**

*Sally,<sup>221</sup> an Indigenous 15 year old, died as a result of hanging. In the days before her death, Sally had arguments with her parents in relation to her alcohol use and non-attendance at her educational institution. The Form 1 indicated that this death was a suspected suicide. Coronial findings stated that the child died by “cerebral hypoxia” caused by “hanging”. No statement was made by the coroner in relation to the intent of the child.*

In accordance with ICD-10 coding rules, suicide is coded when intent is evident in documentation from a medical or legal authority. Therefore, in circumstances where intent is unclear, the default category that coders use is ‘accidental death’.<sup>222</sup>

The Commission suggests that classification of a death to an ‘accidental’ cause is making assumptions relating to intent – it is making a statement of no intent.

As discussed, coroners often do not state intent and the *Births, Deaths and Marriages Act 2003* strictly prohibits the use of the word ‘suicide’ or ‘words to that effect’. Consequently, historical and legislative barriers at a local and state level impede medical or legal authorities from stating intent to suicide to meet International Classification (ICD-10 and World Health Organisation) requirements. Therefore the Commission recommends that statistical agencies (such as the ABS) consult with the NCCH, other child death review teams and coronial systems in Australia to discuss and resolve the status quo specific to the Australian context. The Commission also strongly recommends consideration of an additional character to the standard ICD code so that cases can be analysed as undetermined intent as per the World Health Organisation definition and as suggested by the Mortality Reference Group.

#### **Australian Bureau of Statistics**

The ABS provides the official national, state and regional suicide statistics for Australia, using the ICD-10 to code deaths (Cantor & Neulinger 2000:371). In a meeting with the ABS in December 2005, the Commission sought clarification about the information required and used to code a death as a suicide. It was confirmed that deaths were only coded to suicides in circumstances where the young person had either stated their intent before death or left a suicide note, or where the coroner clearly indicated the intent of the deceased (Australian Bureau of Statistics 2005, pers. comm., 20 December). Therefore, deaths which police note to be suspected suicides, but which do not meet the above conditions, are often coded to ‘accidental’ deaths.

<sup>220</sup> This code specifically relates to deaths as a result of ‘strangulation, suffocation and hanging’. However, suspected suicides (where intent is not clear or is unstated) that occur by other means are also classified according to the new code (for example, a case of falling, jumping or pushed from a high place, unspecified intent = Y30A). The ‘A’ added to the end of the ‘undetermined cause of death’ classification can therefore be transposed across all mechanisms of undetermined death, with the classification being changed from undetermined to unspecified.

<sup>221</sup> Sally is a pseudonym.

<sup>222</sup> The NCCH provided information to the Commission in relation to suicide coding. This information is included in Appendix 10.2.

Cantor et al. (1999:90) note that the ABS's suicide data are likely to underestimate the true suicide numbers, as there has been an increase in the use of the 'undetermined' and 'accidental' death categories in more recent years. Further, delays in resolving cases also affect the accuracy of the suicide data recorded by the ABS. For cases which are not finalised or where findings are not available to the ABS in time for publication of causes-of-death statistics, deaths are coded to other accidental, ill-defined or unspecified causes rather than suicide (Australian Bureau of Statistics 2006:14). Moreover, it is noted that cases which are not resolved before the ABS cut-off date will remain coded to accidental, regardless of the likelihood of the death being deemed a suicide at a later date (Cantor & Neulinger 2000:371). These cases are never reported on and contribute to a significant under-representation of suicide numbers in Queensland and across Australia.

It is also noted that the ABS does not report on suicides for children aged under 15 years of age in the official statistics. For example, the most recent suicide publication released by the ABS, *Suicides: 1994 to 2004*, does not include any data specific to children under 15 years. This non-reporting of childhood suicide has been identified by the Commission as a key factor in the under-appreciation of suicide in children. If these deaths are not reported on, it does not appear that they are occurring.

Further, Cantor et al. (1999:90) have identified a number of deficiencies in official data systems reporting suicide statistics, resulting in:

- underestimates of suicide rates
- unknown numbers of suicides being classified as undetermined and accidental deaths
- additional under-reporting of child suicides, and
- serious contemporary problems in relation to drug overdose deaths.

#### Recommendation 4

The Commission recommends that the Australian Bureau of Statistics works with training bodies such as the National Centre for Classification of Health (a body responsible for the training of mortality coders in Australia), mortality coders, child death review teams in Australia and relevant national representatives of the coronial system to develop a method of coding intentional self-harm, for research and policy development purposes in Australia, that more accurately reflects causes of death where coroners have not clearly stipulated intent or cause because of coronial practices and constraints.

#### Recommendation 5

The Commission recommends that the Australian Bureau of Statistics publicly report on suicides of children and young people under 15 years of age.

The Australian Bureau of Statistics has provided a written response to the Commission in regards to these recommendations. Refer to Appendix 10.3.

#### Impact of under-recording of suicide numbers

The under-reporting of childhood suicides in official statistics has a significant impact on research and resource allocation as well as awareness of this phenomenon. A number of studies have suggested that childhood suicide is rare (Beautrais 2001:647; Wise & Spengler 1997:318) and “not clearly noticeable until the age of 15 years” (Cantor et al. 1999:34). This under-reporting has also resulted in neglect of childhood suicide as an area that requires prevention and intervention. More specifically, while the Queensland Government Suicide Prevention Strategy (QGSPS) 2003–2008 notes that two of the key priority areas are young people and Indigenous young people, information, data and rates are only reported for children aged over 15 years. Moreover, the QGSPS notes that the Indigenous youth focus is for young people aged 15–24 years in particular.<sup>223</sup>

223 Refer to the 'Prevention and intervention' section below for more specific details in relation to the QGSPS.

In contrast, the Commission's *Annual Report: Deaths of children and young people, Queensland, 2004–05* identified suicide as the leading cause of death for children aged 10–14 years, and the second leading cause for 15–17 year olds. This is a finding which has again been made in the current reporting period. The Commission will work with the Queensland Government Suicide Prevention Steering Committee to provide this information and recommend that children under 15 years are also considered as a priority group under the strategy.

When the *Queensland Coroners Act 1958* was repealed in 2003, the use of the term 'suicide' or any reference to self-harming was amended and now is permitted. However, the Registry of *Births, Deaths and Marriages Act (BDMR Act)* did not include a similar revision in relation to the use of the word 'suicide' when it was amended in 2003. Section 37 of the *Registration of Births, Deaths and Marriages Act 1962* (repealed) stipulated that "where an entry of the cause of death is made in any registry of death pursuant to this Act, and the death in question was self-inflicted, there shall not be added to the entry the word 'suicide' or any other word expressly indicating that the death was self inflicted".

Similarly, section 41(5)(b) of the current *BDMR Act* stipulates that, when registering an event, the Registrar must not enter the word 'suicide' or 'words to that effect' into the register.

No other equivalent legislation in Australia has a similar clause to that of the Queensland legislation and, given the recent amendment to the *Coroners Act 2003*, the policy basis for retaining it in the *BDMR Act* is unclear.

As reported in the *Annual Report: Deaths of children and young people, Queensland, 2004–05*, the reluctance of coroners to make a finding of intent to suicide has been attributed to the historical reluctance and legislative direction prohibiting the use of the term 'suicide'.

The prohibition of the word 'suicide' or 'words to that effect' contributes to the under-appreciation and under-reporting of suicide, particularly childhood suicide, and also contributes to the reluctance of

coroners and mortality coders to attribute a death to suicide – particularly for young children.

There appears to be a sound basis on which to request the Registry to give consideration to amending section 41(5)(b) of the *BDMR Act* to remove the stipulation that, when registering an event, the Registrar must not enter the word 'suicide' or words to 'that effect' into the register.

### Recommendation 6

The Commission recommends that by 31 December 2006 the Registry of Births, Deaths and Marriages review section 41(5)(b) of the *Births, Deaths and Marriages Registration Act 2003* and provide advice to the Minister, Justice and Attorney General, about amending the restrictions on entering the word 'suicide' or words to 'that effect' in the register so as to more accurately reflect coronial findings.

## Self-harming and suicide attempts

### Queensland Injury Surveillance Unit data

The QISU<sup>224</sup> provided the Commission with intentional self-harm data for children and young people aged 10–17 years for the financial year 2004–05. During this period, 171 children were recorded as having self-harmed or attempted suicide. Given that not all emergency departments took part in the survey and that not all young people who self-harm are taken to hospital, the real figure is likely to be higher. The details of the QISU data are as follows.

### Demographics

The majority of presentations were of females, representing 79.5%. The data also indicated that young people aged 15–17 years (107 injuries, 62.6%) were more likely than 10–14 year olds to intentionally self-harm (64 injuries, 37.4%).

### Mechanism of injury

The most common form of self-harm presentations were from poisoning through drug or medicinal substance abuse (53.8%), followed by cutting and

224 The QISU currently collects data from 14 hospitals in Queensland which are located in three sample regions: metropolitan (South Brisbane), regional (Mackay and Moranbah Health Districts) and remote (Mt Isa).

piercing (29.8%). Threats to breathing including asphyxia and strangulation comprised only 4.7% of all self-harm/suicide attempt methods. The substances most frequently ingested were paracetamol, followed by other or unspecified drugs. Knives were used most often as cutting utensils. In line with these methods of injury, the QISU found that the majority of presentations were related to poisonings/toxic effects (56.7%), followed by open-wound injuries (26.3%).

### **Place of injury**

By far the most frequent place of injury reported by children and young people was in a free-standing house (97 injuries, 56.7%), with the bedroom the most common room where self-injury occurred (52 injuries). In 29 cases, place of injury was unspecified, and for 15 injuries the self-injurious behaviour occurred at a secondary school (8.8%).

### **Triage and mode of separation**

Almost 50% of children and young people attending hospital for self-injury were assigned a triage status of 'urgent'; 28% were allocated an emergency status and 4 young people required resuscitation (2.4%).

### **Education Queensland data**

In the 6-month period between 1 January and 30 June 2006, Education Queensland reported that Queensland schools filed 204 conduct of harm reports for cases of self-harm by students throughout the state. While most of these reports involved secondary school students (140 cases, 68.6%), 24.5% involved students from preschool through to Year 7. Aboriginal and Torres Strait Islander students comprised 18.6% (38 cases) of the 204 reports received by Education Queensland. Indigenous students appear to be at a greater risk of self-harm than other students.

Most of these reports noted that the parent was not acting protectively (64.2%, 131 cases). The remaining self-harm reports noted that the parents were acting protectively (35.8%, 73 cases).

In addition, Queensland schools filed 189 reports for children reported to be at risk of self-harm. See Appendix 10.4 for complete Education Queensland data.

## **Prevention and intervention**

### **Queensland Government Suicide Prevention Strategy (QGSPS)**

*Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008* was developed to reduce suicide mortality and morbidity in Queensland, particularly in priority populations. The QGSPS aims to assist both government and the community to work towards suicide prevention by:

- providing a better understanding of suicide and suicidal behaviour
- identifying priorities for program development
- implementing these priorities in responsive programs that achieve clear outcomes, and
- building frameworks for robust evaluation and monitoring.

Taking a whole-of-lifespan approach, the strategy recognises that there are different rates of suicide and attempted suicide across age groups, and some specific populations are at higher risk than the general population (Queensland Government 2003:7). Young people are recorded as a key priority area in this strategy. To date, information and rates are only sought for children over 15 years. Indigenous people are also a key target area within this strategy, especially males aged 15–24 years. The Commission is now represented on the Queensland Government Suicide Prevention Steering Committee (QGSPSC) as a supporting agency and is assisting with the evaluation of this strategy and the provision of key data relating to the suicides of Indigenous and non-Indigenous children under 15 years of age.

The Commission would argue that prevention strategies for children under 15 years of age should be considered by the QGSPSC, as the Commission has identified suicide as the leading cause of death for children aged 10–14 years.

## Education Queensland: District Spectrum Plans proposal

Education Queensland has submitted a proposal to carry out a District Spectrum Plan project, approved to be piloted across three geographic districts in Queensland. The District Spectrum Plans aim to provide communities and government and non-government service providers with a plan to work together to support the mental health and wellbeing of young people.

It is acknowledged that school communities, in particular, are under an increasing pressure to provide responses to a range of health and wellbeing problems. The District Spectrum Plans will help coordinate mental health and wellbeing promotion, prevention, management and postvention services for young people across all government departments and relevant non-government service providers. More specifically, the District Spectrum Plans aim to:

- ensure consistent and coordinated responses by schools/districts in addressing and responding to suicide and mental health issues for students
- improve interdepartmental understanding, cooperation and working partnerships in response to suicide and mental health issues in young people
- build the capacity of the community to support and respond to the mental health, wellbeing and suicide concerns of their young people, and
- improve services provided to suicidal young people or those affected by suicide.

The pilots for this project were implemented in July 2006 and will run until June 2007.

## Education Queensland: Suicide Prevention in Schools – Good Practice Guidelines

Education Queensland has recently drafted new suicide prevention guidelines to be implemented in schools across the state. In the past, there has been a significant amount of debate about how to deal with suicide prevention within school settings and, more specifically, within the classroom. These guidelines have been developed on the basis of

national and international research to provide clarification and direction for this often difficult and uncertain area.

In particular, recent studies of suicide prevention programs have raised some serious concerns about the safety and worth of addressing suicide directly when working with students in anything other than a therapeutic context. More specifically, the guidelines identify three areas of a school setting that need to be included in a whole-of-school approach to health issues: curriculum, teaching and learning; policies, procedures, ethos and environment; and partnerships and services.

Education Queensland's guidelines are based on ensuring that schools do no harm. The guidelines are currently in draft form. The Commission has provided feedback on this document and will continue to collaborate with Education Queensland in the development and implementation of the guidelines.

## Queensland Police Indigenous Suicide Awareness and Skills Development Training Program

In January 2006, the Queensland Police Service employed a Senior Project Officer until 30 June 2007 to develop a training package for Police Liaison Officers and Queensland Aboriginal and Torres Strait Islander police to raise their awareness of suicide and self-harm in Aboriginal and Torres Strait Islander people in communities throughout Queensland.

As at 30 June 2006 a draft project plan had been submitted to the Steering Committee of the QGSPS and endorsed, with a time line of 18 months from 1 January 2006 to 30 June 2007.

The project aims to develop and deliver culturally appropriate suicide awareness, prevention and skills training to Queensland Police Service personnel who have regular contact with Aboriginal and Torres Strait Islander people and communities. This training will focus on identification, early intervention and referral to the appropriate services for Indigenous people who are at risk of suicidal behaviour.

## Queensland coronial inquests

As reported in the coronial findings section of this chapter, an inquest was carried out into one of the deaths recorded by the Commission in the Child Death Annual Report, 2004–05. Comments made by the presiding coroner specifically related to the need for improvement of current Education Queensland policies, including:

- the need to review the minimum requirement to communicate with parents of students on each day that a student is absent (truant) from school
- consideration of the compulsory use of software options generating automated SMS messages to parents to tell them that a student is absent, and
- reviews of all Queensland schools' requirements for communication with parents on the issue of truancy, in light of the evidence identified in this inquest.

## National Suicide Prevention Strategy (NSPS): Suicide Bereavement Project

In response to the identification of the significant risk that a family history of suicide, or suicidal behaviour, and/or significant personal grief is often associated with increased suicide risk, the NSPS has developed the Suicide Bereavement Project. The project will undertake four key studies which will:

- evaluate the usefulness and effectiveness of the suicide bereavement support document *Information and Support Pack for Those Bereaved by Suicide or Other Sudden Death*
- conduct a national scoping study of existing bereavement/postvention literature, support, resources, activities and models
- identify options for national coordination of bereavement/postvention activities, and
- provide secretariat support to the National Bereavement Reference Group.

The outcomes of this project will form the basis of a national policy response/strategy for suicide bereavement.

The breadth of these prevention and intervention strategies illustrates that it is the responsibility

of everyone who comes in contact with children, including mental health professionals, teachers, nurses, social workers, physicians and parents, to be aware of the possibility of suicide among children, so that timely intervention toward prevention by evaluation and referral to counselling is successfully achieved. The Commission supports all of the above strategies and recommendations, and commends the relevant Queensland Government Departments and organisations on their work in helping to prevent suicide.

## Future directions

The Commission has found that the problem of childhood and adolescent suicide is a key concern in Queensland. The repetition of these trends in 2005–06 reinforces the importance of understanding the epidemiology and characteristics of children who suicide. In response, the Commission has commenced an in-depth research project into the circumstances surrounding the suicides of Queensland children and young people from 1 January 2004 to 31 December 2006, to be publicly released in mid-2007.

The purpose of this research project is to conduct an in-depth study analysing all cases of suicide and suspected suicide of children and young people under 18 years in Queensland over a 3-year period (1 January 2004 to 31 December 2006). Analysing the demographics, risk factors and circumstances surrounding the deaths of a larger group of cases will make the trends and patterns more easily identifiable and more accurately represented than is the case with year-to-year analysis (in the Commission's annual report of child deaths).

This research project also aims to identify and examine suicide prevention and intervention strategies which target children and young people in Queensland and will identify gaps which may exist in the current delivery of these services. The Commission will make recommendations to reduce the likelihood of these deaths occurring.