# Inquiry into the prevention of youth suicide in New South Wales

National Mental Health Commission
August 2017

## In Summary

The incidence of suicide is tragic. Its causes are complex and multifaceted and the impact it has on families, friends, and entire communities is severe. Patterns of suicide and suicide attempts differ across Australia, and some population groups – including young people – are at higher risk of suicide.

Adolescence can be a very challenging time for young people. There are a number of social and family risk factors that can contribute to the suicidality of youth including but not limited to social disadvantage, parental separation or divorce, family history of suicidal behaviour, and a history of physical and/or sexual abuse during childhood.[1]

The National Mental Health Commission (NMHC) recommends that the New South Wales (NSW) Parliament consider the following gaps that have been identified as opportunities for improvements in the prevention of youth suicide in NSW:

- A coordinated approach working with local communities to planning and service delivery across sectors including health, community services, housing, employment and education is needed.
- Despite the increased suicide prevention services being commissioned at a local level, there continues to be fragmentation[2] and limited services, including in relation to data collection and knowledge at the national level.
- Whilst an increasing number of trials and programs have data evaluation embedded, there is currently no consistent and agreed data collection method for suicide attempts and the support received prior to or following a suicide.
- More needs to be done to identify and prevent suicide clusters which are known to be more prevalent in young people.
- More needs to be done to prioritise both aftercare and postvention activities and programs.
- Suicide prevention activities and programs need to be culturally informed and co-designed with people with a lived experience of suicide and suicide bereavement.

In the submission below, the NMHC will address these gaps and recommendations in more detail.

## About the National Mental Health Commission

The purpose of the NMHC is to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and to act as a catalyst for change

[1] Beautrais, A. L. (2000), Risk factors for suicide and attempted suicide among young people. *Australian and New Zealand Journal of Psychiatry*, 34: 420–436

[2] Department of Health (2017) 'Fifth National Mental Health and Suicide Prevention Plan 2017 to 2022' – advance reading copy

to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

The NMHC seeks to engage with people with a lived experience of mental health issues, including carers and other support people, in all areas of our work. We affirm the right of all people to participate in decisions that affect their care and the conditions that enable them to live contributing lives. Diverse and genuine engagement with people with lived experience, their families and other support people adds value to decision-making by providing direct knowledge about the actual needs of the community, which results in better targeted and more responsive services and initiatives.

Through the National Report Cards on Mental Health and Suicide Prevention, the NMHC has called for further efforts in suicide prevention and a reduction in deaths from suicide. In *Contributing Lives, Thriving Communities - the National Review of Mental Health Programmes and Services* (2014 Review) – the NMHC called for a new approach to suicide prevention, based on a more systematic, evidence based approach, and supported through local planning and coordination.

The NMHC is a leading advocate of 'towards zero' which recognises that the only acceptable rate of suicide is zero. As a community, we need to all work towards achieving this target. This also includes achieving zero deaths in healthcare settings which has been a target adopted by many health organisations, community managed organisation and governments across Australia as well as internationally.

### Australian Advisory Group for Suicide Prevention

In 2015, the Australian Government tasked the NMHC with providing the national advisory functions on suicide prevention, noting that it requires cross sectoral and cross agency input. The Australian Advisory Group for Suicide Prevention (AAGSP) was thereby convened in June 2016 to provide advice, expertise and strategic support on suicide prevention in Australia to the NMHC by identifying priorities and promoting action. Membership of the AAGSP includes people with a lived experience of mental ill-health, thereby enacting the NMHC's commitment to engage people with a lived experience in all that we do.

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

### Aftercare

The NMHC particularly highlighted the potentially tragic consequences of system failure, when people who have attempted suicide do not receive follow-up and fall between the cracks of acute and community based services.

The 2014 Review found that people who attempt suicide are not receiving appropriate support or follow up. People with lived experience of mental ill-health and suicidality share experiences of having been turned away from services or of poor communication with families, highlighting the lack of integrated pathways currently in the system. We know that a previous suicide attempt is a high

risk factor for future suicide[3]. Assertive follow-up during the high risk period, the days and weeks, following a suicide attempt – make it possible to reduce the risk of further suicide attempts. The NMHC supports the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) call for health services to aim for zero suicides within health care settings.[4]

## Postvention

Many organisations have highlighted the important role that the school community plays in suicide postvention. In NSW, NSW Health and the Department of Education are working together to support the NSW School-Link initiative – a state-wide function of Child and Adolescent Mental Health Services which provides specialist mental health services in schools and TAFEs. The action plan makes mention to developing, implementing and reviewing postvention guidelines.

A recent research study *The Ripple Effect* by Suicide Prevention Australia and the University of New England identified that 80% of respondents had been exposed to both suicide attempt and death.[5] Young people may be particularly at-risk of suicidal behaviour following the death of a family member or friend, and can be influenced by the publicity of deaths in the media.[6] As exposure to suicide is a risk factor for subsequent suicide, it is important that postvention activities and programs extend beyond the school setting. Postvention should be a priority action area in all state and territory suicide prevention plans with targeted implementation in workplaces, schools and the community.

*The Ripple Effect* also discussed a number of qualitative responses that were received highlighting the need to address the specific needs of vulnerable populations. The populations groups identified in the report include culturally and linguistically diverse communities, rural and remote communities, people of LGBTIQ experience, those experiencing or who have experienced abuse, refugees and asylum seekers, people who have experienced a bereavement intervention or a trauma during childhood, carers, vulnerable workforce communities (for example construction workers and emergency service workers) and those suffering from severe eating disorders.[7]

The NMHC suggests that it is useful to build on the evidence and work done by some jurisdictions that have progressed youth focused suicide prevention strategies. For example, the Youth Suicide Prevention Plan for Tasmania 2016-2020 prioritises postvention activities.

The NMHC recommends as with all suicide prevention activities and programs, that postvention is culturally informed and co-designed with people with a lived experience of suicide and suicide bereavement.

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[3] Suominen K, et al. Completed suicide after a suicide attempt: a 37-year followup study. *American Journal of Psychiatry*. 2004;161:562-3

[4] Department of Health (2017) 'Fifth National Mental Health and Suicide Prevention Plan 2017 to 2022' – advance reading copy

[5] Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R. (2016) 'The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia'. Sydney: Suicide Prevention Australia.

[6] Beautrais, A. L., above n 1

[7] Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R., above n 5

## Governance arrangements and accountabilities for suicide prevention

Governance and accountabilities for suicide prevention exist at the national, state and regional level.

### Fifth National Mental Health and Suicide Prevention Plan

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), agreed by the COAG Health Council on 4 August 2017, is the first plan to respond to calls for a national approach to address suicide prevention, acknowledging that suicide prevention is the responsibility of all levels of government and government agencies and across portfolios.[8]

As part of dedicated actions in suicide prevention, a new Suicide Prevention Subcommittee of the Mental Health, Drug and Alcohol Principal Committee will be established to set future directions for planning and investment. This group will also develop a National Suicide Prevention Implementation Strategy which includes, amongst others, a priority focus on improved data collections and combined evaluation efforts to build an evidence base for suicide prevention programs policy.

The NMHC will be required to report annually to Health Ministers on the implementation progress of the Fifth Plan.

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

### Primary Health Networks

While national leadership provides direction for improvements to self-harm and suicide prevention initiatives, it is at a local level that people at risk of suicide need to be supported through coordinated systems of care that offer a responsive and networked chain of support.

In its 2014 Review, the NMHC recommended a comprehensive community response to suicide prevention. The new role of Primary Health Networks (PHNs) in planning and commissioning mental health and suicide prevention services provides a significant opportunity to introduce regionally-appropriate suicide prevention models using a systems approach.

**Suicide Prevention trial sites**

The NMHC recommended in its 2014 Review the establishment of local suicide prevention trials in 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention. The areas suggested for an initial focus are those with high rates of suicide and suicide attempts, or where communities are under increasing stress. [9]

The Australian Government has funded 12 suicide prevention trials in regional, rural and remote areas. Of these, two are located in NSW, led by Western NSW and North Coast NSW PHNs. Other suicide trials have a mix of government and philanthropic funding, in NSW these trials of the LifeSpan systems approach to suicide prevention by Black Dog Institute are in four locations– Newcastle, Illawarra Shoalhaven, Gosford/Wyong and Murrumbidgee. beyondblue is trialling in the

[8] Department of Health (2017) 'Fifth National Mental Health and Suicide Prevention Plan 2017 to 2022' – advance reading copy

[9] National Mental Health Commission. Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services. Sydney; 2014.

Hunter region, the Way Back Support Service – a new suicide prevention program focused on aftercare.

The NMHC emphasises the importance of monitoring and evaluating these trials especially given the different approaches and models being used. Sharing information about what works and in what context, will be vital for governments at all levels, PHNs, communities and other stakeholders. It also will be critical for the co-design of future services with people with lived experience, their families and other support people.

## Data collection about the incidence of youth suicide and attempted suicide

### Statistics

The Fifth Plan notes that there has been no significant reduction in the suicide rate over the last ten years despite the ongoing improvement in suicide prevention activities.[10] Nationally, suicide accounts for one in three deaths among those aged 15 to 24 years.[11]

The NSW Parliamentary Research Service has conducted research into the prevalence of suicide in NSW, including specific reference to youth.[12]

In NSW, young people's concerns about mental health have increased. The most recent youth survey conducted annually by Mission Australia reported that youth identified mental health as the third most important issue in Australia today (22.6% in NSW). However, what is significant is the increase in the identification of this issue from 13.6% in 2014. Further to this, the gender difference produces a gap in opinion with females far more concerned about mental health (28.6%) compared to males (15.6%). In 2014, the economy and financial matters, population issues and politics were the top three issues identified. In 2016, there has been a complete shift in important issues with alcohol and drugs, equality and discrimination and mental health being identified as of highest concern.[13]

Although not all people who die by suicide have a mental illness, the suicide rate among people with a mental illness is at least seven times higher than the general population.[14] Suicide can be associated with distressing life events and given adolescence can be a particularly challenging, stressful and confusing time, there is an increased risk of self-harm and suicidal behaviour in this population group.

Nationally, suicide rates for Aboriginal and Torres Strait Islander young people, particularly males, are alarmingly higher that non-Aboriginal or Torres Strait Islander young people.[15]

[10] Department of Health (2017) 'Fifth National Mental Health and Suicide Prevention Plan 2017 to 2022' – advance reading copy
[11] Australian Bureau of Statistics. Causes of Death, Australia, 2014. Cat. No. 3303.0. Canberra 2016.
[12] see Lenny Roth 'suicide prevention' e-brief 3/2017, NSW Parliamentary Research Service, July 2017
[13] Bailey, V., Baker, A-M., Cave, L., Fildes, J., Perrens, B., Plummer, J. and Wearring, A. (2016) Mission Australia's 2016 Youth Survey Report, Mission Australia.
[14] SANE Australia (2017) Suicidal behaviour fact sheet
[15] Youth Action (2016) The Australian Youth Development Index: A Jurisdictional Overview of Youth Development. Sydney: Youth Action.

## Data sources

Suicide rates vary significantly across the population, illustrating the complex nature of suicide and the challenge of developing and implementing suicide prevention responses. In young people, suicide makes up a higher proportion of deaths than in other age groups and is the leading cause of death for Australians aged 15-44 years.[16]

Through both the National Report Cards on Mental Health and Suicide Prevention and the 2014 Review, the NMHC identified that suicide prevention services are fragmented and limited, including in relation to data collection and knowledge at the national level. This message was affirmed at a recent meeting of the AAGSP where concerns with data collection, data exchange and knowledge exchange within the sector were raised again, highlighting the need for priority action.

In 2012, the World Health Organisation stressed the need to be informed by data-driven evidence. Australia's complex health system provides multiple sources of suicide related data nationally, including the Australian Bureau of Statistics' causes of death data and the National Coronial Information System dataset.

The National Committee for Standardised Reporting on Suicide convened by Suicide Prevention Australia, is currently working to establish a National Minimum Data Set, with the aim of improving the quality of suicide deaths data.

Non-direct suicide and self-harm data collection sources include the Australian Trauma Registry which collects national trauma data, including how patients were injured, the nature of the injuries they sustained, the treatment they received and their outcomes. This data also includes information on any intentional self-harm that was treated in a major trauma centre.

In NSW, the Child Death Review Team convened by the NSW Ombudsman, is responsible for maintaining a register of child death and reviewing the deaths of children aged 0-17 years to identify trends and patterns in relation to those deaths. The Team reports on death by suicide and in its most recent publication, it reported the largest number and highest rate of suicide for young people in NSW since 1997, at 26 deaths.[17]

To assist PHNs to implement the right interventions in a timely way, they will require access to reliable and timely data about their local area. This is particularly important when suicide clusters emerge or when the region is affected by other economic, environmental or social factors that are linked to higher suicide rates.

Challenges exist for the PHNs in getting access to reliable and timely data. PHNs have reported poor systems data sharing with general practitioners, compounded by the varying ways data is collected at a local level by the many organisations working in suicide prevention, clinical services, hospitals and emergency services collect their own forms of data, most of which is not publically available or shared.

[16] Australian Bureau of Statistics. Causes of Death, Australia, 2014. Cat. No. 3303.0. Canberra 2016.
[17] NSW Child Death Review Team (2016) 'Child death review report 2015'

## Suicide Clusters

Lack of up to date data makes it difficult to identify potential or existing suicide clusters. Suicide clusters are defined as 'a group of suicides that occur closer together in time and space than would normally be expected.'[18] Suicide clusters are an important consideration as studies have indicated that youth suicides were twice as likely to happen in clusters as adult suicides and that Aboriginal and Torres Strait Islander youth and youth in regional and remote Australia were most at risk.[19] It is therefore necessary to consider which data plays a critical role in trying to understand the reasons behind any observed trend in suicides.

The NMHC recommends access to real-time data (including self-harm data) as a means of early identification of suicide clusters. It is acknowledged that improving access to data is a complex issue, and that jurisdictions can benefit from sharing with other jurisdictions. Victoria and Tasmania have some recent experience in the development of real-time reporting as a more proactive approach to intervention.

# In Conclusion

The NMHC recognises as the ripple effect reaches out to communities that considerable effort is contributed by many people – by communities, providers, schools, first responders – to reduce suicide and to work with those in the community impacted by loss due to suicide. Yet despite the positive work focused on the prevention of youth suicide, including in NSW, the NMHC has identified gaps that still exist in suicide prevention more widely.

The NMHC agrees with the Fifth Plan's call for a commitment by all governments to focus on the 11 elements in WHO's *Preventing suicide: A global imperative,* especially on *surveillance* to increase the quality and timeliness of data on suicide and suicide attempts.[20]

More rapid, accurate and comprehensive local and national data on self-harm, suicide and suicide attempts continues to be urgently needed to inform new prevention efforts. The NMHC believes as part of a broader systematic approach to measuring mental health outcomes, we need to agree on national indicators that can be used to benchmark progress in reducing self-harm, suicide and suicide attempts. This data will also allow us to analyse trends and clusters in suicide and self-harm, and therefore, target more immediate responses to help people and communities at risk – particularly for high-risk groups such as youth.

The NMHC identifies one of the key challenges is that currently there is no consistent and agreed data collection method for suicide attempts and the support received prior to or following a suicide. Linking state and federal administrative data sets may enable the sector to identify, and analyse the effectiveness of, service pathways used by people prior to and following suicide attempts. Performance indicators around active follow-up for people who have attempted suicide should be

[18] Jo Robinson, Lay San Too, Jane Pirkis and Matthew J. Spittal (2016) 'Spatial suicide clusters in Australia between 2010 and 2012: a comparison of cluster and non-cluster among young people and adults' *BMC Psychiatry* 16:417

[19] Jo Robinson, Lay San Too, Jane Pirkis and Matthew J. Spittal, above n 14

[20] Department of Health (2017) 'Fifth National Mental Health and Suicide Prevention Plan 2017 to 2022' – advance reading copy

developed and routinely introduced to assess the availability and effectiveness of post-discharge support.

The NMHC would encourage NSW to look at work in Victoria and Tasmania regarding real-time reporting and a more proactive approach to intervention, as well as Tasmania's approach to prioritising postvention.

The NMHC appreciates the opportunity to comment on the prevention of youth suicide in NSW.