Child and Youth Mortality Review Committee

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Fifth Report to the Minister of Health
Reporting mortality 2002–2008

Chapter 4 Youth Suicide

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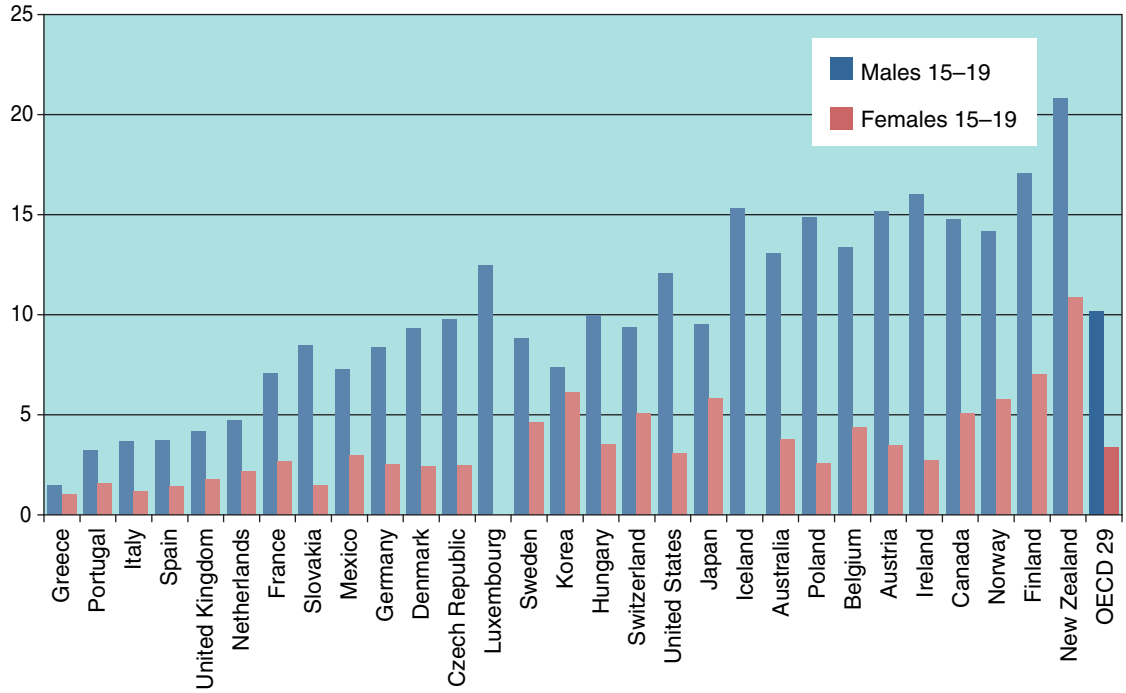
4 Youth Suicide

4.1 Introduction: death from intentional self-harm

International comparisons show that New Zealand has the highest rates of youth suicide in the OECD for both men and women aged between 15–19 years according to a recent OECD publication(OECD 2009a). Caution needs to be taken when making international comparisons of suicide rates because many factors affect the recording and classification of suicide and can result in undercounting of suicide in other countries.[44] However, it is a significant concern that too many young people die by suicide in New Zealand.

Figure 4.1 Youth suicides per 100,000 youth aged 15–19 years in the OECD, by sex (data averaged for the most recent three years)



Source: World Health Organization Mortality Database 2008, *as cited in OECD 2009a: 52.*

Notes: Comparability of suicide statistics is dependent on reporting mechanisms in each country, as varying degrees of social stigma associated with suicide may lead to variations in under-reporting. No data is available for Turkey. There were no reported female youth suicides in Luxembourg and Iceland during the period.

In the early 1900s the highest rates of suicide in New Zealand were in the over 45 year age group. Since the mid-1980s this trend has changed, with the highest rates being in the under 45 years age group, and the highest rates across all ages being in the 15–24 years age group (Ministry of Health 2008a: 4). The rate of suicide in this age group (ie, 15–24-year-olds)

44 Key factors influencing reporting rates are the level of proof that is required for classification of a suicide, which is very thorough in New Zealand and is made after a Coroner's investigation. This means compared to other countries New Zealand has a low number of "undetermined deaths." The stigma associated with suicide may also influence reporting rates as it deters the classification of a death as a suicide in some countries.

increased from 15.6 per 100,000 in 1986 to a peak of 28.7 per 100,000 in 1995 (Ministry of Health 2008b: 6). The rate then decreased until 2000, where it appears to have reached a plateau at an average of 17.8 per 100,000 over the past five years, according to CYMRC data.[45] This rate is still higher than in the early 1980s, and is significantly higher than that recorded during the 1940s to 1960s of less than 5 per 100,000.

Every year approximately 110 young New Zealanders (aged 10–24 years) die by suicide.[46] This accounts for about a fifth of the total number of suicides each year in New Zealand.[47] The development of effective population-based strategies for suicide prevention is dependent on a clear understanding of the risk and protective factors relevant to New Zealand youth, along with ongoing information about the rates and causes of suicidal behaviour.

4.2 Statistics on youth suicide from the CYMRC database and other sources

Suicide now accounts for about 25% of the deaths of young people aged 10–24 years (see Table F.1, Table G.1, and Table H.1 in the appendices.) Approximately 75% of these are males and 25% are females.

Table 4.1 Suicide deaths (numbers and age-specific rates per 100,000), by age group, 2003–2007[48]

Age group	Gender	Deaths						
		2003	2004	2005	2006	2007	Total	Average rate
10–24 years	Female	33	37	24	28	26	148	6.6
	Male	71	85	86	100	70	413	17.9
	Total	104	122	110	128	96	561	12.4
15–24 years	Female	32	32	24	23	25	137	9.3
	Male	66	80	83	99	68	396	26.4
	Total	98	112	107	122	93	533	17.9

Māori young people have a disproportionate rate of death due to suicide compared to their non-Māori counterparts. The rates of suicide in Māori aged 15–24 are over two times that of non-Māori in the same age group. Although the rates of suicide in Māori and non-Māori have decreased from a peak in 1996, this decrease has been substantially less in Māori. The rate of suicide in Māori has decreased by 14% since the peak in the late 1990s, and during this same period the rate in non-Māori has decreased by 21% (Ministry of Health 2008a: 5).

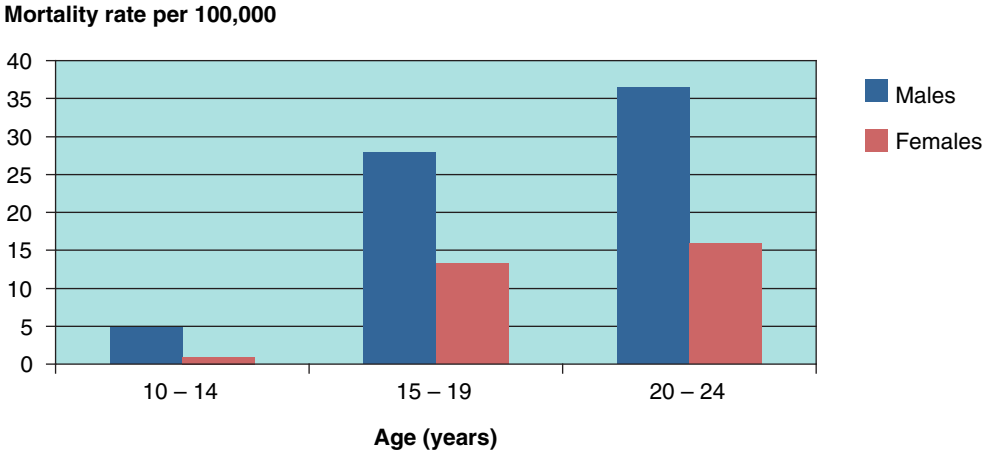
45 This average rate was calculated using data from Table 4.1 and data from the CYMRC's *Fourth Report to the Minister of Health*. The 2008 data included in Appendices G and H is not considered here as too many cases were awaiting coroners when the data extract occurred. Appendices G and H can be found online at http://www.cymrc.health.govt.nz, *Fifth Report to the Minister of Health: Reporting mortality 2002–2008.*

46 This average was calculated using data from Table 4.1.

47 'Each year approximately 500 New Zealanders die by suicide' (Ministry of Health 2008b: iii).

48 The CYMRC suicide data on the number of suicides per year differ from that published in the Ministry of Health Suicide Facts series. This is primarily because the Ministry of Health reports by year of registration of death whereas the CYMRC reports by calendar year of death. It will also differ because the number awaiting coroner changes over time and local review groups may amend the cause of death before it is reported by the coroner.

Figure 4.2 Suicide deaths (age-specific rates per 100,000), by ethnicity and age group, 2003–2007 combined



Risk factors for suicide have been shown to include mental health disorders including depression, non-heterosexual attractions, adverse experiences, including sexual, physical and emotional abuse, neglect, family breakdown, family violence, parental mental illness, alcohol and drug abuse, and having a friend or family member attempt suicide.[49]

4.2.1 The National Survey of the Health and Wellbeing of New Zealand Secondary School Students

An understanding of emotional health is very important to understand New Zealand suicide rates. The CYMRC data alone is unable to provide such detail, but the findings from the Adolescent Health Research Group complement the CYMRC data in this regard. This group, at the University of Auckland, has conducted two national surveys (one in 2001 and a second in 2007) of New Zealand secondary school students. These surveys provide valuable information on the emotional health of New Zealand youth.

Issues of mental health and wellbeing are a concern for many New Zealand youth, particularly females. Emotional health concerns such as depression dramatically increase around puberty, and significant numbers of young people, especially females, have high rates of depressive symptoms (Adolescent Health Research Group 2008a: 24). Twenty-seven percent of young people attending high school in New Zealand in 2007 reported being depressed for two weeks or more in the past 12 months; 20% of them had deliberately self-harmed in the last 12 months; and about 15% of those who deliberately harmed themselves required treatment by a doctor or nurse (Ibid: 102).

While the majority of young people indicated they had good emotional wellbeing, with 86% reporting some sense of satisfaction with their life, almost 15% of females and 7% of males reported levels of depressive symptoms that are considered to be serious and in need of professional assistance. In addition, 14% of the young people surveyed (19% of females and 9% of males) reported that they had serious thoughts of suicide in the past 12 months, 8.6% had made a suicide plan and 4.7% (7% of females and 3% of males) reported having attempted suicide (Adolescent Health Research Group 2008a: 24; Adolescent Health Research Group 2008b: 103). About 25% of these attempts were significant enough to have required treatment by a doctor or nurse (Adolescent Health Research Group 2008b: 103). While these numbers are still too high, the data from 2007 does show "a marked improvement in students' emotional

49 See Ministry of Health 2008a for more detail on risk factors associated with suicide.

wellbeing and associated behaviours" compared to the 2001 findings (Adolescent Health Research Group 2008a: 25).

Young people rated emotional worries as one of the health issues they had the most difficulty getting help with, second only to getting help for an injury or accident (Adolescent Health Research Group 2008b: 93). Nine percent had difficulty getting help for an emotional worry (Ibid). Reasons for not accessing health care included not wanting to make a fuss, not being bothered, being too scared, concerns about confidentiality, cost, not being able to get an appointment, lack of transportation, not feeling comfortable with the person, and not knowing how to get help or contact the health professional (Adolescent Health Research Group 2008b: 92–93).

Young people are the least likely of any age group to visit a health service for mental health concerns. This is despite their high levels of mental health needs. Young people are more likely to access health services if they are youth friendly and targeted to their needs (eg, school-based or 'one-stop-shop' health centres).

Violence is closely associated with suicide attempts in young people. Factors associated with suicide attempts in young people were witnessing family violence against adults, being the perpetrator of any serious violence, unwanted sexual contact, frequent bullying and frequent physical violence (Fleming et al 2007).

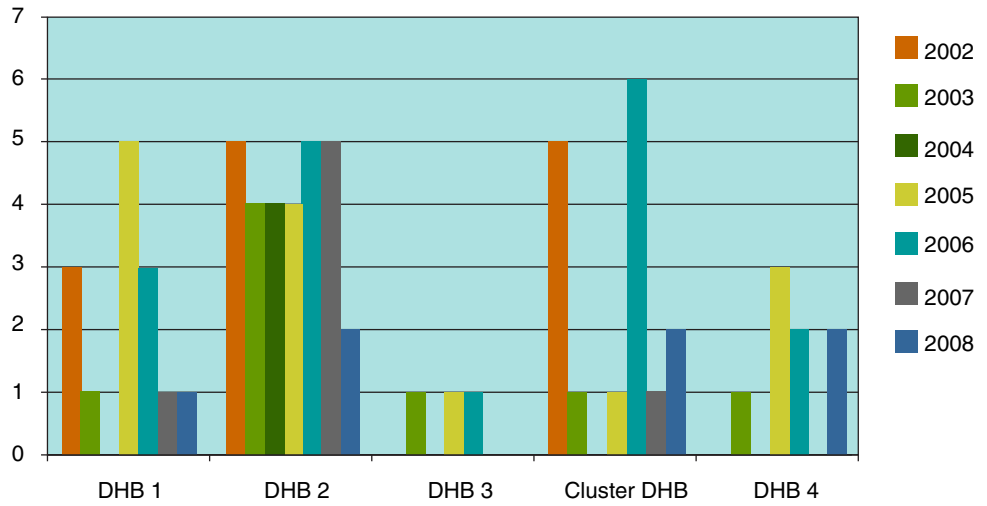
A cluster of adolescent deaths from self-harm in 2006: report of a local child and youth mortality review group investigation
by Barry Taylor

Introduction

During six months in 2006 there were six deaths by suicide of adolescents aged 15–18 years in an area of New Zealand where normally there would only be one death every two years. After reviewing various definitions of clustering we were able to find this constituted a cluster.

This cluster of adolescent suicides was not recognised as such until after the fifth death, when the possibility of a contagion effect was raised. The CYMRC process enabled an intersectoral multidisciplinary review to occur, and this report summarises the main findings and recommendations.

Figure 4.3 Deaths from intentional self-harm, 15–18-year-olds, cluster DHB and four comparison DHBs, 2002–2008



The review of the cluster consisted of three integrated processes.

1. Review of cases

The initial focus was to examine the events surrounding the identified cases.

The agreed case definition was 'a person aged 15 to 18 years living in the cluster DHB who died from self-inflicted injuries between 1 June 2006 and May 2007.

A survey instrument was developed to systematically collate information on each case. The focus was on describing the characteristics of the cases, identifying any risk factors and precipitating events, and considering whether contagion had occurred, as well as highlighting any systems issues of concern.

Sources of information were:

- health records from hospital psychiatric services, GPs and any involved community agencies
- school records from school counsellors
- public health nurses
- police information from forensic examination of computers and cell phones
- interviews with family members who wished to talk to the review team.[50]

50 The mortality review group does not usually contact the families of cases it reviews, although parents and whÐnau do have an opportunity to provide comment related to the events surrounding the deaths of loved ones by accessing the national CYMRC website (http://www.cymrc.health.govt.nz/). The investigation group decided that the chair of the group (a paediatrician with experience in talking to families after the death of their child) and co-ordinator should make contact with appropriate family members of the cases to request a further interview based on key questions developed by the review team. A letter was sent to the families explaining the purpose of the request for a meeting, along with assurances that any information gathered would remain confidential and anonymous if used in any report. A follow-up letter and phone call were made to those families who had not responded within two weeks. Three families agreed to an interview.

2. Review of non-fatal suicide attempts presenting to emergency departments

To ascertain if there had been any increase in non-fatal self-harm admissions contiguous with the cluster a paper review was made of a random selection of these admissions. No increase in admissions for self-harm was seen, and there appeared to be timely and appropriate assessment by the emergency mental health services.

3. Review of interface between school counsellors and health services

A meeting with all local school counsellors was held to discuss school counsellor involvement with suicidal youth and access to mental health services.

Main findings

- The funeral for the index case was large and attended by a large proportion of the involved school.
- There were contacts or connections between at least four of the cases – probably mainly through the informal social networks.
- Knowledge of the suicide cases spread rapidly among the youth of the region and subsequently to parents. The use of texting appears to be important in this rapid spread of information.
- There was considerable misinformation spread by these means, both about the number of cases and about the possibility of a 'suicide pact' among young people in the region.
- There were clearly identifiable predisposing factors and precipitating events (usually relationship break-up) in most of the cases.
- Most were not involved with primary or secondary mental health services. For those who were, some difficulties were identified relating to appropriate 'engagement' and co-ordination of care over long time periods.
- For many of the cases there was extensive use of the internet and cell phone texting. Text and internet bullying does occur, but a case series such as this does not allow us to determine if this is a significant risk factor.
- There are considerable improvements possible in how the DHB monitors the mental health of youth, how it identifies youth mental health issues, and how it connects individuals requiring mental health support to appropriate well-trained services.
- A number of issues related to school counsellors arose:
  - Schools are not *required* to employ any school counsellors.
  - There are no national or local recommendations for what is the appropriate school counsellor to pupil ratio.
  - There is a gap in training among some school counsellors relating to crisis intervention after non-fatal and fatal suicides.
  - School counsellors are not required by the schools to have any formal training or registration with a professional counselling body. This may be due in part to a lack of understanding by the school of counselling and the counsellor's role in the school. In the DHB concerned, about 70% do have training, or registration with an appropriate body.

  - School counselling is a difficult and taxing occupation. School counsellors need to have their practice under regular review by a process of formal supervision. This supervision should be with a professional with recognised expertise in the mental health area.
  - A formal consultation with local youth suggests that most would find it difficult to approach and confide in school counsellors because they are seen as one of the 'teaching' staff. The dual roles of teaching and pastoral care may therefore act as a barrier to access.
- The DHB emergency services appropriately deal with acute self-harm events and are attended to immediately by the emergency psychiatric service.
- On referral to specialist secondary care, mental health services engagement can be slow (51% seen by the service more than 7 days after presentation). This strongly limits the ability of the service to engage the client. Also, specialist secondary care mental health services connection and liaison with schools has not been a priority and has therefore been erratic. The perception from the school level is of difficulty getting adequate and quick responses when they are needed from the specialist secondary care mental health services.
- There is a gap in the availability of counselling services for those youths who fall outside the moderate to severe category of mental health.
- Support for the family and friends of those who die from suicide is limited in the cluster DHB.

4.3 Recommendations from the CYMRC local review process

A review of the recommendations made by the local child and youth mortality review groups regarding death by suicide shows a number of common themes.

- **Access to health services.** Access to health services is one of the most common themes that has emerged from the local child and youth mortality group reviews of death by suicide. For some young people this means difficulty accessing needed services. Some reviews showed that there appears to be a lack of youth-friendly services related to mental health and/or drug and alcohol addiction.
  Not all youth mental health services maintain a supportive relationship with school counsellors. Supporting school counsellors could be identified in the job description of specific staff to make sure school counsellors have access to resources to help them cope with the mental health needs of students. Current systems can have waiting times that make appropriate engagement at the right time difficult, and so the DHB could consider establishing mechanisms for meeting this need (eg, funding private sector counsellors or psychologists for this work, or possibly using the model used by the Family Court referral scheme for relationship and parenting issues). This would provide early intervention for moderate-needs youth.
  There were instances of referral but no follow-up when the young person did not attend appointments. This indicates a different kind of problem. Health care providers must have checks and balances in place to prevent patients – particularly patients who are at high risk of self-harm – from falling through the cracks in the system. (See Chapter 5 on System Improvements.)
  At times families and friends recognised the distress a young person was suffering but were unsure where to seek help or were unable to persuade the young person to engage help

before suicide was completed. It seemed primary health care was not viewed as the obvious place to seek help for emotional distress or depression.

- **Staff skills and practice.** Not all health professionals are adequately skilled to provide assistance to young people. Health care providers need additional skills in understanding confidentiality issues both from the point of view of when to preserve confidentiality and when they are obliged to share information. (See Chapter 5 on System Improvements.) Full psycho-social health assessments such as the HEADSS assessment done by appropriately skilled staff do not always occur. They should be universally performed by staff skilled in their use, as screening and detection tools in much the same way as family violence screening occurs.
- **Multiple service providers.** Another common theme identified in the local reviews was the sharing of information between multiple service providers. While many of the reviews showed that the youth had a history of service provision, sometimes information was not being shared between providers.
  In at least one DHB region the local mortality review of youth suicides has directly resulted in system changes in protocols between police and mental health services to support collaboration and enhance the potential to prevent further deaths.
- **Bereavement.** The reviews also showed that youth who have experienced the death of a loved one (often via suicide as well) are at a greater risk for self-harm. For this reason, the development of after-death care pathways are important. (See Chapter 5 on System Improvements.) The Ministry of Education post traumatic incident support was seen by local groups as very helpful and supportive. Not all schools choose to use this service. Schools often need support around managing involvement in funeral care and organisation so as to minimise distress and the potential to promote suicide contagion. The media has an important role with regard to the responsible reporting of suicide. Media guidelines have been developed to reduce the potential for future copycat suicides (Ministry of Health 2008a: 48).
- **Building resiliency.** Childhood and adolescence are times when the development of positive coping strategies and increased self-esteem can lead to increased resilience despite adverse events. Protective factors include warm and caring families, and safe schools and communities. (Simon Denny argues the same point in Chapter 3.) Youth mentor programmes can be very effective in building resiliency for young people. Research shows that young people are more resilient when they have healthy connections with family, school, culture and community as well as a sense of purpose.

4.3.1 Suicide prevention in New Zealand

In 1998, the *New Zealand Youth Suicide Prevention Strategy* ('In Our Hands' and 'Kia Piki te Ora o te Taitamariki') was launched as a result of collaborative work across three Ministries (Ministry of Youth Affairs et al). The five goals it contained remain valid today and are echoed in the issues raised in the cluster review and from the CYMRC local reviews. They are also relevant to youth support in general and reducing the toll from risky behaviours highlighted in Chapter 3 of this report.

1. **Promoting Wellbeing** – To prevent young people becoming at risk of suicide through strengthening families and whānau, young people and communities.
2. **Early Identification and Help** – To better identify and help young people at risk of suicide, and reduce opportunities which present suicide as an option.

3. **Crisis Support and Treatment** – To improve support and treatment for young people who have attempted suicide or who are suicidal.

4. **Support After Suicide** – To give effective support to those who are bereaved or affected by a suicide, and to reduce the potential for further suicides.

5. **Information and Research** – To improve information about the rates and causes of suicidal behaviour in young people to inform effective prevention efforts.

In 2006, the focus on suicide prevention in New Zealand changed to one to involve all ages with the publication of the *New Zealand Suicide Prevention Strategy 2006–2016* because almost 80% of suicides occur over the age of 25. With development of this all-ages approach it is important that the specific needs of young people are not forgotten. The vision and inspiration for the strategy is:

a society where all people feel they:

- are valued and nurtured
- value their own life
- are supported and strengthened if they experience difficulties
- do not want to take their lives or harm themselves.

It is very easy to appreciate that the needs of young people in these regards will be very different from the needs of others.

To achieve the above vision, the Strategy sets out broad areas for action, described as seven goals. Covering the spectrum of prevention and setting the directions for New Zealand's efforts for the next 10 years, the seven goals are as follows:

1. Promote mental health and wellbeing, and prevent mental health problems.
2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.
3. Improve the care of people who make non-fatal suicide attempts.
4. Reduce access to the means of suicide.
5. Promote the safe reporting and portrayal of suicidal behaviour in the media.
6. Support families/whānau, friends and others affected by a suicide or suicide attempt.
7. Expand the evidence about rates, causes and effective interventions.

These documents have provided a valuable focus on prevention and the Ministry of Health continues to lead a multi-sectoral approach to suicide prevention. As new work, such as the primary mental health initiative, is developed, it is very important the needs of young people continue to be considered.

The local child and youth mortality review groups have been asked to use the seven goals as a framework to highlight what preventive interventions might have averted each completed suicide.

Five DHBs are currently running pilot studies with local suicide prevention co-ordinators. Some of these co-ordinators are also members of local child and youth mortality review groups. This is a particularly valuable link because these individuals can gain access to information to inform their work and their specific role allows them to convert the learning from local review into practice.

4.4 Recommendations by the CYMRC on suicide prevention

4.4.1 Policy

1. The CYMRC supports, as a high priority, specific preventive work in every DHB with central leadership to achieve the seven goals of the *New Zealand Suicide Prevention Strategy*.
2. The youth-focused actions suggested from *In Our Hands* should be remembered and youth specific elements should continue to be formulated within the current suicide prevention initiatives.
   - Health services geared towards, and accessible to, young people (eg, youth one-stop shops and school health clinics).
   - Endorsement of worldwide youth health standards, similar to those promoted by the Society of Youth Health Professionals Aotearoa New Zealand (SYHPANZ).[51]
   - Greater intersectoral collaboration, working across primary and secondary care, school services and mental health services, including drug and alcohol.
   - Support research about the nature, correlates and causes of suicidal behaviours, and research into resiliency.
3. The impact of modern communications technologies on adolescent suicide should be acknowledged and better understood.
   - The Ministry of Health review of its guideline *Suicide and the Media* should include advice around modern technologies.
   - Health research funding bodies should consider funding research to identify if and how modern technologies contribute to suicidal predisposition, precipitation and completion.
4. The Ministries of Health and Education should jointly review the role of school counsellors. This review should consider: whether the role is educational guidance counsellors or health/social services counsellors; staffing levels; training requirements; professional development; and how they might be better supported by the health sector. School counsellors should:
   - have appropriate skills
   - be registered with a professional association
   - be integrated into the whole of the school
   - have regular supervision from someone with appropriate skills
   - have a supportive relationship with mental health workers.
5. Appropriate procedures and use of Ministry of Education post traumatic incident support by schools should be included within the elements of school performance reviewed by the Education Review Office.
6. The Ministry of Health should monitor and respond to performance of primary health organisations (PHOs) with regard to coverage of service and capitation for care in young people.

51 For more information see http://www.nzaahd.org.nz/index.php/youth-health/youth-health-professionals.

4.4.2 District Health Boards

7. Each DHB should have in place:

- a suicide prevention action plan to implement the *New Zealand Suicide Prevention Strategy 2006–2016*, with a focus on youth
- a mechanism for identifying community-based health crises, including those relating to mental health and suicidality, which links to a multidisciplinary response with clearly assigned responsibilities
- a mechanism for supporting families bereaved by suicide
- a system that uses what is learnt from cases of suicide to modify local systems of care, prevention and support
- an assigned role for specific staff to maintain a strong supportive relationship between youth mental health services and school counsellors
- a system whereby referrals from school counsellors receive timely care
- a system that ensures all mental health concerns are taken seriously
- PHOs need to make efforts to improve coverage of care for young people and use strategies such as youth one-stop shops and school based clinics to enable increased coverage.

Community messages

- In communities where leadership across sectors results in services that are connected, collaborative and cohesive, it is easier for young people to obtain support and connect to the services they need.
- Developmentally young people can be vulnerable and we need to be vigilant to changes in mood, presentation and actions.
- Emotional and mental health problems can be serious and require professional attention. General practice or youth health clinics are appropriate places to seek help.
- When a young person has been identified who needs mental health services, there are a number of youth-specific resources available, such as Youthline, Mental Health Line and What's Up.
- Spend time with young people to build connections, give a sense of purpose and enhance resiliency.
- Strengthen the whānau, social networks and community networks around young people. Disengaged young people are at particular risk.
- Value young people, focus on their strengths and support them in finding purpose.
- Involve young people in decision-making.