Thematic review of deaths of children and young people through probable suicide, 2006-2012

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Foreword

Suicide is a major cause of death in teenage years. Although a rare event, around one in four deaths which are from external causes (60 of 260 in the last decade) among those aged 12-17 are likely to have been through suicide. Whenever someone takes their own life it is a tragedy and causes distress for many people - family, friends, professionals and the wider community. It can be particularly difficult to cope when that person is a child or young person.

Suicide in children and young people is often the end point of a complex history of risk factors and adverse life events. This review identifies opportunities for suicide prevention. It was performed with the collaboration of a truly cross sectoral panel who all brought their knowledge and expertise. They ranged from health to education, the police to the third sector. It was clear that each organisation had a contribution to make in preventing these deaths and that this would be achieved most effectively when they worked in partnership.

This thematic review sought to examine modifiable factors that may have contributed to suicide deaths, identify opportunities for prevention and make recommendations to reduce the risk of suicide for children and young people in Wales.

There is a real opportunity for this review to build on the steps set out in *Talk to me*, Welsh Government's national action plan to reduce suicide and self-harm in Wales, and influence future policy, as the plan is refreshed later this year. Suicides are not inevitable and we all have a part to play in trying to prevent further deaths.

Professor Keith Lloyd
Chair of Thematic Review Panel; Dean and Head of the College of Medicine, Swansea University; Consultant Psychiatrist; Board Member Samaritans Cymru

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Every suicide is a tragedy and causes distress for many people - family, friends, professionals and the wider community. It can be particularly difficult to cope with the traumatic experience of losing a child or young person through suicide. Although a rare event, suicide is a major cause of death in teenage years, with around 60 of the 260 (almost one in four) of the external cause deaths of children and young people aged 12-17 in the last decade in Wales likely to have been through suicide. *Talk to me*[1], the five year national action plan to reduce suicide and self harm in Wales, was published in 2009.

The Child Death Review Programme undertook this thematic review to examine factors that have contributed to suicide deaths, identify opportunities for prevention and make recommendations to reduce the risk of suicide for children in Wales.

Method

Children and young people aged 10 to 17 who died through suicide, 2006-2012, were included in the review. Information on the children and young people was obtained from multiple sources and summarised using anonymised life charts. These were presented to a multi disciplinary thematic review panel, together with evidence reviews on risk factors and effectiveness of interventions to prevent suicide. The panel met twice, formed key messages and recommendations and agreed the final report.

Findings

Thirty-four children and young people were included in the review. Two thirds of these children were aged 16 or 17, and three quarters were male. A number of factors relevant to the deaths of these children were identified including socio-demographic and educational factors, individual negative life events and family adversity, involvement with services, factors proximal to the death and access to means of death.

Key messages

The key messages highlight possible opportunities for suicide prevention and processes that might support this. They include: access to means of suicide, improving partnership working, focusing on evidence based interventions, public awareness and stigma, and undertaking future thematic reviews.

Key Recommendations

The panel made 20 recommendations. The following were strong recommendations:

- Welsh Government should pursue mechanisms to restrict the access of children and young people to alcohol. This includes a minimum price per unit, regulation of marketing and availability, and action on under-age sales. This may be through working within existing powers, seeking further or additional powers, or lobbying the UK government for changes.

- Welsh Government should develop mechanisms for an all-Wales child protection register to which all local authorities contribute which is accessible by relevant services as needed, and emergency departments in particular.

- Welsh Government should support and develop mechanisms to ensure that NICE guidance on the short and longer term management of self harm in children and young people is implemented in Wales particularly with regard to hospital admission, psychosocial assessment, evidence based interventions and staff training.

- Agencies delivering interventions and programmes which may prevent suicide or promote mental health and wellbeing should ensure that these are in line with the current evidence base for effectiveness and are evaluated.

- Welsh Government should develop explicit statutory mechanisms to support information sharing for the Child Death Review Programme.

- Welsh Government and the Child Death Review Programme should ensure deaths of children and young people through probable suicide remain a regular focus for child death thematic review on a 3 yearly basis.

1 Introduction

Following the National Child Death Review pilot study and the subsequent favourable evaluation, the Child Death Review Programme is now established in Wales. In July 2013, the programme released its first annual report[2] and also published the *Thematic review of deaths of teenagers in motor vehicles, 2006 - 2010.*[3]

The aim of the programme is to identify and describe patterns and causes of child death, including any trends, and to recommend actions to reduce the risk of avoidable contributory factors.[4] The steering group advises the programme on themes to be reviewed. It is informed by the data and emerging themes identified through the child death review database, topical issues, issues of concern raised by stakeholders and the potential for prevention.

In April 2013, the steering group agreed that on completion of the review of teenage deaths in motor vehicles, the programme should review the deaths of children and young people through probable suicide, including any relevant data from the child death review pilot review.

Every suicide is a tragedy and causes distress for many people including family, friends, professionals and the wider community. It can be particularly difficult to cope with the traumatic experience of losing a child or young person through probable suicide. Although a rare event, sadly, suicide remains a major cause of death in teenage years. Sixty of the 260 (23%) children and young people aged 12-17 who died due to external causes in Wales between 2002 and 2011, did so either through intentional self harm, or an event where the intent could not be determined. This is about one in eight of all deaths in this age group.[1]

There is no single reason why a child or young person takes their own life. It is best understood by looking at each person's life and circumstances. However suicide is potentially preventable. This review provides an opportunity to examine factors that have contributed to these deaths, identify opportunities for prevention and make recommendations to reduce the risk of suicide for children and young people in Wales.

2 Background

Suicide among children and young people is a major public health and social challenge. It is the second most common cause of death worldwide among young people in the 15-19 years age group after accidents.[5] Many young people have thoughts of suicide. Only a very small number of those who harm themselves or who think about suicide will die in this way, however, it is always a tragic outcome which affects the individual, family, friends, professionals and the community at large.

Although the factors that contribute to a suicide are many and complex, suicide and self harm are potentially preventable. The risk factors for suicide and self harm can be addressed at individual, group or population level. This requires the collective action of individuals, communities, services, organisations, government and society.

Approaches to suicide prevention include:

Universal interventions which aim to eliminate or attenuate risk and strengthen protective factors and are aimed at whole populations across different settings, such as:

- Increasing public and professional awareness
- Tackling stigma
- Improving community resilience and social connectedness
- Encouraging help seeking behaviour
- Increasing the ability to respond to someone in crisis
- Supporting responsible media reporting
- Restricting access to the means of suicide

Selective/targeted interventions which are aimed at individuals or groups within a population at increased risk of suicidal behaviours, such as:

- Gatekeeper training targeted within particular settings such as schools, prisons and healthcare, or within communities

- Early identification of, and evidence based interventions for, depression, psychosis and other mental disorders

- Provision of initiatives following a completed suicide for the family, friends and wider community (postvention)

- Screening for suicide risk

- Prevention, identification and treatment of substance and alcohol misuse

Indicated interventions which aim to reduce recurrence in those with known suicidal behaviours, such as:

- evidence based interventions for those who self harm

The Child Death Review pilot for Wales analysed deaths occurring from suicide and apparent suicide in children and young people in Wales under 18 years that occurred between October 2006 and September 2009.[2] It highlighted the specific issues of:

- Bullying (mostly school related)

- Misuse of drugs and alcohol

- Physical, emotional and sexual abuse

- Self harm

- Deprivation

- Social connections

The current thematic review builds on and extends this work. It aims to identify successful prevention initiatives and produce focused recommendations to enable these to happen, in order to prevent and reduce suicide in children and young people in Wales.

3 Methods

3.1 Case definition

Children and young people's deaths for this review were defined as probable suicides (intentional self harm and events of undetermined intent) aged 10 to 17 years normally resident in Wales, or who died in Wales, between 1 January 2006 and 31 December 2012.

We identified deaths using the following ICD-10 classifications:

- Intentional self harm (recorded as suicide verdict): X 60 – X 84

- Event of undetermined intent (including open and narrative verdicts) in those over 15 years of age: Y 10-34 (excluding Y 33.9 other specified events of undetermined intent, coroner's verdict pending)

Where an ICD code had not yet been assigned or there was a death of undetermined intent in a child under the age of 15 years, a judgment was formed by the professional lead in conjunction with the Child Death Review Team, based on information available, as to whether the case was a probable suicide for the purposes of this review.

3.2 Data sources

Data were collected from a number of sources to improve completeness and depth. These sources were:

- Child death review database
- Office for National Statistics Mortality data
- Serious Case Review Executive Summaries
- Procedural response to unexpected deaths in childhood (PRUDiC) meeting minutes. The PRUDiC meeting should identify lessons to be learned from individual deaths which may be addressed locally through local safeguarding children boards including the child practice review process if appropriate. Highlighting these lessons in the forms (Notification of Child Death and Record of Child Death) sent to the Child Death Review Team enable them to be shared nationally
- Police incident investigation reports
- Suicide Information Data base - Cymru (SID-Cymru) – funded by the National Institute for Social Care and Health Research and using anonymously linked routinely collected data from Swansea University's Secure Anonymised Information Linkage Databank on all cases of probable and possible suicide in Wales 2003-2011
- External unofficial sources including media and internet reports

Coroners in Wales were approached by the professional lead and the Child Death Review programme manager to provide data to the thematic review. All those approached were willing to collaborate with the process. Unfortunately, due to time constraints, only a small amount of information from coroners could be included within the current review.

3.3 Research evidence review

Two evidence reviews of the literature were undertaken by Public Health Wales for the purpose of this review following a prototype process developed for Child Death Review evidence reviews.

The objective of the first review was to identify epidemiological studies on the risk factors for suicide in children and young people aged between 10 and 17 years. To increase relevance to the Wales context, only studies undertaken in countries that joined the Organisation for Economic Co-operation and Development before 1974 were reviewed. Additionally only articles written in English and published from 2000 onwards were included. The evidence addressed the following question:

> What are the main risk factors for suicide in children and young people?

The objective of the second review was to identify measures or interventions that have potential for preventing suicide in children and young people. The effectiveness review addressed the following question:

> What interventions might be effective in reducing rates of suicide, self harm and suicide ideation in young people in Wales?

The second review followed a systematic review methodology but used only secondary sources of evidence. These included National Institute for Health and Care Excellence (NICE) guidance and systematic reviews of primary research. It was structured according to whether the interventions were universal, selective/targeted or indicated.

Full details of the methodologies used, together with the findings of each evidence review are in the research evidence review report available separately to this report at

www.publichealthwales.org/ childdeathreview

3.4 Thematic panel

A thematic panel was convened. Members were drawn from academia, nursing, safeguarding, public health, children's social care, the police force, education, the third sector, primary care, emergency medicine and specialist mental health services (see page 4 for further details).

Two all day meetings were held. The first was held on 13 November 2013. The morning session included a presentation of the risk factor review and an in depth narrative discussion of 14 deaths of children and young people. These were selected because of the quality of information available which enabled discussion of a broad range of themes. Life charts for each case were presented, a methodology frequently used in suicide research.[6] The afternoon focused around identification of key themes from these deaths and additional data needed to support further understanding.

The second meeting was held on
11 December 2013. During the
morning, the panel was presented
with a quantitative overview of all
the deaths and then further developed
key messages and conclusions.
The panel considered the high level
evidence statements of the review of
the effectiveness of interventions and
developed draft recommendations.

The professional lead and the Child
Death Review Team drafted the first
report to which the panel provided
comment. The draft was then
re-circulated to the panel members
for final comment and was also
shared with the Child Death Review
Steering Group for consideration with
a particular view to assessing the clarity
of conclusions and recommendations
and their potential to lead to action and
achievable outcomes.

The thematic panel agreed the final
report.

3.5 Policy context

Suicide prevention requires a truly
cross governmental, cross sectoral and
collaborative ("the 3 Cs") approach that
is broader than mental health services.
This needs to span health and social
care, economics, housing, transport,
justice, substance misuse and third
sector organisations. It also requires
an awareness of particular settings for
intervention such as schools, prisons,
hospitals, emergency departments,
railways, bridges.

In 2009 the Welsh Government
published *Talk to me*[1] a five year
national action plan to reduce suicide
and self harm. The plan had seven key
commitments:

- Promote mental health and well
  being

- Deliver early intervention
- Respond to personal crisis
- Manage the consequences of suicide
  and self harm
- Promote learning, research and
  improve information on suicide and
  suicide prevention
- Work with the media to ensure
  appropriate reporting on mental
  health and suicide
- Restrict access to the means of
  suicide.

The plan is currently being updated for
late 2014 so it is an ideal time for the
Child Death Review recommendations
to influence policy.

In 2012 the Welsh Government
launched *Together for mental health*[7]
its 10 year strategy to improve mental
health and wellbeing in Wales.
Together for mental health includes
measures to develop individual
resilience across the life course and
build population resilience and social
connectedness within communities.
It also covers the treatment and
management of mental health
disorders such as depression.
The successful implementation of
Together for mental health can
be expected to make a significant
contribution to the prevention of
suicide and self harm in Wales.
This would be achieved through altering
the life trajectories of people before
they become suicidal. The strategy
explicitly refers to suicide prevention
and the National Advisory Group on
Suicide and Self Harm Prevention to
Welsh Government.

TABLE 1 Outline of key policy and activity contributing to suicide prevention in children and young people

Risk factor	Relevant policy, action or intervention	Life stage
Deprivation	Child Poverty Strategy for Wales 2011	Early years
	Growth and Sustainable Jobs Programme	Working age
	Welsh Government: Programme for Government Tackling Poverty Programme Equality Programme	All ages
Substance misuse	The All Wales School Liaison Core Programme Integrated Family Support Services. Statutory Guidance and Regulations	Children and young people
	Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018 Wales Substance Misuse Treatment Framework	All ages
Mental and emotional wellbeing	A Strategic Vision for Maternity Services in Wales 2011 Flying Start Families First Personal and Social Education (PSE) and Social and Emotional Aspects of Learning (SEAL)	Early years
	Thinking Positively; Emotional Health and Wellbeing in Schools and Early Years Settings Respecting Others; Anti-bullying Guidance 2011 WAGC 005/2008 Safeguarding Children in Education: The Role of Local Authorities and Governing Bodies Under the Education Act 2002 Welsh Network of Healthy School Schemes School based counselling in Wales, a National Strategy, 2008 Office of the Children's Commissioner for Wales Rights of Children and Young Persons (Wales) Measure 2011 Child & Adolescent Mental Health Services: Everybody's Business 2001 The National Assembly for Wales. Breaking the Barriers (CAMHS Action Plan) 2010 Breaking the Barriers. Annual Report 2011 Breaking the Barriers. Final Report 2013	Children and young people
	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales	All ages

Risk factor	Relevant policy, action or intervention	Life stage
Mental disorder	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales	All ages
	The Mental Health (Wales) Measure 2010.	
	The Mental Health Act 2007. (Wales Code of Practice)	
Adverse life events	All Wales Antenatal Routine Enquiry into Domestic Abuse	Early years
Child Abuse & Neglect	Safeguarding Children: Working Together Under the Children Act 2004	All ages
	All Wales Child Protection Procedures 2008	
Domestic abuse	*The Right to be Safe:* Strategy for Tackling Violence Against Women	
	Domestic Abuse Guidance: Supporting People and Multi-agency Working	
Housing and homelessness	Supporting People Programme Grant (SPPG) guidance Wales 2013	All ages
	Ten Year Homelessness Plan for Wales 2009-2019	
	Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups	
Offending	All Wales Youth Offending Strategy	Children and young people
	Preventing More Young Offenders from Re-offending. Ministry of Justice for England & Wales 2013.	

4 Findings

Where findings relate to fewer than five children and young people they are presented as such in accordance with reporting of small numbers and non-identifiable information.

4.1 Risk factor evidence review

Suicide in children and young people is usually the outcome of a complex interaction between factors including those identified in the literature review:

biological, genetic, psychiatric, cultural, social and psychological factors. This is illustrated in Figure 1.

The risk factors for suicide in those between the ages of 10 and 17 identified in the risk factor literature review are shown in Table 2. Further details on the studies can be found in the evidence review technical document.

FIGURE 1 Key risk factors for adolescent suicide and self harm
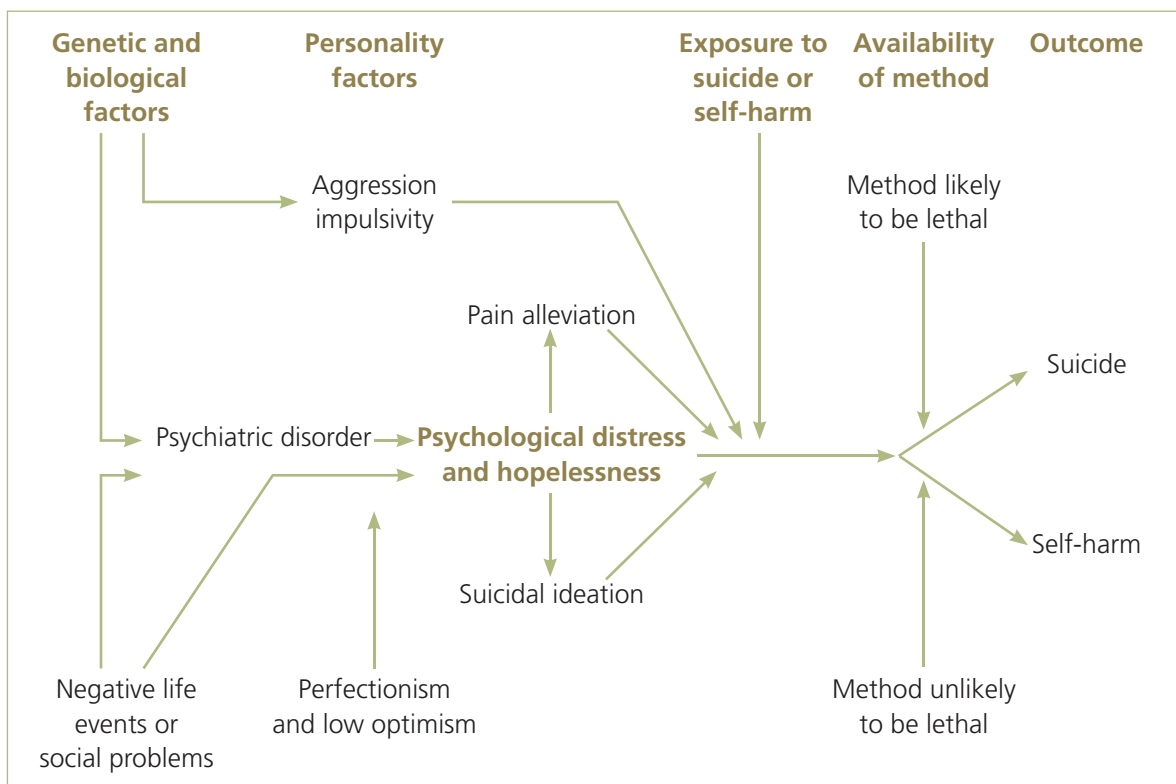
Source: Hawton, Saunders, O'Connor, 2012.[8] Reproduced with both author and publisher's [Elsevier] permission.

TABLE 2 Key risk factors for suicide among children and young people identified in literature review

Associated risk factor	Study
Male gender	Hawton et al 2012[8]
	Haw et al 2013[9]
History of self harm	Hawton et al 2012[8]
Mental disorder	Fowler et al 2013[10]
Diagnosable (but not necessarily diagnosed) mental disorder especially depression, attention deficit hyperactivity disorder, anxiety disorder, Asperger syndrome, conduct disorder	Freuchen et al 2012[11]
	Hawton et al 2012[8]
	Moran et al 2012[12]
	Kidger et al 2012[13]
	Kelleher 2012[14]
	Hurtig 2012[15]
Parental mental disorder	Hawton et al 2012[8]
	Ljung et al 2012[16]
Experience of loss	Fowler et al 2013[10]
● Suicides in the family or local community	Freuchen et al 2012[11]
● Parental death	Haw et al 2013[9]
	Hawton et al 2012[8]
Family history of suicidal behaviour	Hawton et al 2012[8]
Substance misuse	Fowler et al 2013[10]
Alcohol and drugs	Haw et al 2013[9]
Physical or sexual abuse	Hawton et al 2012[8]
Minority sexual orientation	Fowler et al 2013[10]
Interpersonal difficulties	
● Increased connectedness with peers reduced risk of repeated suicide attempt	Czyz 2012[17]
	Fowler et al 2013[10]
● Conflict, including conflict with parents, friends, the police and school, in some instances death occurs within hours of the reported conflict	Freuchen et al 2012[11]
Parental separation/divorce	Hawton et al 2012[8]
Being bullied	Freuchen et al 2012[11]
Impulsivity	Hawton et al 2012[8]
Restricted educational achievement	Hawton et al 2012[8]
Low socio-economic status	Hawton et al 2012[8]
Adverse childhood experiences	Hawton et al 2012[8]

4.2 Children and young people included in this review

Thirty-four children and young people met the case definition for the thematic review of probable suicide. Twenty-two were deaths through intentional self harm and 10 were events of undetermined intent. Four of the deaths had not yet been assigned a code by ONS but were assessed as described in the Child Death Review protocol by the professional lead and Child Death Review Team through the information available. Two of the children and young people were included following this assessment.

Hanging, suffocation and strangulation was used in 25 of the deaths of children and young people. Other methods used included gas poisoning; firearms; moving objects e.g. trains; blunt instrument; overdose and substance misuse.

4.3 Sources of information

Twelve of the children and young people included in the review had died after the commencement of the Child Death Review pilot programme on 1 October 2009. Three of these had not been notified to the programme.

The review had access to 13 serious case review executive summaries. Serious case reviews were undertaken by local safeguarding children boards in response to deaths where neglect or abuse may have been a factor. This was a statutory function under Section 32 (2) of the Children Act 2004. Six serious case review summaries were requested via the relevant local safeguarding children board on 1 October 2013 and have not, as yet, been received. In three deaths the decision was made not to perform a serious case review. A letter was issued by Welsh Government allowing for the exclusion of deaths through suicide from the serious case review process by local safeguarding children boards for children and young people not known to statutory services (Letter dated 7 November 2011 from the Deputy Director Children's Social Services Directorate). We were unable to ascertain whether a serious case review had been performed in five instances. The remaining deaths occurred after the serious case review process was stopped. There was one set of PRUDiC meeting minutes which forms part of the procedural response to unexpected child deaths. Twenty-five police incident investigation reports were received and information was received from the coroners in eight of the deaths of children and young people.

4.4 Summary of information

Eight of the children and young people included were female and 26 were male.

Ten of the children and young people had experienced issues at school to do with attendance, engagement and achievement. Seven had no such issues and for 17 there was insufficient information to make an assessment. Eight of the 34 children and young people were school leavers, 14 were in school, less than five were in transition (not yet made a decision whether returning to education) and for the remainder there was insufficient information to make a judgement.

We were unable to identify any significant social connections between the children and young people included in the review based on the information available.

TABLE 3 Ages of children and young people

Age years	Number	Percentage
10-15	11	32
16	10	29
17	13	38

TABLE 4 Year of death

Year	Number
2006	5
2007	6
2008	8
2009	<5
2010	<5
2011	6
2012	<5

TABLE 5 Area based deprivation quintile

Quintile of deprivation	Number
1	<5
2	<5
3	7
4	8
5	12

Welsh Index of Multiple Deprivation

TABLE 6 Whether or not children and young people were known to services during life time

Service	Known to service	Not known to service	Unable to determine if known or not known
Looked after children	<5	24	6-10
Child protection	<5	22	8-12
Child in need	11	5	18
Police	13	<5	17-21
Youth offending	7	7	20
Emergency department	5	6	23
Child & adolescent mental health	8	12	14

TABLE 7 Social circumstances

Circumstance	Yes	No	Insufficient information
Parental separation	8	14	12
Adverse childhood circumstances	10	7	17
History of sexual or physical abuse	10	7	17
Family history suicidal behaviours	<5	11	19-23
Bullying	7	7	20
History self harm	6	12	16
History of alcohol abuse	9	10	15
Alcohol associated with death	<5	10	20-24
History of drug misuse	6	14	14
Drugs associated with death	<5	12	18-22

4.5 Factors identified in narrative review

The panel had an in depth narrative discussion of 14 of the children and young people included in the review.

There is no single reason why someone may take their own life. This is best understood by looking at each person's life and circumstances. However the panel identified a number of factors common to many of the children and young people.

4.5.1 Socio-demographic and educational factors

- Many had specific educational needs or had restricted educational achievement

- Many were not in education, employment or training (NEET) and as such received little or no support from services

- A few of the children and young people were waiting to join the military and had been in contact with armed forces personnel involved in recruitment

- Low socio-economic status

- Mostly male

4.5.2 Individual negative life events and family adversity

- Family breakdown, be that between parents or between adolescents and their parents

- Bullying within school, as well as, when going to and from school, including victims and perpetrators

- History of neglect, physical abuse and domestic violence

- History of allegations of sexual abuse

- A number of the children and young people had recently relocated (within the previous two years) to a new area, possibly resulting in compromised social networks

- Some were either living alone, with relatives, foster carers or in supported accommodation

- Looked after children

- Children who are carers

4.5.3 Children and young people known to services (mental health, child protection, criminal justice)

- Parental mental health issues

- Mental health disorders (attention deficit hyperactivity disorder, autistic spectrum disorder, obsessive compulsive disorder, psychosis, depression)

- Risky behaviours leading to, for example, unwanted pregnancies or minor misdemeanours and contact with the police and criminal justice system

- Escalating self-harm

4.5.4 Proximal factors associated with the event itself

- Drugs and alcohol
- Escalating self-harm
- Family estrangement
- Inter-personal difficulties
- A number of children and young people had precipitating identifiable life events including bereavement

4.5.5 Access to means

Access to means is a key factor in completing suicide. The particular issues identified were with respect to firearm storage, railway access and storage of toxic medication in the homes of children and young people who were known to be self harming or vulnerable to suicidal ideation. Storage of potentially toxic and/or prescribed medication was a particular issue where these children and young people were living with adults with significant current mental health or substance misuse problems.

4.6 Effectiveness review

Fifty two sources of evidence were included in the effectiveness review and grouped according to whether they address universal, selective/targeted or indicated interventions (Table 8).

A full report on the effectiveness review is available at

www.publichealthwales.org/childdeathreview

below is a selection of key findings available in table 8.

TABLE 8 Summary of evidence, or lack of evidence, relating to interventions in the prevention of suicide, self harm or suicidal ideation

Intervention	Evidence	Comment
Universal interventions - including those aimed at whole school populations		
School based suicide prevention programmes, i.e. to increase knowledge and understanding of suicide, change attitudes towards suicide, increase awareness of risk factors and encourage help seeking behaviour	There is some evidence from randomised controlled trials that such interventions have an impact on improving knowledge, attitudes and help seeking behaviour, at least in the short term. It is not known whether they have an impact on suicidal behaviour.	Within Wales, school based prevention programmes are not in routine use and no programmes developed or tested in the UK were identified in the evidence review. Youth Mental Health First Aid is available in Wales although this is not a specific school based suicide prevention initiative and it did not feature in the systematic reviews included here.
School based interventions to prevent and reduce alcohol use	NICE guidance & Cochrane review suggest these have some effect, but the evidence is not consistent.	No programmes identified in the Cochrane review or NICE guidance had been developed and tested in the UK. Alcohol is addressed as an element of the Welsh Network of Healthy School Schemes; decisions on which approach or programme to use is made at school level.
Promotion of social and emotional wellbeing in primary and secondary education	NICE guidance published	Guidance can inform the Welsh Network of Healthy School Schemes
School based programmes to prevent victimisation (being bullied)	Moderate to good evidence from studies, some of which were randomised studies suggests that programmes can reduce victimisation (being bullied) by between 17 to 20 per cent.	A large number of programmes exist and the research evidence included three programmes developed and trialled in the UK. Bullying is addressed as part of the Welsh Network of Healthy School Schemes. The choice of which programme or approach to adopt is made at a school level.

Intervention	Evidence	Comment
Universal interventions - including those aimed at whole school populations		
Gatekeeper training, i.e. training those who may be perceived as sources of help, e.g. teachers, to be confident in recognising those who may be at risk of suicide and referring them appropriately for help	There is some evidence, including from some randomised control trials, that this type of training increases knowledge and confidence and changes attitudes. Evidence from randomised controlled trials of the impact on suicidal behaviour is lacking.	Most programmes have been developed and trialled in the USA. Applied Suicide Intervention Skills Training (ASIST) is used in Wales but was not included in any of the systematic reviews included here.
Universal approaches to prevent specific mental disorders i.e. psychological and educational programmes to prevent the development of mental disorders in children and young people	Evidence is mixed. There is some randomised controlled trial evidence that psychological or educational interventions may have an impact on the onset of symptoms of depression. Most of these programmes contained some element of cognitive behavioural therapy (CBT). Randomised controlled trials of programmes to prevent the development of eating disorders suggest that they are unlikely to be effective.	The majority of these programmes in relation to depression have been developed and tested in the USA.
Prevention of harmful drinking	NICE guidance for practice and policy has been developed. This is for government, industry, the NHS, and all those whose actions affect the population's attitude towards and use of alcohol. These include minimum price per unit, recommendations on marketing and availability and action on under-age sales, all relevant to access for children and young people. Practice recommendations in the NICE guidance relevant to children and young people includes screening (based on some research conducted in the UK) and brief interventions (based on evidence from the USA).	NICE public health guidance has no formal status in Wales but is regarded as a useful source of reviewed evidence

Intervention	Evidence	Comment
Universal interventions - including those aimed at whole school populations		
Family and multi-component programmes aimed at preventing uptake or reducing drinking in children and young people	There is some evidence supporting the use of multi-component programmes. The best evidence seems to be for family programmes although the impact is small. None of the included programmes had been developed or tested in the UK.	The Strengthening Families Programme, which originated in the USA has been subject to a randomised controlled trial in Wales, however the results of this do not appear to currently be available in a peer reviewed journal.
Mentoring to prevent or reduce drug and alcohol use	There is some evidence from randomised control trials, again from the USA, that mentoring can be useful in preventing or reducing drug and alcohol use but it is not conclusive.	Mentoring programmes involved either older peer mentors or community elders.
School based educational programmes to prevent child sexual abuse	Cochrane review of these suggests that they do increase knowledge and protective behaviours but the evidence is not conclusive and some studies reported harms. It is not known if these improvements translate to reduce sexual abuse. That some studies reported outcomes, such as increased anxiety in the children involved, increased fear of strangers, aggressiveness to peers and a reluctance to go to school, suggests the need to carefully monitor any similar interventions.	The majority of the included studies were from the USA, none were developed or trialled in the UK.

Intervention	Evidence	Comment
Selective/targeted interventions		
Management of depression in children and adolescents	NICE guidance published in 2005. Two subsequent Cochrane reviews (one on newer generation antidepressants, the other on psychological therapies in combination with antidepressants or alone) have been published since. The findings of these do not differ significantly from current NICE guidance.	NICE clinical guidelines have formal status in Wales. This means that health professionals (and the organisations that employ them) are expected to take NICE clinical guidelines fully into account when deciding what treatments to give people.
Management of post traumatic stress disorder (PTSD)	NICE guidance published in 2005. A Cochrane review on psychological therapies for PTSD in children was published in 2012. The findings are in line with the existing NICE guidance in supporting the use of psychological therapies, particularly CBT. A systematic review suggests that there is some evidence that trauma focused CBT is effective for PTSD as a consequence of childhood maltreatment; again this is in line with the existing NICE guidance on PTSD.	NICE clinical guidelines have formal status in Wales. This means that health professionals (and the organisations that employ them) are expected to take NICE clinical guidelines fully into account when deciding what treatments to give people.
Other mental disorders	A wide range of NICE guidance exists.	
School based interventions to prevent and reduce alcohol use	NICE guidance also addresses school based identification of, and brief interventions for, children who are drinking.	In Wales this might be considered as a role for school nurses or school based counsellors.

Intervention	Evidence	Comment
Selective/targeted interventions		
Responding to suspected child maltreatment	NICE has published guidance on when healthcare professionals who are not child protection specialists should suspect child maltreatment. This does not include guidance on managing the sequelae of this.

A Cochrane review suggests that CBT may have the potential to have a positive effect on the sequelae of sexual abuse including depression and behavioural problems but overall the evidence was not conclusive. The reporting of studies was poor and there were weaknesses in their methodology. The authors concluded that cognitive-behavioural approaches merit consideration as a treatment of choice for sexually abused children who are experiencing adverse consequences of that abuse. There is relatively consistent evidence that cognitive-behavioural approaches may lead to reductions in depressive, anxiety and post- traumatic stress symptoms in children. NICE guidance on PTSD also recommends CBT for children with PTSD who have been sexually abused.

There is a lack of evidence on the effectiveness of psychoanalytic/psychodynamic approaches. | |

Intervention	Evidence	Comment
Selective/targeted interventions		
Parenting programmes for the treatment of physical abuse and neglect of children	Cochrane review concluded that there is a lack of evidence regarding the effectiveness of parenting programmes for reducing physical abuse and neglect of children.	
Indicated Interventions		
Management of self harm	NICE has issued guidance on both the short and longer term management of this. Key recommendations in the guidance include: the appropriate training of triage nurses, overnight admission of children and young people and the strong advice not to use risk assessment tools to predict future suicide or repetition of self harm or determine management.	This guidance has formal status in Wales which means that it should be fully taken into account in the management of self harm in children and young people. A recent paper which described the management of self harm in 32 hospitals in England concluded that services for hospital management of self harm remained variable despite NICE guidance.[16] In particular the authors found no evidence of increasing psychosocial assessment over time. The Panel felt the current implementation of NICE guidance on the short and long term management of self harm in Wales is variable.

5 Strengths and limitations

A major strength of this review was the multi sectoral nature of the panel. There was representation from health (primary, secondary, tertiary and public health across different specialties), education, social services, safeguarding services, the police, academia and the third sector. This allowed for a truly representative discussion of the deaths that extended beyond health.

This national review covered a seven year period, collecting information from a wide range of sources allowing opportunities to identify themes and potentially modifiable contributory factors to suicide deaths in Wales. Life charts were used as a way of chronicling important information about the life and death of the children and young people. This tool proved extremely useful to inform panel discussion.

The information on deaths of children and young people included in this review is akin to a case series; it allows contributory factors to be identified, but does not provide high level evidence for effectiveness. For this reason the review is supported by a review of international evidence which has informed the recommendations.

There were a number of areas on which the panel could not draw a conclusion due to a lack of information. In some instances it was not clear how many children and young people were affected by particular factors. Serious case reviews executive summaries are limited in the depth of information they provide for the purposes of a thematic review. Police and coroner's reports were identified as useful new sources of information. Child Death Review data collection templates were further developed as part of this review which will improve this for probable suicide thematic reviews conducted in the future. Prospective collection of data on notification of a probable suicide to the Child Death Review Programme will also improve the information available for future thematic reviews.

Capturing information about the quality of relationships in these children and young people's lives was limited as was information regarding any social connections between them. There was limited information on social media use as well. These are all important factors in this age group. Capturing this information for future thematic

reviews will be important. Similarly mechanisms to encourage schools and further education establishments to share information will also improve the information available.

Within England, current guidance states that families should be involved in the local safeguarding children boards' child death review processes. This was not done in the current review and consideration will be given in the future on how best to overcome the challenges to doing this.

6 Key messages

There is no single reason why a child or young person takes their own life. It is usually the outcome of a complex interaction between various factors. Many of the children and young people included in this review came from deprived areas and such apparent inequalities are a major challenge to suicide prevention.

The following section highlights the key messages with regard to factors that may have contributed to these deaths. These key messages highlight possible opportunities for suicide prevention and processes that might support this.

6.1 Education, employment and training

Many of the children and young people either had restricted educational achievement or were not in education, employment or training (NEET). Those over 16 years of age received little or no support from any services.

In general the panel identified a lack of information about the educational context for these children and young people. Schools and further education colleges could contribute to the information provided to the review.

A few of the children and young people were waiting to join the military. Armed forces personnel recruiting young people should be considered key gatekeepers (please see section 6.4.5).

6.2 Factors associated with the event

A number of the children and young people reviewed had precipitating adverse life events. Following life events or stressful circumstances such as being a witness in court or bullying, the focus should be on supporting the child or young person and their family or carers by services and within schools and workplaces. Where a child or young person is in crisis, but particularly one who is vulnerable, consideration should be given to the provision of safe havens to avoid them being held in places such as custody suites or on adult mental health wards.

6.3 Access to means

Access to means is a key factor in completing suicide. Most children and young people died of hanging, strangulation or suffocation. Restricting access to these means is particularly difficult outside of secure or inpatient settings. Nonetheless, other means of death that are amenable to intervention identified by this review included firearm

storage, access to alcohol for children and young people and storage of toxic medication in the homes of children or young people known to be self harming or vulnerable to suicidal ideation. Storage of potentially toxic, often prescribed medication was a particular issue where these children and young people were living with adults who had significant current mental health or substance misuse problems.

6.4 Partnership working

6.4.1 Improved communication

Consistent with the findings of many individual case reviews the panel felt there was a need for improved communication between services and co-ordination across agencies to help prevent some of these deaths.

6.4.2 Child protection registers

The current child protection register system is not as effective as it could be to support communication, across nations and services or within local authority areas, about children who have been recognised as at risk of significant harm. There are 22 registers across Wales and access to different area based registers is not always timely or even possible.

6.4.3 Families and carers

Services should work in partnership with families and carers where possible. This is already a guiding principle of many of our services. Families can provide invaluable information regarding risk factors and vulnerabilities although the rights and wishes of the child or young person should always be taken into account. Self report by a child or young person may fail to identify issues such as alcohol or substance misuse.

6.4.4 Settings

The panel identified the role of schools, colleges and workplaces as crucial settings to engage the vulnerable children and young people who attend. In particular, they provide opportunities to implement and evaluate evidence based interventions and programmes.

6.4.5 Key gatekeepers

The panel identified key gate keepers who come into frequent contact with children and young people on a regular basis, usually, but not exclusively on account of their professional status or occupation. Their role is often about giving an immediate, appropriate and proportionate response to individuals in distress or disclosing thoughts of suicide or self-harming behaviour in order to build trust and create opportunities for further engagement with sources of help. This may occur through referral, signposting or a compassionate response that does not discourage future help seeking behaviour.

Key Gatekeepers identified include:

- Primary health care providers
- Mental health care providers
- Emergency health care providers
- Teachers and other school and further education staff
- Community leaders
- Police officers
- Other first responders including ambulance staff and fire-fighters
- Armed forces recruitment officers
- Social care workers
- Spiritual and religious leaders
- Sports organisations
- Youth offending services providers

6.5 Interventions

There is good to reasonable evidence of effectiveness for a number of interventions that could prevent suicide in children and young people.

The research evidence review highlighted a number of areas where there is evidence to support the benefits of universal, selective/targeted and indicated interventions. Much is already being done but there are a range of issues that are supported by the evidence base that could be explored in Wales. These include:

- Developing and evaluating school based suicide prevention programmes in Wales

- Whether alcohol education, initiatives to address bullying and action to promote social and emotional wellbeing in schools are sufficiently informed by the existing evidence base as to content and delivery and whether those already in place are being appropriately evaluated

- Whether it is feasible and appropriate for school's counselling staff or school nurses to be trained in delivering brief alcohol interventions

- Measures to reduce access to alcohol for children and young people

- The outcome of the Strengthening Families Cymru programme

- Whether sufficient attention is being given to addressing the sequelae of child sexual abuse and whether this is being done early enough to change the life trajectories of some children and young people

- Whether NICE guidance on the short and long term management of self harm has been appropriately implemented in Wales

- Whether NICE guidance on Depression in Children and Young People in Wales has been appropriately implemented in Wales

- Whether it is appropriate and feasible to develop postvention services in Wales

6.6 Thematic Reviews of probable suicide deaths in children and young people

6.6.1 Age limit of child death reviews

There is no agreed definition of a young person. Chronological age is just one of the ways it can be defined. Others include cognitive development or physical characteristics. The panel recognised that transition to adult services and vulnerabilities or indicators that bridge the traditional child/adult age boundaries would benefit from an extension of the scope of future child death thematic reviews of probable suicide to older age groups.

6.6.2 Information sharing

There was little consistency of information sharing of serious case review executive summaries with the Child Death Review Programme. Where they were shared, triangulation with other information sources highlighted their limitations in terms of providing information for a thorough review of the death of the child or young person for the purposes of the Child Death Review Programme. A mechanism should be sought to enable the Child Death Review Team to have access to the full reports of relevant reviews.

Serious case reviews have been replaced by the child practice review process which does not generate a detailed chronology. It is therefore essential that the PRUDiC response is initiated and completed for all deaths of children and young people by probable suicide and that the Notification of Child Death and Record of Child Death are completed and returned to the Child Death Review Team. Currently some PRUDiC information sharing and planning meeting minutes are made available to the Child Death Review Team; however these are inadequate for a thorough child death programme thematic review. The case discussion and case review meeting minutes may provide more depth of information. Local safeguarding children boards are accountable for ensuring lessons learned from individual deaths are implemented.

The majority of Coroner's expressed a willingness to provide information for this review.

6.6.3 Accountability and reviewing of deaths through suicide in children and young people

The Welsh Government strategy on suicide and self harm prevention, 2009-2014, *Talk to me*[1] is currently being updated. It highlights a requirement to identify a process to review all suicide deaths. Currently suicide deaths in children and young people not known to services are not extensively reviewed. Consequently lessons to be learned may be lost and there does not appear to be clear accountability for identifying and implementing specific preventative interventions following a children or young person's death through suicide where that individual was not known to services.

SID - Cymru may provide valuable information in the reviews of suicide deaths in those not known to services. It should be emphasised that a child or young person not being known to services does not mean they should not have been known. Probable suicide deaths in those known to mental health services are reviewed in National Confidential Inquiry into Suicide and Homicide. Collaboration and information sharing across agencies and regions with this process would enrich the data available for panel discussion in those instances.

6.6.4 Family and carer engagement

The panel felt engaging families, bereaved relatives and young people in the Child Death Review Programme was important. Priority setting in the selection of thematic reviews and participation on panels, particularly at the recommendation stage was discussed.

6.7 Public awareness

Stigma related to suicide remains a major challenge to prevention efforts. Stigma may prevent people from seeking help and may be a barrier to accessing suicide prevention services and postvention support. Increasing awareness of the risk factors identified is needed to tackle stigma and enable personal responses to children and young people in distress. Mental health literacy among the general population, front line professionals, schools and other settings such as sports clubs is pivotal to suicide and self harm prevention efforts. While efforts to reduce stigma in relation to mental illness will benefit this process, additional efforts to reduce stigma attached to suicidal behaviours (thoughts and self harm) are required.

Any campaign or intervention needs to adequately consider how to make messages meaningful for children and young people, engage them in the development process and evaluate effectiveness.

6.8 Digital media

Social media sites and specific websites were mentioned in relation to some of the deaths of children and young people. It was beyond the scope of the current review to make an assessment of these new media and any part they could play both as an associated factor and an opportunity for intervention.

7 Recommendations

The panel made recommendations based on the information on the children and young people who died, the evidence review and their expertise. Recommendations highlighted in bold were considered by the panel to be strongly recommended.

7.1 Recommendations for Welsh Government

1 **Welsh Government should pursue mechanisms to restrict the access of children and young people to alcohol. This includes a minimum price per unit, regulation of marketing and availability and action on under-age sales. This may be through working within existing powers, seeking further or additional powers, or lobbying the UK government for changes.**

2 Welsh Government should explore mechanisms to ensure children and young people between the ages of 16 and 18 years are supported in education or training, which includes work based training. This could be enabled by raising the school leaving age to 18 years.

3 **Welsh Government should develop mechanisms for an all-Wales child protection register to which all local authorities contribute which is accessible by relevant services as needed, and emergency departments in particular.**

4 Welsh Government should explore and support mechanisms to co-ordinate this all Wales child protection register with child protection plans of other nations.

5 Welsh Government should issue explicit guidance to ensure that across Wales, repeat attendances of children and young people at emergency departments following episodes of self harm, mental health concerns or with alcohol or drug misuse, result in a referral and assessment by children's social care with lower thresholds for holding strategy meetings and earlier multiagency planning.

6 **Welsh Government should support and develop mechanisms to ensure that NICE guidance on the short and longer term management of self harm in children and young people is implemented in Wales particularly with regard to admission, psychosocial assessment, evidence based interventions and staff training.** Consideration should be given to including healthcare improvement approaches and to formally requesting health boards give assurances that the guidance is fully implemented.

7   Welsh Government should support greater awareness of the risk factors for probable suicide amongst the public to tackle stigma and enable personal responses to children and young people in distress. This could include suicide awareness training, mental health literacy, an awareness raising campaign and a national suicide and self harm prevention website.

8   Welsh Government should support the training of key gatekeepers in suicide awareness, mental health literacy and signposting to suitable services. Any such training programmes should be evaluated appropriately.

9   Welsh Government should continue to support new research in the epidemiology and prevention of suicide and self harm in children and young people.

7.2 Recommendations for Police

10 Police forces in Wales should ensure that licensed fire arms are stored at home in a safe and secure manner, paying particular attention to the potential for children or young people acting impulsively to easily access them.

7.3 Recommendations for healthcare commissioners and providers, including clinicians

11 Healthcare commissioners and providers should ensure that evidence based cognitive behavioural therapy services are available for all children who have suffered sexual abuse, including the non-offending parent. They should also ensure pathways are in place to encourage access to these services.

12 Clinicians caring for children or young people at risk of suicide should consider the capacity of adults within the household to safely store potentially toxic medication or drugs and liaise with other services as required. Relevant bodies, such as The Royal College of Psychiatrists and the medicines management programme, should consider developing guidance on this issue.

7.4 Recommendations for partnerships and agencies

13 Communication between professionals for the prevention of suicide should be strengthened, in particular:

a) Suicide prevention partnerships should ensure representation is truly cross governmental and cross sectoral, including health, local government and the third sector.

b) Services should work together to consider mechanisms for improving communication about children and young people at risk of suicide; in particular, they should consider lowering the threshold for multi-agency meetings for such individuals.

14 **Agencies delivering interventions and programmes which may prevent suicide or promote mental health and wellbeing should ensure that these are in line with the current evidence base for effectiveness and are evaluated.** Where that evidence base is not yet available or the programme is developed locally, an evaluative framework should be developed from the onset to identify what works. Those that are not effective should be stopped and resources deployed to more effective interventions. Particular consideration in respect to this recommendation should be given to programmes in school based settings including those delivered to address and prevent bullying.

7.5 Recommendations to support future reviews

15 **Welsh Government should develop explicit statutory mechanisms to support information sharing for the Child Death Review Programme.**

16 Local safeguarding children boards should ensure that the PRUDiC process is initiated, progressed through further meetings and completed for every probable suicide involving a child or young person and that the required information for the Child Death Review Programme is completed and returned to the programme.

17 **Welsh Government and the Child Death Review Programme should ensure deaths of children and young people through probable suicide remain a regular focus for child death thematic review on a 3 yearly basis,** including examination of specific types of death and collaboration with National Confidential Inquiry into Suicide and Homicide and Suicide Information Database-Cymru. Such forward planning will allow for the timely collection and collation of information relating to children and young people included in the review. A future review of possible suicides i.e. accidental hangings and poisonings excluding narcotics is particularly relevant.

18 Welsh Government should sponsor mechanisms to review deaths through suicide in all those under the age of 25 years (known and unknown to mental health services) to identify opportunities for prevention. Commissioning the Child Death Review Programme to do this work may be an appropriate mechanism.

19 The Child Death Review Programme should follow up progress made against the recommendations in this review and publish them in its annual report after one year.

20 The Child Death Review Programme should develop mechanisms to engage families and children or young people in the delivery of the programme, which may include involvement in specific aspects of thematic reviews.

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