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Child Death
Review Programme

Thematic Review

Deaths of Children
& Young People through
Probable Suicide 2013–2017

MAIN
REPORT

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Foreword

It is very hard to put into words the enormity of losing a child or young person to suicide. The loss of every one of the 33 children and young people included in this review is an immense tragedy which will have devastated families, friends, schools and whole communities.

Suicide is the leading cause of death for young people in their teenage years and there is evidence of an increase in suicide rates in 15 – 19 year olds. The Children Young People and Education Committee's *Mind Over Matter* report called for the emotional and mental health of children and young people in Wales to become a stated national priority. Within that, nothing is more important than preventing young people dying by suicide. I believe it is nothing short of a public health emergency.

As a Committee, we have tried to ensure that we listen to young people and have the views of young people at the heart of everything we do. I recently spoke at a conference about young people's mental health and emphasised the importance of listening to children and young people. At the end a delegate came up to me and asked me what the young people who had died by suicide would say if they were there that day. I found those incredibly difficult, challenging and painful words to hear because of course we cannot ask them.

That is why this thematic review is so very, very important – it is the nearest thing we have to retrospective recommendations directly from those young people themselves about how we could have helped them and how to prevent future deaths. It is the closest thing we have to hearing the voices of those young people who have died by suicide.

I am very grateful to Professor Ann John for leading this review process and to the cross sectoral panel who worked with her to inform this important report. This included colleagues from health, social care, the police and the third sector. The finding that each organisation had a role to play in preventing these deaths emphasises just how crucial effective partnership working is – because suicide prevention is everybody's business.

The review identifies clear opportunities for suicide prevention. The challenge now is for those of us in a position to influence and change policy in Wales to really push for those opportunities to be embraced with vigour, determination and urgency. We owe it to the young people who died by suicide and to those young people who are still with us and need our support.

Lynne Neagle, AM

Chair of the Children, Young People and Education Committee

Chair of the Cross Party Group on Suicide Prevention

Member Health, Social Care and Sport Committee

Foreword

Whenever someone takes their own life it is a huge tragedy and causes distress for many people – family, friends, professionals and the wider community. That impact is multiplied when a child or young person dies by suicide.

Suicide in children and young people is often the end point of a complex interaction of life circumstances, risk factors and adverse life events. This review, which was led by Professor Ann John and facilitated by the Child Death Review Programme Team, identifies opportunities for suicide prevention. There is a real opportunity for this review to build on the steps set out in *Talk to Me 2*, Welsh Government's national action plan to reduce suicide and self-harm in Wales. Suicide is not inevitable and we all have a part to play in the prevention of further deaths.

All children have Human Rights under the United Nations Convention on the Rights of the Child. These include the inherent right to survival and development, and the right to receive the best possible standard of healthcare, including mental health support and treatment. Children also have a right to be listened to and have their views taken seriously. This is particularly vital when feeling without hope and in despair.

Embedding children's human rights across all our services that support vulnerable children, and ensuring children understand the rights to which they have an entitlement, present an opportunity for suicide prevention. I have witnessed several occasions where children have only spoken up and sought help after they'd been explicitly told they have rights and how to take them up.

I am passionate about pushing for earlier and more joined up support for children's mental health and social care needs. This review provides stark evidence of the importance of the need for these changes in Welsh communities.

Professor Sally Holland
Children's Commissioner for Wales

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Summary

Background

Suicide is a tragic event that causes distress for many people. It can be particularly difficult to lose a child or young person through suicide. There is rarely a single reason why a child or young person takes their own life. It is usually due to a complex interplay of risk factors, circumstances and adverse experiences. Despite this, suicide is potentially preventable.

The Child Death Review Programme committed to repeating a review of deaths of children and young people in Wales through suicide following its first review in 2014. This review was undertaken to examine factors that have contributed to suicide deaths, identify opportunities for prevention and to disseminate findings to reduce the risk of suicide for children and young people.

Method

Children and young people aged 10–17 who died by probable suicide (suicide and deaths of undetermined intent) from 2013 to 2017 were included in the review. Information on the children and young people was obtained from multiple sources including health boards, local authorities, Police and Coroners. Anonymised information was presented to a multidisciplinary thematic panel along with an updated research evidence review of effective interventions. The thematic panel discussed a broad range of themes and identified opportunities for prevention. The professional lead and Child Death Review Programme team then developed the opportunities for prevention to take forward.

Findings

Thirty-three children and young people were included in the review. Nineteen were aged 16 or 17 years. Hanging, suffocation and strangulation were used in the majority of the deaths. A number of issues emerged including sexual abuse; sexual assault or rape; domestic violence; bereavement; shame; disrupted living arrangements; difficulties in education, employment or training; lack of awareness regarding the importance of self-harm as a risk factor or opportunity for intervention; young parenthood; internet and social media; substance misuse; looked after children; poverty; custodial sentences and information sharing.

Opportunities for prevention

This review identified many existing activities that contribute to the prevention of suicide, as well as new opportunities that could inform action.

The opportunities not to be missed are:

- **Management of self-harm:** Full implementation of NICE guidance for the management of self-harm relating to children and young people.
- **Prevention of alcohol and substance misuse:** Ongoing action to restrict access of children and young people to alcohol, and full implementation of NICE guidance to prevent substance misuse.
- **Mitigation of ACEs:** Optimising provision and access and ensuring continued engagement with interventions for children who have experienced adverse childhood experiences such as sexual abuse, sexual assault or domestic violence; and engagement with safeguarding boards to raise awareness of the importance of protecting children from the effects of domestic violence and sexual abuse to prevent suicide and self-harm.
- **Raising age of participation in education, employment or training:** Exploration of mechanisms to ensure children and young people between the ages of 16 and 18 are supported in education, employment or training including work based training.
- **Better information sharing:** Exploration of how information can be shared between non-state education settings (such as private schools) and statutory services.
- **Better knowledge and awareness:** Exploration of evidence-based ways of increasing knowledge and awareness of: self-harm and other risk factors for suicide; safety planning; help seeking and accessing services; and tackling stigma.

1. Introduction

Every suicide is a tragedy and causes distress for many people including family, friends, professionals and the wider community [1]. It can be particularly difficult to cope with the traumatic experience of losing a child or young person through suicide. Suicide is the leading cause of death in teenage years in England and Wales partly because medical causes such as cardiovascular disease are rarer than in older populations [2]; around one in five (21%) children and young people who die in Wales aged 12–17 do so either through intentional self-harm, or an event where the intent could not be determined [3].

In 2014, the Child Death Review Programme published its Thematic review of deaths of children and young people through probable suicide, 2006–2012. One recommendation was a repeat review every three to five years and this thematic review is the first update. It is timely given there appears to be a rise in rates of suicide amongst 15–19 year olds in England and Wales since around 2010 [4].

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. This review provides an opportunity to examine factors that have contributed to suicide deaths, identify opportunities for prevention and to disseminate findings, 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 10–24 years age group after road-traffic accidents [5]. Although 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. When any person takes their own life it hugely affects individuals, family, friends, professionals and the community at large and those impacts can last for a long time.

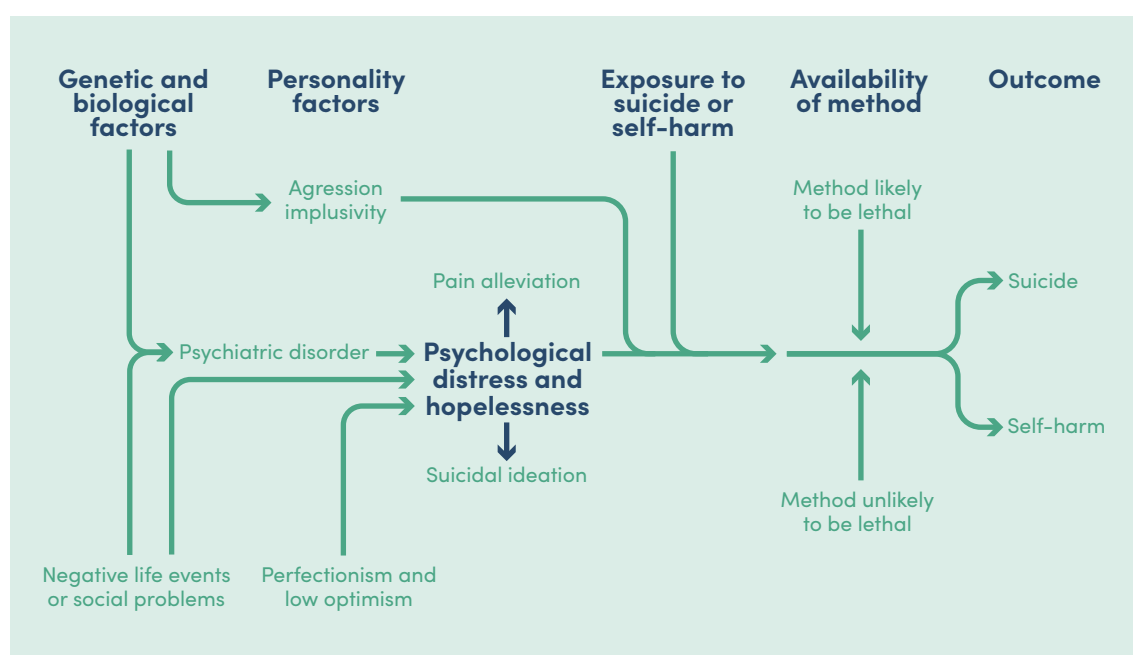
Although the factors that contribute to an individual taking their own life are many and complex, suicide is potentially preventable. The risk factors for suicide can be addressed at individual, group or population level. This requires the collective action of individuals, communities, services, organisations, government and society. No single organisation can act in isolation to prevent suicide.

2.1 Risk factors

Suicide in children and young people is usually the outcome of a complex interaction between biological, genetic, psychiatric, cultural, social and psychological factors. This is illustrated in Figure 1.

The key risk factors for suicide in those between the ages of 10 and 17 are shown in Table 1.

Figure 1: Key risk factors for adolescent suicide and self-harm



Source: Hawton, Saunders, O'Connor, 2012 [5]

Table 1: Key risk factors for suicide and self-harm among children and young people

Associated risk factor	Study
Sex <ul style="list-style-type: none"> • Male (risk of suicide) • Female (risk of self-harm) 	Hawton et al 2012 [5] Haw et al 2013 [6] O'Connor et al 2014 [7] Gilies et al 2018 [8] Lauw et al 2018 [9]
History of self-harm	Hawton et al 2012 [5] Tuisku et al 2014 [10]
Mental disorder Diagnosable (but not necessarily diagnosed) mental disorder especially depression, attention deficit hyperactivity disorder, anxiety disorder, Asperger syndrome, conduct disorder, bipolarity	Fowler et al 2013 [11] Freuchen et al 2012 [12] Hawton et al 2012 [5] Moran et al 2012 [13] Kidger et al 2012 [14] Kelleher 2012 [15] Hurtig 2012 [16] Peixoto et al 2017 [17] Lauw et al 2018 [9]
Parental mental disorder	Hawton et al 2012 [5] Ljung et al 2012 [18] Bjorkenstam et al 2017 [19]
Experience of loss <ul style="list-style-type: none"> • Suicides in the family or local community • Parental death 	Fowler et al 2013 [11] Freuchen et al 2012 [12] Bjorkenstam et al 2017 [19] Haw et al 2013 [6] Hawton et al 2012 [5]
Family history of suicidal behaviour	Hawton et al 2012 [5]
Exposure to suicidal behaviour of others	McMahon et al 2013 [20] Teevale et al 2016 [21]
Substance misuse Alcohol and drugs	Fowler et al 2013 [11] Haw et al 2013 [6] Lauw et al 2018 [9] Tuisku et al 2014 [10] Liu et al 2014 [22] Chan et al 2013 [23]
Physical or sexual abuse	Hawton et al 2012 [5] Chan et al 2013 [23] Castellvi et al 2017 [24]

Associated risk factor	Study
Minority sexual orientation	Fowler et al 2013 [11] Caputi et al 2017 [25]
Interpersonal difficulties Increased connectedness with peers reduced risk of repeated suicide attempt Conflict, including conflict with parents, friends, the police and school, in some instances death occurs within hours of the reported conflict	Czyz 2012 [26] Fowler et al 2013 [11] Freuchen et al 2012 [12]
Parental separation/divorce	Hawton et al 2012 [5]
Bullying (traditional and cyberbullying) Being bullied, bully, perpetrators, cybervictimisation, cyberbullying perpetrators	Holt et al 2015 [27] John et al 2018 [28]
Impulsivity	Hawton et al 2012 [5]
Restricted educational achievement	Hawton et al 2012 [5]
Low socio-economic status	Hawton et al 2012 [5]
Adverse childhood experiences	Hawton et al 2012 [5] Hughes et al 2017 [29]
Exposure to violence	Castellvi et al 2017 [24]
Parental criminality	Bjorkenstam et al 2017 [19]
Child maltreatment	Brown et al 2018 [30]
Pathological internet use	Kaess et al 2014 [31]
Low perceived social support	Tuisku et al 2014 [10]
Poor sleep	Lundh et al 2013 [32]
Low levels of family connections	Teevale et al 2016 [21]

2.2 Thematic review of deaths of children and young people through probable suicide in Wales, 2006–2012

The previous Child Death Review Programme thematic review examined factors that contributed to suicide deaths, identified opportunities for prevention and made recommendations to reduce the risk of suicide for children in Wales.

Thirty-four children and young people aged 10 to 17 who died through suicide 2006–2012 were included in that review. Information on the children and young people was obtained from multiple sources including police reports and serious case reviews. 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 [33].

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.

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

The panel made a number of recommendations including six 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.
- 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 that 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 should remain a regular focus for child death thematic review on a 3 yearly basis.

One year after the release of the thematic review of deaths of children and young people through probable suicide, 2006-2012 the Child Death Review Programme Team approached agencies to enquire about progress against recommendations [34].

There was generally a good response to the request for information although a few organisations did not respond. In some cases, agencies were unaware of the recommendations.

The responses to the recommendations included:

- New guidance on firearms licensing law published in October 2014 incorporates the recommendation about safe storage of firearms including inspection by police of storage arrangements.
- The thematic review informed the Welsh Government's consultation strategy on suicide and self-harm prevention, *Talk to Me 2*. Children and young people from vulnerable backgrounds, particularly those not in education, training and employment were a priority group for action in Wales and the Child Death Review Programme was referenced as a mechanism by which deaths through suicide in young people would be regularly reviewed in Wales.
- Policies relating to minimum unit pricing of alcohol were adopted in Wales but are yet to be implemented.

2.3 Current epidemiology in Wales

Knowing who, at what age and when individuals have died by suicide is essential to suicide prevention efforts, since it allows us to identify changes over time, enabling responsive priorities to be set to inform policy and practice, and document the impact of any interventions.

When looking at trends over time it is important to look over a relatively long period, not any one year in isolation. There will be year on year fluctuations that are unlikely to be a reflection of 'true' changes in trends. For this reason, we often use rolling averages. Where populations are small, as in for those aged under 18 who die by suicide, rates can be unreliable since a small change in the number of suicides will have a large impact on rates. When this occurs, it is demonstrated by relatively wide confidence intervals (bars around points in graphs, ranges in brackets). In these analyses, any comparisons should be interpreted with caution and particular attention paid to overlapping error bars where differences are then not statistically significant i.e. we cannot really say there is a 'true' difference.

2.3.1 Suicide rates

Suicide is the leading cause of death in both males and females aged 10–19 years in England and Wales [35]. There is some evidence of a rise in rates of suicide amongst 15–19 year olds in England and Wales [4] and 10–24 year olds in the UK since around 2010 [2]. This does not appear to be the case in Wales when reviewing 5-year rolling rates for 10 to 17 year olds since confidence intervals overlap but numbers are too small to detect these differences statistically. In the 7 years of the previous review, there were 34 children and young people who died by suicide in Wales between 2006–2012, however, in this current review of 5 years there were 33 between 2013–2017.

Figure 2: Trends in suicides, 5-year rolling crude rate per 100,000, males and females aged 10-17, Wales. 2008-2017



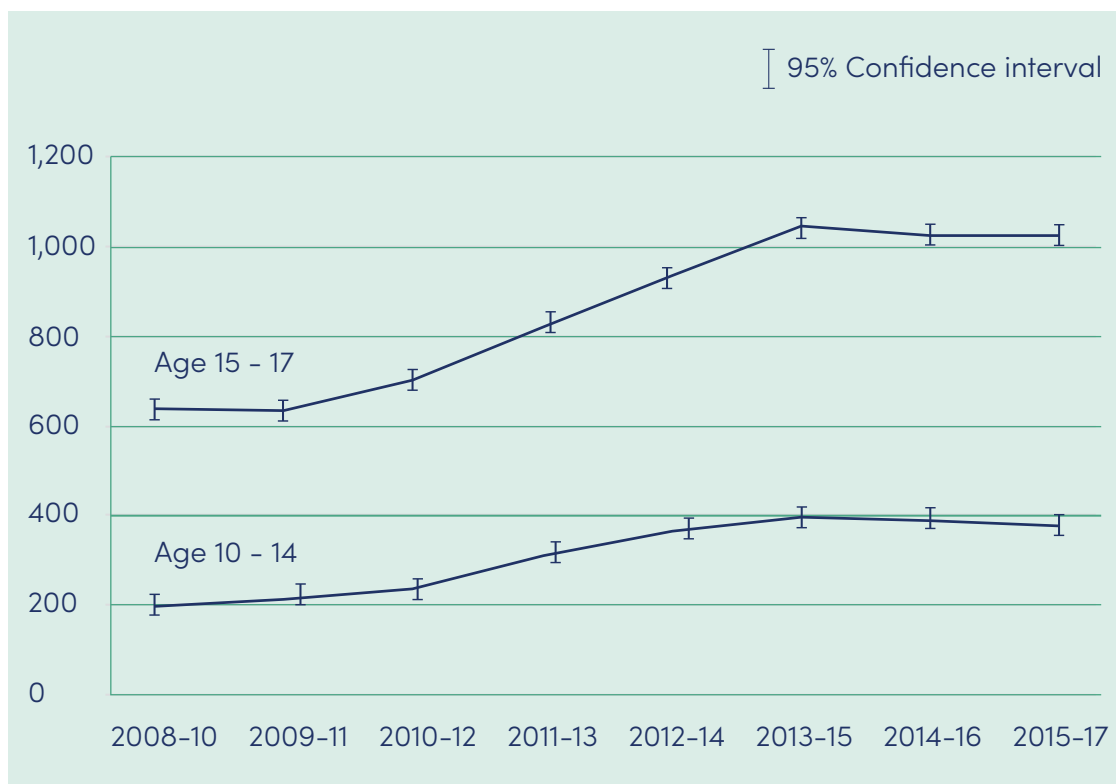
Produced by Public Health Wales Observatory, using PHM & MYE (ONS)

2.3.2 Self-harm admission data

The most reliable data for self-harm available in Wales is derived from hospital in-patient data. Many children and young people who harm themselves do not attend health services. This is a serious impediment to our understanding of the scale of the problem in Wales and to planning effective service organisation and delivery.

The age and sex distribution of those admitted for self-harm is very different to that for suicide (Figure 3, 4) with higher rates among females than males.

Figure 3: Hospital admission for self-harm*, 3-year rolling age-specific rate per 100,000, females aged 10-17, Wales, 2008-17

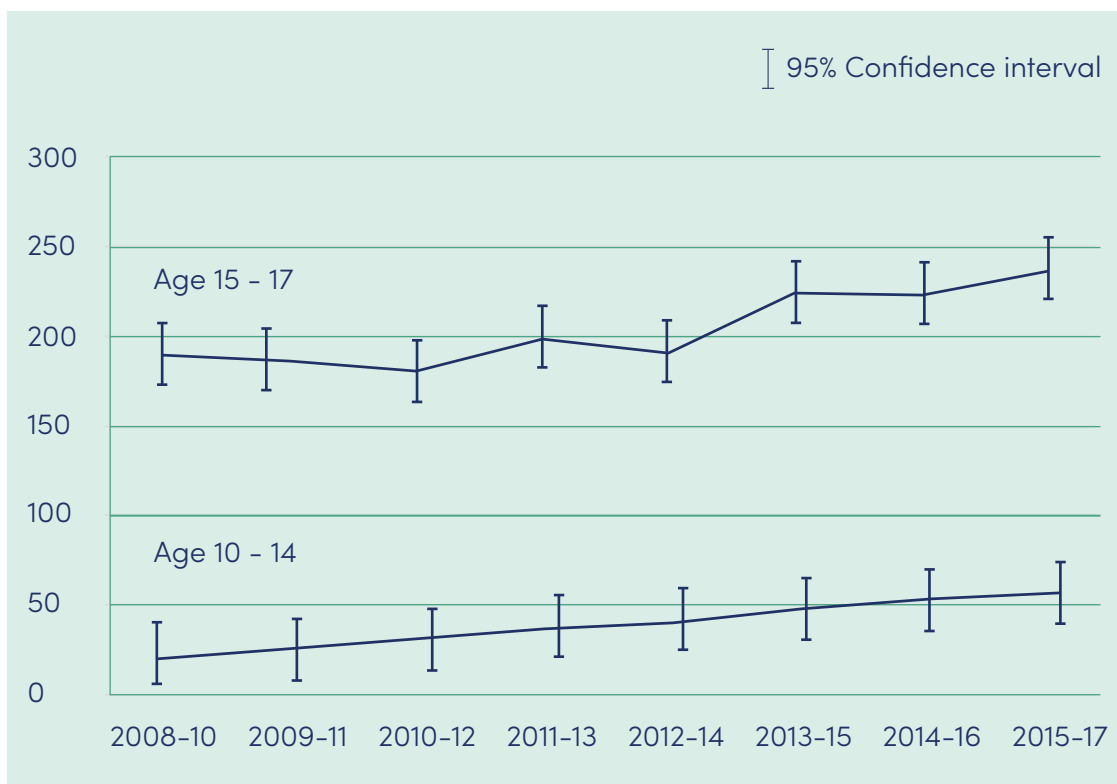


Produced by Public Health Wales Observatory, using PEDW (NWIS) & MYE (ONS)

*individual patients were counted a maximum of once per year even where there were multiple admissions. ICD-10 codes for self-harm (X60-X84) were searched for within the whole diagnostic record, rather than just the primary diagnosis field; therefore, in some cases the patient was admitted for a primary diagnosis of depressive episode, for example, and self-harm was mentioned lower down in the diagnostic record.

The increase in rates in those aged 10-17 years may reflect a genuine increase in self-harm rates, increased awareness and help-seeking combined with reduced stigma and/or improved management of self-harm in young people in line with NICE guidance (2004) which advises that individuals under the age of 16 presenting to hospital for self-harm should always be admitted for a comprehensive psycho-social assessment. There is evidence from the Adult Psychiatric Morbidity Survey 2014 [36] that rates of self-harm have increased in the community, particularly in 16-24 year old females, with one in nine (11.7%) reporting having ever self-harmed in 2007 and one in five (19.7%) in 2014.

Figure 4: Hospital admissions for self-harm*, 3-year rolling age-specific rate per 100,000, males aged 10-17, Wales 2008-17



Produced by Public Health Wales Observatory, using PEDW (NWIS) & MYE (ONS)

*individual patients were counted a maximum of once per year even where there were multiple admissions. ICD-10 codes for self-harm (X60-X84) were searched for within the whole diagnostic record, rather than just the primary diagnosis field; therefore, in some cases the patient was admitted for a primary diagnosis of depressive episode, for example, and self-harm was mentioned lower down in the diagnostic record.

2.4 Current Policy context in Wales

Suicide prevention requires a truly cross-governmental, cross-sectoral and collaborative ("the 3 C's") approach that is broader than mental health services. It needs to include, amongst other sectors, 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, and bridges.

In 2015, the Welsh Government published *Talk to Me 2* [1] a five-year national action plan to reduce suicide and self-harm. The plan had six key commitments:

- Awareness, knowledge and understanding – shame and stigma
- Responses to personal crisis, early intervention and management of suicide and self-harm
- Information and support to those bereaved by suicide
- Support the media in responsible reporting
- Reduce access to the means
- Learning and information systems.

In 2012, the Welsh Government launched Together for mental health [37], 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.

Since 2004, the Welsh Government has used the United Nations Convention on the Rights of the Child (UNCRC) as the basis of its work for children and young people. Table 2 outlines key policy initiatives contributing to suicide prevention in Wales. The Wales National Strategy on violence against Women, Domestic Abuse and Sexual Violence – 2016–2021 [38] aims to increase awareness in children and young people of the importance of safe, equal and healthy relationships and that abusive behaviour is always wrong and the actions planned to achieve this objective through work with schools, local authorities and regional education consortia.

Table 2: Outline of key policy and activity contributing to suicide prevention in children and young people

Area	Relevant policy, action or intervention	Life stage
Rights	Rights of Children and Young People (Wales) Measure 2011 Children (Abolition of Defence of Reasonable Punishment (Wales) Bill	All ages
Mental and emotional wellbeing	Joint Ministerial Task and Finish Group on a Whole-School Approach to Mental Health and Well-being Health and well-being one of six core Areas of Learning and Experience in the new curriculum for Wales Together For Children and Young People Programme (T4CYP) Early Years Outcomes Framework Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales Social Services and Wellbeing (Wales) Act 2014 Well-being of Future Generations (Wales) 2015	Children and young people Early years All ages
Mental disorder	Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales Mental Health Crisis Care Concordat Mental Health (Wales) Measure 2010 Mental Health Act 2007 Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS)	All ages
Suicide and self-harm	<i>Talk to Me 2</i>	All ages

Area	Relevant policy, action or intervention	Life stage
Substance misuse	<p>All Wales School Liaison Core Programme</p> <p>Integrated Family Support Services: Statutory Guidance and Regulations</p> <p>Compendium of Good Practice Guidance on Integrated Care for Children & Young People aged up to 18 years of age who Misuse Substances</p> <p>Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018</p> <p>Substance Misuse Treatment Framework for Wales</p> <p>Alcohol Misuse Framework for Wales</p> <p>All Wales drug and alcohol helpline</p> <p>Revised Guidance for Commissioning Substance Misuse Services</p> <p>Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem</p> <p>Out of Work Service – Peer Mentoring</p> <p>Housing (Wales) Act 2014- this Act specifies that whether a person or a member of that person's household is at risk of abuse, including domestic abuse, is a factor in determining whether it is reasonable to continue to occupy accommodation.</p>	<p>Children and young people</p> <p>All ages</p>
Adverse childhood experiences (ACEs)	<p>Respecting others: Anti-bullying overview</p> <p>Respecting others: cyberbullying</p> <p>Respecting others: anti-bullying guidance (NAFWC 23/03)</p> <p>Respecting others: bullying around race, religion and culture</p> <p>Respecting others: Bullying around special educational needs and disabilities</p> <p>Respecting others: Homophobic bullying</p> <p>Respecting others: Sexist, sexual and transphobic bullying</p> <p>Social Services and Wellbeing (Wales) Act 2014</p> <p>National Strategy on Violence against Women, Domestic Abuse and Sexual Violence – 2016 – 2021</p> <p>National Child Sexual Exploitation Action Plan 2016</p> <p>National Action Plan Preventing and Responding to Child Sexual Abuse – 2019</p> <p>Welsh Government Palliative and End of Life Care Delivery Plan</p>	<p>Children and young people</p>
Online	HM Governments Online Harms White paper	All ages

2.5 Adverse Childhood Experiences (ACEs)

ACEs, as defined by Public Health Wales, are stressful experiences that occur during childhood that directly hurt a child (e.g. maltreatment) or affect them through the environment in which they live (e.g. growing up in a household with domestic violence) [39]. ACEs may impact on a child's health throughout their life. ACEs in The Welsh Adverse Childhood Experience (ACE) and Resilience Study are listed in Table 3 [40]. The World Health Organization also include bullying and bereavement as ACEs [41].

Table 3: Adverse Childhood Experiences- Public Health Wales Study

ACE	Question All ACE questions addressed to adults were preceded by the statement “While you were growing up, before the age of 18....”	Response indicating ACE
Parental separation	Were your parents ever separated or divorced?	Yes
Domestic violence	How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?	Once or more than once
Physical abuse	How often did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way? This does not include gentle smacking for punishment	Once or more than once
Verbal abuse	How often did a parent or adult in your home ever swear at you, insult you, or put you down?	More than once
Sexual abuse	How often did anyone at least 5 years older than you (including adults) ever touch you sexually? How often did anyone at least 5 years older than you (including adults) try to make you touch them sexually? How often did anyone at least 5 years older than you (including adults) force you to have any type of sexual intercourse (oral, anal or vaginal)?	Once or more than once to any of the three questions

ACE	Question All ACE questions addressed to adults were preceded by the statement “While you were growing up, before the age of 18....”	Response indicating ACE
Physical neglect	Did your parent/caregiver for long periods of time not provide you with enough food or drink, clean clothes or a clean and warm place to live when they could have?	Once or more than once
Emotional neglect	Were there times when there was no adult living with you who made you feel loved?	More than once
Mental illness	Did you live with anyone who was depressed, mentally ill or suicidal?	Yes
Alcohol abuse	Did you live with anyone who was a problem drinker or alcoholic?	Yes
Drug abuse	Did you live with anyone who used illegal street drugs or who abused prescription medications?	Yes
Incarceration	Did you live with anyone who served time or was sentenced to serve time in a prison or young offenders’ institution?	Yes

The ACEs described are well known risk factors for self-harm and suicidal behaviours (Figure 1). Choi and colleagues found that adults who had experienced ACEs were more likely to have attempted suicide in their lifetime than those who had not experienced ACEs [42]. These findings remained even after accounting for mental and substance use disorders. The data used were from the 2012 to 2013 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) to match people who had attempted suicide with those who had not, based on the presence or absence of nine mental and substance use disorders that are associated with suicide risk.

The ACEs included in the study [42] were (1) psychological abuse; (2) physical abuse; (3) sexual abuse; (4) emotional neglect; (5) physical neglect; (6) witnessing violence against a mother or other adult female; (7) substance misuse by a parent or other household member; (8) mental illness, suicide attempt, or suicide death of a parent or other household member; (9) incarceration of a parent or other household member; and (10) parents' separation or divorce.

Researchers found that:

- Men who had experienced four or more ACEs and women who had experienced two or more ACEs had a significantly increased risk of attempting suicide at least once, compared to members of each sex with no ACEs.
- Men and women who reported having a parent or relative with mental illness were more likely to have attempted suicide than those who did not.
- Men who had experienced childhood emotional neglect were more likely to have attempted suicide than those who had not.

The age at which respondents experienced ACEs, and the duration and severity of ACEs, were not measured and causality could not be inferred from the study. However, the findings still highlight a potential need for early detection of ACEs so evidence-based early interventions specific to individual ACEs can be delivered in a timely manner, including targeted interventions to prevent future suicide attempts, alongside enhanced support where required [42].

The Welsh Adverse Childhood Experience (ACE) and Resilience Study did not provide evidence on early detection of ACEs [40]. Adoption of 'ACE checklists' or screening approaches should be assessed using appropriate research design, service evaluation and screening programme criteria [42]. Another USA study [43] reported that physical, sexual, and emotional abuse, parental incarceration, and family history of suicidality each increased the risk by 1.4 to 2.7 times for suicidal ideation and suicide attempts in adulthood. The accumulation of ACEs increased the odds of suicide ideation and attempts. Compared with those with no ACEs, the odds of seriously considering suicide or attempting suicide in adulthood increased more than threefold among those with three or more ACEs [43].

Given the categorisation of ACEs and the growing evidence base in relation to ACEs and self-harm and suicide, we assessed ACEs in the current review. We included where recorded: verbal and emotional abuse; physical abuse; sexual abuse; sexual assault (the rationale for including this separately is given below, section 2.5.1); parental separation; household domestic violence; household mental illness; household alcohol abuse; household drug use; household member incarcerated; neglect (which incorporated physical and emotional neglect because this was not differentiated in our sources); bullying; and bereavement.

2.5.1 Sexual abuse, sexual assault and rape

There is some confusion regarding the terms sexual abuse, sexual assault and rape in children. It helps to be as consistent and precise as possible when using these terms to inform opportunities for prevention of the behaviours themselves and their impacts.

Sexual abuse is used to describe behaviour towards children and is defined, according to the Social Services and Wellbeing (Wales) Act 2014, as forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening, including: physical contact, including penetrative or non-penetrative acts; non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways [44]. Sexual abuse of a child is a criminal act.

According to the Sexual Offences Act 2003, anyone aged 18 years or over commits an offence if he/she engages in any sexual activity with a child under the age of 13 years [45]. If an adult engages in sexual activity with a child under 16, and does not reasonably believe that the child is aged 16 or over, then the adult commits an offence. If an adult in a position of trust in relation to a child under 18, engages in sexual activity with that child, and does not reasonably believe them to be aged 18 or over, then the adult commits an offence. In practice, young people who have consensual sexual relationships with other young people of their own age are not criminalized.

Rape is a criminal act when intentional penile penetration of another person's vagina, anus or mouth occurs without consent. The definition of rape neither relates to the relationship between victim nor perpetrator, neither does it relate to force. Rape and sexual assault are often used interchangeably. Sexual assault is any sexual act that a person did not consent to and can describe a range of criminal acts that are sexual in nature, from unwanted touching and kissing, to rubbing, groping or forcing the victim to touch the perpetrator in sexual ways.

Perpetrators can include relatives, intimate partners and strangers, although most are known in some way. It can happen anywhere – in the family/household, school, outside-school activities, public spaces and social settings and during war/conflict situations.

In the Wales ACEs programme, sexual abuse is assessed through the following questions addressed to adults:

While you were growing up before the age of 18:

- How often did anyone at least 5 years older than you (including adults) try to make you touch them sexually?
- How often did anyone at least five years older than you (including adults) force you to have any type of sexual intercourse (oral, anal or vaginal)?
- How often did anyone at least 5 years older than you (including adults) ever touch you sexually?

The 5-year age difference is used to distinguish peer relationships but there is some debate as to the appropriate age difference to use.

It is possible that the different nature and context of any sexual abuse such as the relationship with the perpetrator, age and circumstance through which the abuse occurs may have different impacts, require different interventions and offer different opportunities for prevention.

A Sexual Assault Referral Centre (SARC) is a special facility where recent victims of rape or sexual assault can receive immediate help and on-going support. In the initial phase, this includes access to a forensic medical examination, which should be carried out by an experienced and qualified doctor, and the opportunity to speak to the Police about what has happened to them if they wish to do so. During this process, SARC clients also receive help and advice from a Crisis Worker who can offer to support them and stay with them throughout the process.

Ongoing support is provided by the Independent Sexual Violence Advisor (ISVA) who should:

- tailor support to the individual needs of the victim or survivor
- provide accurate and impartial information to victims and survivors of sexual violence
- provide emotional and practical support to meet the needs of the victim or survivor
- provide support before, during and after court
- act as a single point of contact
- ensure the safety of victims and survivors and their dependants
- provide a professional service.

Availability, access and engagement with post-sexual abuse or assault psychological services are variable and time-limited.

3. Methods

3.1 Case definition

Children and young people's deaths for this review were defined as 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 2013 and 31 December 2017.

We identified deaths using the following ICD-10 classifications:

- Intentional self-harm (recorded as suicide verdict): X60 – X84
- Event of undetermined intent (including open and narrative verdicts): Y10–Y34, in those over 15 years of age.

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 Programme Team, based on information available, as to whether the case was a probable suicide for the purposes of this review.

Accidental hangings (asphyxiation), single vehicle deaths, accidental poisoning deaths and accidental drowning deaths in children 10 to 17 years are not included in 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 Programme database
- Office for National Statistics (ONS) Mortality data
- Procedural response to unexpected deaths in childhood (PRUDiC) review meeting minutes. The PRUDiC review meetings should identify lessons to be learned from individual deaths, which may be addressed locally through Regional Safeguarding Children Boards including the child practice review process if appropriate. Highlighting these lessons in the forms (Appendix 5 – Notification of Child Death and Appendix 6 – Record of Child Death) sent to the Child Death Review Programme Team enable them to be shared nationally
- Child Practice Reviews (CPR)
- Coroners' inquest recordings that were transcribed by members of the Child Death Review Programme Team
- Emergency Department (ED) attendance data
- External unofficial sources including media and internet reports.

3.3 Research evidence review

An evidence review of the literature regarding interventions to prevent suicide in children and young people was undertaken by Public Health Wales and Swansea University. This followed a systematic review methodology detailed in a protocol (available on request). Systematic reviews aim to provide an objective, reliable synthesis of the evidence base through following an explicit methodology which is transparent, repeatable and which aims to minimise bias.

In brief, evidence sources (clinical guidelines and well-designed systematic reviews from organisations known to use robust and transparent methods) located by the systematic search strategy were filtered for relevance and type of source based first on their titles and then on details contained in abstracts. The full-text of sources that were retained following this filtering process were then examined. Relevant data were extracted from included sources, into an Evidence Summary Table and conclusions drawn about the quality, strength and direction of the evidence of effectiveness.

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 2013 (the end date of the previous search strategy) onwards were included. Where no new studies were identified, findings from the previous review were included for completion.

The objective of the 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 children and young people in Wales?

It was structured according to a population-based approach whether the interventions were:

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

- Increasing public and professional awareness
- Tackling stigma
- 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 aimed at individuals at risk, such as those with a mental disorder 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 suicide for the family, friends and wider community
- Screening for suicide risk
- Prevention, identification and treatment of substance and alcohol misuse.

Indicated interventions, which aim to reduce recurrence in children and young people with known suicidal ideation and self-harm, such as:

- Evidence-based interventions for those who self-harm.

3.4 Thematic panel

A thematic panel was convened. Members were drawn from academia, safeguarding, public health, the police force, Welsh Ambulance Service Trust, the third sector, emergency medicine and specialist mental health services (see inside front cover for further details).

One full day meeting was held in January 2019. The morning session included a presentation of the evidence review and an in depth narrative discussion of ten deaths of children and young people selected because of the quality of information available which enabled discussion of a broad range of themes. The afternoon focused around identification of key issues and opportunities for prevention from these deaths.

The professional lead developed the first draft report for comment by the Child Death Review Programme team. The second draft was then produced to which the panel provided comment before Public Health Wales colleagues made further comments.

The professional lead and the Child Death Review Programme team then disseminated findings to relevant individuals and organisations through a series of meetings.

4. Findings

Where findings relate to fewer than three children and young people, it is presented as such in such a way as to maintain the anonymity of those involved.

4.1 Children and young people included in this review

Thirty-three children and young people met the case definition for the thematic review of suicide. Seventeen were deaths through intentional self-harm and 12 were events of undetermined intent. Six children and young peoples' deaths had not yet been assigned a code by the Office for National Statistics but were assessed as described in the review protocol by the professional lead and Child Death Review Programme Team through the information available. Four children and young people were included following this assessment.

Twenty-three children and young people were male (70%) and 10 female (30%). Nineteen (57%) were aged 16 or 17 years. The youngest was thirteen years old. Hanging, suffocation and strangulation were used in 25 (85%) of the deaths of children and young people. Other methods used included poisoning through drug overdose, jumping and gas poisoning.

Six of the children and young people had expressed their distress on social media prior to their deaths and in 11, the family reported a history of low mood. Five had a family history of suicide or suicidal behaviour. Eight had recently experienced a relationship break-up. Six had experienced issues with attendance at school and truancy.

Tables 4-11 summarise our findings.

4.2 Sources of information

Table 4: Sources of information

Information received	Number
Coroner's inquest & PRUDiC/Child Practice Reviews (CPR)	11
PRUDiC/CPR only	13
Coroner's inquest only	5
No inquest, PRUDiC/CPR	4
Total	33

Notification documents in the Child Death Review Programme database were available for all 33 children and young people.

4.3 Summary of children and young people

Table 5: Ages of children and young people

Age years	Number	Percentage %
10-14	5	15
15	9	27
16	7	21
17	12	36

Table 6: Year of death

Year	Number
2013	8
2014	4
2015	3
2016	7
2017	11

Table 7: Welsh Index of Multiple Deprivation Area based deprivation fifths

Deprivation fifth	Number
1 (least deprived)	5
2	7
3	4
4	10
5 (most deprived)	7

Table 8: Whether or not children and young people were known to services during their lifetime

Service	Known to service	Not known to service	Unable to determine if known or not known
Known to Child and Adolescent Mental Health Services (CAMHS)	11	19	3
Known to Youth Offending Service	4	26	3
Known to Police	3	27	3
Child known to Social Services	11	19	3
Family known to Social Services	5 (plus 11 families would be known due to child)	14	3
Looked after child	4	26	3
On child protection register or had previously been on child protection register	5	25	3

4.4 Other factors including ACEs and known risk factors

Table 9: Adverse childhood experiences

ACE	Yes	No	Unable to determine
Recorded verbal/emotional abuse*	5	24	4
Physical abuse*	5	24	4
Sexual abuse*	5	24	4
Sexual assault	3	26	4
Parental separation*	18	11	4
Household domestic violence*	7	22	4
Household mental illness*	8	21	4
Household alcohol abuse*	<3	27-29	4
Household drug use*	<3	27-29	4
Household member incarcerated*	<3	27-29	4
Neglect*	4	25	4
Bullying	10	19	4
Bereavement	6	24	4

* ACEs -10 categories used in Public Health Wales studies (neglect is separated into physical neglect and emotional neglect in Public Health Wales studies, but amalgamated in one category here).

Table 10: Number of Adverse childhood experiences

Number of ACEs	ACEs (all 13 categories)	ACEs*(10 categories)
0	4	6
1	8	11
2	5	3
3	2	2
4	4	2
5+	6	5
Unable to determine	4	4

Table 11: History of alcohol use, substance misuse or self-harm

Risk factor	Yes	No	Unable to determine
History of alcohol use	8	22	3
History of substance misuse	11	19	3
History of self-harm	16	13	4
Self-harm with no appropriate follow up	7	22	4
Known ED presentation with self-harm (all referred to CAMHS/admitted under Paediatrics)	6	27	0

4.5 Associated factors

The panel had an in depth narrative discussion of 10 of the children and young people included in the review. We were unable to identify any social connections between the children and young people based on the information available. The panel identified a number of factors common to more than one of the children and young people.

These were: sexual abuse; sexual assault or rape; domestic violence; bereavement; shame; disrupted living arrangements; difficulties in education, employment or training; lack of awareness regarding the importance of self-harm as a risk factor or opportunity for intervention; young parenthood; internet and social media; substance misuse; looked after children; poverty; custodial sentences and information sharing.

These factors and other key issues identified are discussed in Section 6.

4.6 Research evidence review

Twenty-nine articles were included in this effectiveness review: twenty NICE guidelines and nine systematic reviews (including five Cochrane reviews). They were grouped according to whether they address universal, selective/targeted or indicated interventions (Table 12).

A full report on the evidence review is available from www.publichealthwales.org/childdeathreview. A selection of key findings are shown in table 12.

Table 12: 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		
School-based suicide and self-harm prevention programmes	There is some evidence from randomised controlled trials that such interventions have an impact on reducing suicide attempts and suicidal ideation in both the short and long term. These interventions are also effective at improving knowledge and attitudes about depression and suicide.	SEYLE (European), GBG (USA), SOS (USA). No programmes identified had been developed and tested in the UK. SEYLE contained three components: gatekeeper training, screening, and education. Only the educational component was effective at reducing suicidal behaviour. Within Wales, school based prevention programmes are not in routine use and no programmes developed or tested in the UK were identified.

Intervention	Evidence	Comment
Universal interventions		
School-based programmes to prevent bullying and victimisation	<p>NICE guidance suggests these programmes are effective in preventing and reducing traditional bullying, cyberbullying and cyber-victimisation.</p> <p>Good evidence from four randomised controlled studies suggests that programmes can reduce victimisation (being bullied) by between 17 to 20%.</p> <p>One Randomised Controlled Trial (RCT) considered a whole-school approach to preventing cyberbullying. 35 schools were randomised to either the intervention or the control. The intervention group showed significant declines in involvement in cyber-victimisation and perpetration but there were no other significant differences.</p>	<p>NICE guidance currently being amalgamated and updated.</p> <p>A large number of programmes exist and the research evidence included three programmes developed and trialled in the UK.</p> <p>Bullying is addressed as part of the Healthy Schools Scheme in Wales. The choice of which programme or approach to adopt is made at a school level.</p>

Intervention	Evidence	Comment
Universal interventions		
Promotion of social and emotional wellbeing in primary and secondary education	NICE guidance published. National Institute for Health and Care Excellence (2017) Surveillance report 2017 – Social and emotional wellbeing in primary education (2008) NICE guideline PH12 and Social and emotional wellbeing in secondary education (2009) NICE guideline PH20 – Appendix: Evidence summary for NICE guideline PH20. London: NICE.	The evidence was reviewed in December 2017 and new evidence was identified that could have an impact on the recommendations. A decision was made to update and amalgamate the guidelines on social and emotional wellbeing in primary education [PH12] and social and emotional wellbeing in secondary education [PH20]. A number of on-going research trials were found that related to improving resilience, health behaviours and mental health.

Intervention	Evidence	Comment
Universal interventions		
School-based programmes for the prevention of child sexual abuse	<p>Cochrane review (2015) found evidence that school-based sexual abuse prevention programmes were effective in increasing participants' skills in protective behaviours and knowledge of sexual abuse prevention concepts. Knowledge gains (measured via questionnaires) were not significantly eroded one to six months after the intervention for either intervention or control groups. There was no evidence that programmes increased or decreased children's anxiety or fear. Children exposed to a child sexual abuse prevention programme had greater odds of disclosing their abuse than children who had not been exposed, although there was some uncertainty about this effect. Studies have not yet adequately measured the long-term benefits of programmes in terms of reducing the incidence or prevalence of child sexual abuse in programme participants nor long-term impacts on those abused.</p>	

Intervention	Evidence	Comment
Universal interventions		
Interventions that provide information, advice, education for staff or public to increase public and professional awareness of suicide and self-harm	<p>NICE guidance published. National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings: Evidence report 4 for information, advice, education and training. NICE guideline NG105. London: NICE.</p> <p>Evidence on the effectiveness of interventions on suicide attempts and suicidal ideation were largely from RCT studies. All interventions had a beneficent effect on suicide rates, showing a reduction in suicide events after the implementation of suicide prevention interventions. However, the impact of interventions on suicide attempts and suicidal ideation were not consistent.</p>	

Intervention	Evidence	Comment
Universal interventions		
Motivational interviewing for the prevention of alcohol misuse	A Cochrane review published in 2016 suggests this intervention is effective, but the evidence is not consistent.	<p>The majority of these programmes have been developed and tested in the USA. No programmes identified in the Cochrane review or NICE guidance had been developed and tested in the UK.</p> <p>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.</p>
Prevention of harmful drinking	NICE guidance for practice and policy was developed in 2010. 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).	Public health guidance has no formal status but is regarded as a useful source of reviewed evidence NICE guidance on school-based interventions to prevent alcohol use among children and young people is currently being updated.

Intervention	Evidence	Comment
Universal interventions		
Primary care behavioural interventions to prevent illicit drug use	Some systematic review evidence supporting the use of this intervention but it is not conclusive. The body of evidence is small and inadequate on the benefits of primary care-relevant behavioural interventions in reducing illicit drug use in children and young people.	No programmes identified had been developed and tested in the UK.
School-based educational programmes to prevent child sexual abuse	Cochrane review published in 2015 suggests that they do increase knowledge of sexual abuse prevention concepts and protective behaviours but the evidence is not conclusive and some studies reported harms. Programme participation may increase the odds of disclosure, however there is a need for more programme evaluations to routinely collect such data. It is not known if these improvements translate to reduce sexual abuse. Studies have not yet adequately measured the long-term benefits of programmes in terms of reducing the incidence or prevalence of child sexual abuse in programme participants.	The majority of these programmes have been developed and tested in the USA. No programmes identified had been developed and tested in the UK.

Intervention	Evidence	Comment
Universal interventions		
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	Some systematic review evidence suggesting psychological depression prevention and/or treatment interventions are effective in reducing suicidality in adolescents, but the evidence is not consistent.	
Prevention of suicide in community and custodial settings	NICE published guidance on this in 2018. This guidance addresses multi-agency partnerships, local suicide plans, interventions to respond to suicide clusters, interventions to increase public and professional awareness, restricting access to means of suicide, media reporting of suicides, and suicide awareness campaigns.	

Intervention	Evidence	Comment
Universal interventions		
Restricting access to means of suicide	NICE published an evidence review on this in 2018. Evidence was provided on the effectiveness of: physical barriers at jump sites, restrictions on road access to high frequency sites, safety nets, guard rails on windows, platform screen doors in railway or subway stations, crisis telephone (or telephone hotline), signposts, blue light-emitting-diode lights, and surveillance (CCTV camera or police patrol). There was a paucity of evidence on restrictions to access to means in custodial settings such as removal of ligature points or timed surveillance.	
Selective/targeted interventions		
School-based gatekeeper training	Some systematic review evidence supporting the use of this intervention but it is not conclusive. Findings suggest that school-based gatekeeper training is effective in improving knowledge, skills, self-efficacy and likelihood to intervene, while mixed evidence exists in changing attitudes and gatekeeper behaviour. Due to methodological issues, such as lack of randomised controlled trial evidence and the inability to use validated measures, conclusions cannot be drawn from included studies.	The majority of these programmes have been developed and tested in the USA. No programmes identified had been developed and tested in the UK.

Intervention	Evidence	Comment
Selective/targeted interventions		
Management of depression in children and adolescents	<p>NICE guidance published in 2005 (updated in 2017). One Cochrane review on psychological therapies in combination with antidepressants or alone, was subsequently published. The findings of the Cochrane review do not differ significantly from the NICE guidance.</p> <p>One systematic review on psychosocial interventions for depression published in 2016 found evidence in support of this intervention however the evidence was inconsistent and it is not possible to draw a conclusion.</p> <p>It is unclear whether psychological treatments are more effective than no treatment since no study has used a no-treatment control group. There is evidence to suggest that Cognitive Behavioural Therapy interventions produce pre-post reductions in suicidality with moderate effect sizes and are at least as efficacious as pharmacotherapy in reducing suicidality; however, it is unclear whether these effects are sustained. There are several trials showing promising evidence for family-based and interpersonal therapies, with large pre-post effect sizes, and further evaluation with improved methodology is required. Depression prevention interventions show promising short-term effects.</p>	<p>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.</p>

Intervention	Evidence	Comment
Selective/targeted interventions		
Management of post-traumatic stress disorder (PTSD)	NICE guidance published in 2018. The guidance is in support of psychological therapies, particularly CBT, for the prevention and treatment of PTSD in children and young people.	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.	
Prevention of suicides in residential custodial and detention settings	NICE published an evidence review on this in 2018 and noted the paucity of evidence on preventing suicide in custodial settings. Evidence from one study showed a reduction in the number of suicides in a prison after the implementation of peer support service. The reduction was not statistically significant and low certainty of evidence did not provide a robust evidence base for strong recommendations. However, the committee assessing the evidence, based on their experience, suggested that peer support could have a potential beneficial effect on prisoners such as a reduction in a feeling of distress and an improvement in their help-seeking.	

Intervention	Evidence	Comment
Selective/targeted interventions		
Local interventions to support those bereaved or affected by suicide	<p>NICE published an evidence review on this in 2018. Recommendations made include the use of rapid intelligence gathering and data from sources such as coroners to identify anyone who may be affected by a suspected suicide or may benefit from bereavement support; and offering those who are bereaved or affected by a suspected suicide practical information expressed in a sensitive way, such as the Help is at Hand guide – Cymru guide [46].</p> <p>The PRUDiC process may also be used to identify those affected by a suspected suicide.</p>	The Welsh Government response to 'Everybody's Business' [47] suggests a Wales suicide bereavement pathway will be developed. There have been issues accessing The Help is at Hand booklet.
Interventions to prevent substance misuse	NICE guidance published in 2017. Recommendations made include: Delivering drug misuse prevention activities as part of existing services; assessing whether someone is vulnerable to drug misuse; providing skills training for children and young people who are vulnerable to drug misuse; providing information to adults who are vulnerable to drug misuse; and providing information about drug use in settings that people who use drugs or are at risk of using drugs may attend.	

Intervention	Evidence	Comment
Selective/targeted interventions		
Responding to suspected child maltreatment	NICE guidance published in 2009 (updated in 2017) gave guidelines on when healthcare professionals who are not child protection specialists should suspect child maltreatment. This guideline covers the signs of possible child maltreatment in children and young people aged under 18 years. Recommendations are made on: physical features; clinical presentations; neglect by failure of provision and failure of supervision; emotional and behavioural states and behavioural disorders or abnormalities; and parent–child interaction.	

Intervention	Evidence	Comment
Selective/targeted interventions		
Responding to child abuse and neglect	<p>NICE guidance published in 2017 covering physical, sexual and emotional abuse, and neglect. This does not include guidance on managing the sequelae of this. Recommendations are made on: principles for working with children, young people, parents and carers; factors that increase vulnerability to child abuse and neglect; recognising child abuse and neglect; assessing risk and need; early help for families showing possible signs of child abuse or neglect; multi-agency response to child abuse and neglect; therapeutic interventions for children, young people and families after child abuse and neglect; and planning and delivering services.</p> <p>A Cochrane review published in 2015 suggests that CBT may have the potential to have a positive effect on the sequelae of child sexual abuse including depression and behavioural problems but overall the evidence was not conclusive.</p> <p>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.</p>	

	<p>There is relatively consistent evidence that cognitive behavioural approaches may lead to reductions in depressive, anxiety and post- traumatic stress symptoms in children.</p> <p>There is a lack of evidence on the effectiveness of psychoanalytic/ psychodynamic approaches.</p>	
Intervention	Evidence	Comment
Indicated interventions		
Management of self-harm	<p>NICE has issued guidance on both the short (2004) and longer-term (2011) management of this. A Cochrane review was published subsequently in 2015. The findings are in line with the existing NICE guidance.</p> <p>There have been relatively few investigations into interventions for children and adolescents who engage in self-harm. Thus, there is not much evidence on which to draw conclusions on effects of interventions for self-harm in this population. While there were some very limited positive findings regarding dialectical behavioural therapy for adolescents (DBT-A), mentalisation, and therapeutic assessment, these approaches require further evaluation before any definitive conclusions about their use in clinical practice can be made.</p>	

5. Strengths and limitations

A major strength was the multi-sectoral nature of the panel. This allowed for a truly representative discussion of the deaths that extended beyond health. This national review covered a five-year period, collecting information from a wide range of sources affording opportunities to identify themes and potentially modifiable contributory factors to suicide deaths in Wales.

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 this reason, the review is supported by a review of international evidence alongside panel discussion and data. There were a number of areas where the panel could not draw a conclusion due to a lack of information. Child Practice Reviews were in-depth and a good source of information regarding ACEs. Recordings of coroner's inquests were also useful sources of information. However, we acknowledge certain limitations in the recording of ACEs and that these are likely to be underestimated. It was not possible to distinguish between physical and emotional neglect from our sources. It is likely that capturing information such as parental separation is more accurate than assessments of verbal or emotional abuse. The previous thematic review had access to police investigation reports including interview statements. Some information available in police reports is not always raised at inquest or in PRUDiC meetings.

Capturing information about the quality of relationships in these children and young people's lives was limited, as was any information regarding any social connections between them. There was limited information on social media use and online expressions of distress. These are important factors in this age group. Capturing this information for future thematic reviews will be important. Police reports may be a source of this information along with encouragement of reporting this in PRUDiC reviews. Mechanisms to encourage schools and further education establishments to share information will also improve the information available.

In England, statutory guidance states that families should be involved in child death review processes put in place by child death review partners [48] and that parents should be assured that any information concerning their child's death which they believe might inform the meeting would be welcome. In Wales, this is not statutory. Parents can contribute information through the PRUDiC process. Families were not involved in the review and consideration will be given on how to overcome the challenges to doing this in the future. It may be that certain suicide bereavement charities led by bereaved parents are invited to comment on future reports.

6. Issues identified in this review

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.

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

6.1 ACEs

A large number of children had been exposed to adverse childhood experiences. Seventy percent (n=23) had experienced at least one ACE (from the list of ten ACEs used in previous Public Health Wales studies, Table 10). This is compared with 50% of the Wales population self-reporting as adults which is not directly comparable since it may be subject to recall bias and the nature of the questions asked [40]. The impact of parental separation may have changed with time as it becomes more common. Almost one third of the children and young people had experienced three or more ACEs from the list of ten ACEs. If parental separation was excluded from the list of ten ACEs, 45% (n=15) had experienced at least one ACE. Neglect did not appear to be clearly recorded in our data and verbal/emotional abuse is likely to have been underestimated.

6.1.1 Domestic violence

Seven of the children and young people were exposed to domestic violence in the household and five experienced physical abuse.

The National Assembly for Wales's Children, Young People and Education Committee considered the general principles of the Children (Abolition of Defence of Reasonable Punishment) (Wales) Bill [49], and launched a public consultation to inform the work during April and May 2019. The consultation explored the general principles of the Bill, including looking at whether there was a need for legislation; any potential barriers; unintended consequences arising from the Bill; financial implications; and appropriateness of the power in the Bill for Welsh Ministers to make subordinate legislation. A debate took place in Plenary in September 2019 and the motion to agree the general principles of the Bill was agreed. The Committee are currently (October 2019) considering amendments to Bill.

6.1.2 Sexual abuse and sexual violence

It is estimated that approximately one in 20 children have been sexually abused with over 90% of these being abused by someone they knew [50]. Eight of the 33 children and young people who died by suicide in this review were known to have experienced sexual abuse or rape. A number of the children and young people in this review did not engage with existing services or if they were seen in a SARC appeared to be lost to any follow up if a prosecution was not brought or a conviction not made. Although appropriate sign-posting may have occurred, there is no evidence of any uptake.

We note that a Cochrane review [51] found evidence that school-based sexual abuse prevention programmes were effective in increasing participants' skills in protective behaviours and knowledge of sexual abuse prevention concepts and encouraged disclosure.

Domestic violence and sexual abuse or violence are not mutually exclusive and since power and control forms the basis of both, may commonly overlap. However, sexual violence has the potential to occur within a greater range of settings and situations. We note that Welsh Government plan to work with a wide body of professionals and organisations to ensure that families identified and needing support for living with adverse childhood experiences relating to domestic violence and sexual violence, have access to existing interventions delivered by specialist services. Providing support for children and people experiencing domestic violence and sexual violence is complex, since experiences and needs can be vastly different.

The WHO also include bullying and bereavement as ACEs [41].

6.1.3 Bullying

Almost a third of children and young people who died by suicide experienced bullying.

The bullying identified through the review was very real to the child, however, in some instances, it was not recognized by the professionals involved with the child and family.

A recent Public Health Wales report shows the return on investment of £15 for every £1 spent on evidence based anti-bullying initiatives [52].

6.1.4 Bereavement and loss

A number of the children and young people had experienced recent bereavements of close family members. Other children had experienced the loss of a pet, or a break up of a relationship. Welsh Government commissioned a bereavement scoping study to gather information on existing bereavement support services across Wales. This includes bereavement due to suicide. An interim report was published in May 2019 [53].

6.2 Shame

A number of young people had potentially experienced shame following activities where it had been alleged that they were a perpetrator of abuse (bullying, sexual).

6.3 Young carers, pregnancy and parenthood

A number of young people had caring responsibilities for close family members. Young carers often have poor access to services as a consequence of their caring responsibilities.

A number of the children were teenage parents or expectant teenage parents. Young parents and their children are vulnerable to a wide range of poor outcomes including higher rates of infant mortality, premature births and higher rates of attendance to Emergency Departments [54]. Young parenthood may impact on educational attainment and on mental health. The panel highlighted that more specific support for young parents' well-being and their context as children and parents is required with an equivalent focus on fathers and mothers.

6.4 Education, employment and training

Many of the children and young people either had restricted educational attainment or were not in education, employment or training (NEET) or their attendance was poor with a number of exclusions (both within and out of school). Those over 16 years of age often appeared to receive little or no support from any services.

6.5 Substance misuse – drugs and alcohol

Almost half of the children and young people (n=15) had recorded issues with drugs and/or alcohol. Cannabis use was frequently reported and in a number of children and young people, this had been recognized as an issue by services they were in contact with.

6.6 Management of self-harm

Almost half of the children and young people (n=16) had a recorded history of self-harm. A number of young people who self-harmed received no follow up since they were either not transported to ED or no follow up was arranged. Verbal advice to parents was sometimes given to seek further assessment, which in some was not followed. There was no oversight regarding whether this had occurred.

6.7 Parental awareness of the relevance of self-harm

A number of young people had episodes of self-harm where parents were unsure of how to respond and so were not accessing services even when this was suggested by schools or healthcare services. Stigma related to self-harming behaviours remains a major challenge to suicide prevention efforts.

6.8 Living arrangements

Children and young people experiencing parental separation and divorce or breakdown of family relationships may experience poor emotional health and wellbeing. This can be exacerbated if they experience isolation due to their living arrangements. A number of children and young people were having difficulties with insecure living arrangements.

Twenty-five percent of adults self-reported parental separation in Public Health Wales studies compared with 55% of children and young people from families where parents had separated in our review [40]. However since patterns of parental separation and divorce have changed over time this is not comparable.

6.9 Deprivation

There is a recognised relationship between deprivation and suicide [55]. Just over half of the children and young people were from the two most deprived fifths of areas. Such apparent socio-economic inequalities are a major challenge to suicide prevention.

6.10 Schools and further education colleges

The panel highlighted the role of schools and colleges as crucial settings to engage vulnerable young people and which hold important knowledge of their students' unique life circumstances. They are often the only 'safe place' in the lives of some children and young people. The difficulties in some children and young people's lives presented as poor attendance and poor adherence to rules regarding uniform and resulted in disciplinary action. The panel discussed communication between schools and healthcare services when children and young people presented with self-harm to health services.

The panel noted the Joint Ministerial Task and Finish Group, which brings together key strategic stakeholders from across education, health, the wider public and third sectors to facilitate a Whole-School Approach to Mental Health and Well-being. This has been informed by the Children, Young People and Education Committee's inquiry and key recommendations in their *Mind Over Matter* report [56], which called for emotional and mental wellbeing and resilience to be a stated national priority.

The panel were concerned about a possible gap in information sharing between private schools and health and social care services, as well as, a lack of contact with services in home-schooled children and young people. The panel noted that in July 2019 the Welsh Government launched a public consultation on draft statutory guidance for the support and oversight of children who are home educated.

There were instances where schools had advised a parent to contact primary care or CAMHS services but this contact did not occur.

There was evidence that deaths in school pupils caused considerable distress to the school community and access to bereavement support following a death by suicide was important.

6.11 Social services

One third of the children and young people in this review were known to social services. For five other children, their families were known to social services. It was unclear in these situations what oversight of the child or young person occurred when they were not specifically known themselves. It was also unclear whether specific consideration had been given to siblings in the same household living with similar adverse experiences. Some of the children were under local authority care when they took their lives. A number of the children had been on the child protection register at some point during their lives.

6.12 Multi-disciplinary working within healthcare

A number of the children and young people had sporadic contact across a number of services. This included:

- referrals made to SARC counselling services or GPs where young people did not engage or were not brought (rather than did not attend)
- where paramedics attended after an episode of self-harm but the young person was not transported to the ED so did not enter any care pathway
- where the young person did not meet the threshold following a CAMHS referral or stopped attending following earlier diagnoses such as Attention Deficit Hyperactivity Disorder (ADHD)
- where the suicide risk of child or young person was not recognised by healthcare professionals including CAMHS so no follow up was arranged.

As such these opportunities for intervention were missed with little apparent oversight, communication or follow-up of loss of contact.

6.13 Multi-agency partnership working

For a number of children and young people communication of issues across services related to social circumstances or self-harming behaviours did not occur – for example between the police and health, schools and health, schools and the police, the police and children's social care services.

6.14 Social media sites and internet use

Use of social media platforms and specific websites were mentioned preceding some of the deaths of children and young people. It was beyond the scope of the current review to make an assessment of these media channels and any part they could play both as an associated factor and an opportunity for intervention. However, a number of children expressed their distress online via social media sites or via private electronic communications (messaging, text messages). It is recognised in the literature that young people increasingly express their distress online such as prior to attending the ED with an episode of self-harm [57].

6.14 Media reporting

The panel noted some of deaths in these children and young people were widely reported in the media. It is recognised that death by suicide in young people is more widely reported than similar deaths in other age groups [58]. Responsible reporting of suicide deaths can minimise any effects on vulnerable individuals and further distress to family and friends [59].

7. Opportunities for prevention

The panel contributed advice, analysis and discussed opportunities for prevention based on the data, the evidence review and their expertise, and their contribution informed the development of the opportunities created by the authors.

As a general principle services and programmes should be based on up-to-date knowledge and have fidelity to the evidence base of what works for positive engagement by children and young people and good outcomes. Children and young people should be given the opportunity to articulate the support they need. In 2011, Wales became the first country to make the United Nations Convention on the Rights of the Child part of its law and the principles outlined are underpinned by this [60].

Our review identifies the value of existing activities and suggests some opportunities to further enhance these. These are discussed in section 7.1. New opportunities for prevention are listed in section 7.2. The opportunities for prevention that the professional lead and the CDRP team felt should not be missed are **highlighted in bold**.

7.1 Existing activities which contribute to the prevention of suicide

7.1.1 ACEs

Domestic violence, physical abuse and sexual abuse

- Families identified and needing support when living with adverse childhood experiences relating to domestic violence and sexual abuse or assault have access to existing interventions delivered by specialist services.

There is an opportunity for developing an understanding of why young people do not initiate engagement with services, optimising provision and access and ensuring continued engagement through a needs-led approach (i.e. be responsive to individual support and intervention needs) and through meeting or developing relevant quality standards.

An example includes the Violence against Women, Domestic Abuse and Sexual Violence framework of accredited quality service standards which provide benchmarks for service providers, funders and commissioners about the extent and mix of services that should be available, who should provide them, and the principles and practice base from which they should operate [51].
- We support the principles of the Children (Abolition of Defence of Reasonable Punishment) (Wales) Bill. The purpose of the Bill is to abolish the common law defence of reasonable punishment so it is no longer available in Wales to parents or those acting in loco parentis as a defence to assault or battery against a child. The Bill is intended to support children's rights, and also to further change attitudes to parenting so that more positive parenting methods are used.
- The provision of SARC services are currently being addressed in Wales. Funding and commissioning SARC services nationally (currently there are National Pathways with local implementation) with quality standards regarding follow up on referral to support services could be considered.

Bereavement and loss

- Health Boards and a number of third sector organisations, already provide support to bereaved young people. This could be built upon in a number of ways including raising the awareness of professionals about existing services e.g. bereavement counselling pathways or community psychological therapies/supportive counselling and schools counselling. This is especially important for vulnerable children such as looked after children, young carers, and children and young people bereaved through suicide.
- Welsh Government's current review on bereavement support services aims to ensure that every bereaved family has access to appropriate support. Specific provision for children and young people could be considered in this review, particularly those bereaved through suicide.

Prevention

- The Adverse Childhood Experiences (ACE) Support Hub was established in 2017 to help create the environment for change and support individuals, communities and organisations to create an ACE aware society. The Hub aims to prevent ACEs from occurring in children's lives, support early intervention when children are experiencing ACEs to minimise their impacts, and to build resilience in adults who have experienced ACEs to stop any inter-generational impacts. The focus of the Hub is to:
 - Disseminate information and knowledge about ACEs
 - Share evidence about what the organisations can do differently to prevent and mitigate ACEs
 - Develop knowledge and skills amongst professionals
 - Synthesize and share learning from individuals, communities and organisations
 - Drive change and system transformation at local and national levels.

The Hub has recently published its annual report delivery plan for 2019/20 and further information can be found at: www.aceawarewales.com

7.1.2 Shame

- The vulnerabilities of perpetrators (e.g. alleged perpetrators of sexual abuse or cyber/ traditional bullies) is well recognised in the literature. Restorative practices are being used in some circumstances for young people in schools. It is important that appropriate support is provided for those who may be experiencing shame; and an acknowledgement that those involved are children and may have been victims themselves in the past. This in no way detracts from the support available to victims.

7.1.3 Young carers, pregnancy and parenthood

- The Young Carers network and social services provide support for young carers. It is important that all those in contact with young people in primary care and community settings, including schools, are aware of the network and the eligibility for a social services assessment.
- A range of services are provided for young parents, which offer support (home visits, education, childcare) and promote positive parenting practices. Continued development of partnership working could offer opportunities to enhance this further to include the whole family context (including living arrangements, finances); their own well-being as children themselves; and specific support for teenage fathers.

7.1.4 Education, employment and training

- The Education Welfare Officer has oversight of the needs of children referred to the service and is well placed to provide a focus on the needs of children and young people not engaging with educational settings (poor attendance, multiple exclusions).

7.1.5 Substance misuse – drugs and alcohol

- Existing mechanisms and ongoing action to restrict access of children and young people to alcohol should continue. This includes the minimum price per unit, regulation of marketing and availability and action on under-age sales. This may be through existing powers or lobbying UK Government for changes.
- NICE guidance exists to prevent substance misuse, including providing skills training for children and young people who are vulnerable to drug misuse, and screening for harmful drinking and brief interventions. Full implementation across Wales could contribute to suicide prevention.

7.1.6 Management of self-harm

- NICE guidance exists on the short, longer term and community setting management of self-harm relating to children and young people. Full implementation with audit of processes across Wales, particularly with regard to emergency department attendance, admission, psychosocial assessment, referral, sign-posting, evidence based interventions and staff training, could contribute to suicide prevention.

7.1.7 Public and Parental Awareness

- Use of the leaflet from the Charlie Waller Trust could be encouraged: https://docs.wixstatic.com/ugd/b5791d_7d13f090db464315b2f76a6f614cffffb.pdf

7.1.8 Living arrangements

- Young people experiencing parental divorce, separation or family relationship difficulties are supported by agencies such as educational establishments and social services. It is important to recognise that these situations may impact on their living arrangements necessitating additional help through these transitions by appropriate services, with access to information to support their needs.

7.1.9 Deprivation

- Continuing the efforts to eradicate child poverty at government level offers an opportunity for suicide prevention. Clear and strong leadership, and measuring progress against targets such as the National Indicators under the Well-being of Future Generations Act will help to focus this agenda.

7.1.10 Schools and further education colleges

- The Healthy Schools scheme addresses bullying and the focus on anti-bullying should continue, including the delivery of known evidence based programmes.
- Schools provide opportunities to develop and evaluate evidence-based interventions and programmes which offer early intervention and enhanced support. Adequate resourcing including monies for evaluation building on existing evidence will enhance the ability of these changes in practice to contribute to the evidence base and be sustainable. Opportunities have been recognized in the *Mind Over Matter* report of the Children, Young People and Education Committee [56] including the review of schools access to specialist mental health advice and pathways for sign-posting.
- Welsh Government published guidance to schools and further education establishments on self-harm in September 2019 [61]. Opportunities to actively share and disseminate this to support implementation need to be encouraged.
- Existing guidance and services for education communities experiencing the loss of a student by suicide, such as Samaritans 'Step-by-Step' service.

7.1.11 Social services

- Where social services are involved with a family for reasons unrelated to a particular child, oversight of all children in the family needs to be encouraged with this explicitly stated in plans.

7.1.12 Multi-disciplinary working in healthcare

- Health care providers have policies to deal with situations where a child is not brought for a planned appointment. Full implementation of these policies ensures that children are not lost to follow up.

7.1.13 Multiagency partnership working

- Continue to embrace efforts by professionals and organisations to prevent silo working and to strengthen the interfaces between services such as GP and CAMHS, social services and primary care, child and adult services to prevent young people 'falling through the cracks'. Ongoing development of electronic records e.g. between health and social care may support this.
- Work to address possible barriers to engagement with services is already in existence. Engagement with health services may be improved through accessible therapeutic consultation and liaison services. There are opportunities to design and configure services so that they are accessible by every child, which address the circumstances for the individual child, accessibility in the community, alongside more proactive approaches when young people do not engage, such as assertive outreach.
- Awareness of and engagement with Regional Suicide Prevention Fora would ensure local suicide prevention action plans have a focus on children and young people and include evidence based interventions.

7.1.14 Social media sites and internet use

- The School Health and Wellbeing curriculum in the area of Learning and Experience includes content for young people relating to taking care of their own wellbeing and having healthy relationships. Further to this, it could prove helpful when addressing distress expressed by peers electronically.

7.1.15 Responsible media reporting

- Samaritans media reporting guidelines are a useful tool and could be more actively promoted in Wales: www.samaritans.org/wales/about-samaritans/media-guidelines/best-practice-suicide-reporting-tips/

7.1.16 Research and surveillance

- Ongoing research in the epidemiology and prevention of suicide and self-harm in young people may identify new risks or opportunities for prevention.
- The Child Death Review Programme undertake surveillance of suicide deaths in under 18s and this may identify further opportunities for prevention

7.2 New Opportunities for prevention

7.2.1 Adverse Childhood Experiences – domestic violence and sexual abuse

Engagement with Regional Safeguarding Children Boards to raise awareness of the importance of protecting children from the impact of domestic violence and sexual abuse in contributing to the prevention of suicide and suicidal behaviours.

7.2.2 Education, employment and training

Explore mechanisms to ensure children and young people between the ages of 16 and 18 years are supported in education, employment or training including work based training. This could be supported by raising the age of participation to 18 years with guaranteed options to access education, work based training or apprenticeships up to this age.

7.2.3 Schools

Explore the inclusion into the school curriculum of evidence-based school programmes that empower children and young people to understand their rights to protection from abuse including sexual abuse and that encourage protective behaviours.

7.2.4 Information Sharing

Engage in discussions about the development of an all-Wales child protection register to which all local authorities contribute which is accessible by relevant services as needed. This would afford additional protection to the most vulnerable children.

Consider schools based staff permission to write to the GP when a parent or young person is advised to access services.

There is an opportunity to explore how information can be optimally shared between non-state education settings, such as private schools or those home schooled and statutory agencies (education, health, social care). This could provide a safety net for those educated in these settings who are most vulnerable. Improved communication would also support postvention.

7.2.5 Public and Parental Awareness

Explore effective evidence-based ways of increasing knowledge and awareness of the importance of the following to enable caring responses to children and young people in distress (see 7.1.7, NICE guidance 105, section 1.5):

- **self-harm and other risk factors for suicide**
- **safety planning with the young person**
- **help-seeking and accessing services in self-harming behaviours in this age group**
- **tackling stigma associated with attending the GP and counselling services for these issues.**

7.2.6 Child Death Review Programme

The development of statutory guidance for child death review processes in Wales with involvement of families would assure parents that any information concerning their child's death which they believe might inform any meeting would be welcome and can be submitted.

8. Conclusion

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. Although the factors that contribute to an individual taking their own life are many and complex, suicide and self-harm are potentially preventable. This review identified many existing activities that contribute to the prevention of suicide, as well as new opportunities that could inform action.

The opportunities not to be missed are summarised below. These were selected as there is a real chance that development of these opportunities could inform action to prevent deaths of children and young people through suicide.

The opportunities not to be missed are:

- **Management of self-harm:** Full implementation of NICE guidance for the management of self-harm relating to children and young people.
- **Prevention of alcohol and substance misuse:** Ongoing action to restrict access of children and young people to alcohol, and full implementation of NICE guidance to prevent substance misuse.
- **Mitigation of ACEs:** Optimising provision and access and ensuring continued engagement with interventions for children who have experienced adverse childhood experiences such as sexual abuse, sexual assault or domestic violence; and engagement with safeguarding boards to raise awareness of the importance of protecting children from the effects of domestic violence and sexual abuse to prevent suicide and self-harm.
- **Raising age of participation in education, employment or training:** Exploration of mechanisms to ensure children and young people between the ages of 16 and 18 are supported in education, employment or training including work based training.
- **Better information sharing:** Exploration of how information can be shared between non-state education settings (such as private schools) and statutory services.
- **Better knowledge and awareness:** Exploration of evidence-based ways of increasing knowledge and awareness of: self-harm and other risk factors for suicide; safety planning; help seeking and accessing services; and tackling stigma.

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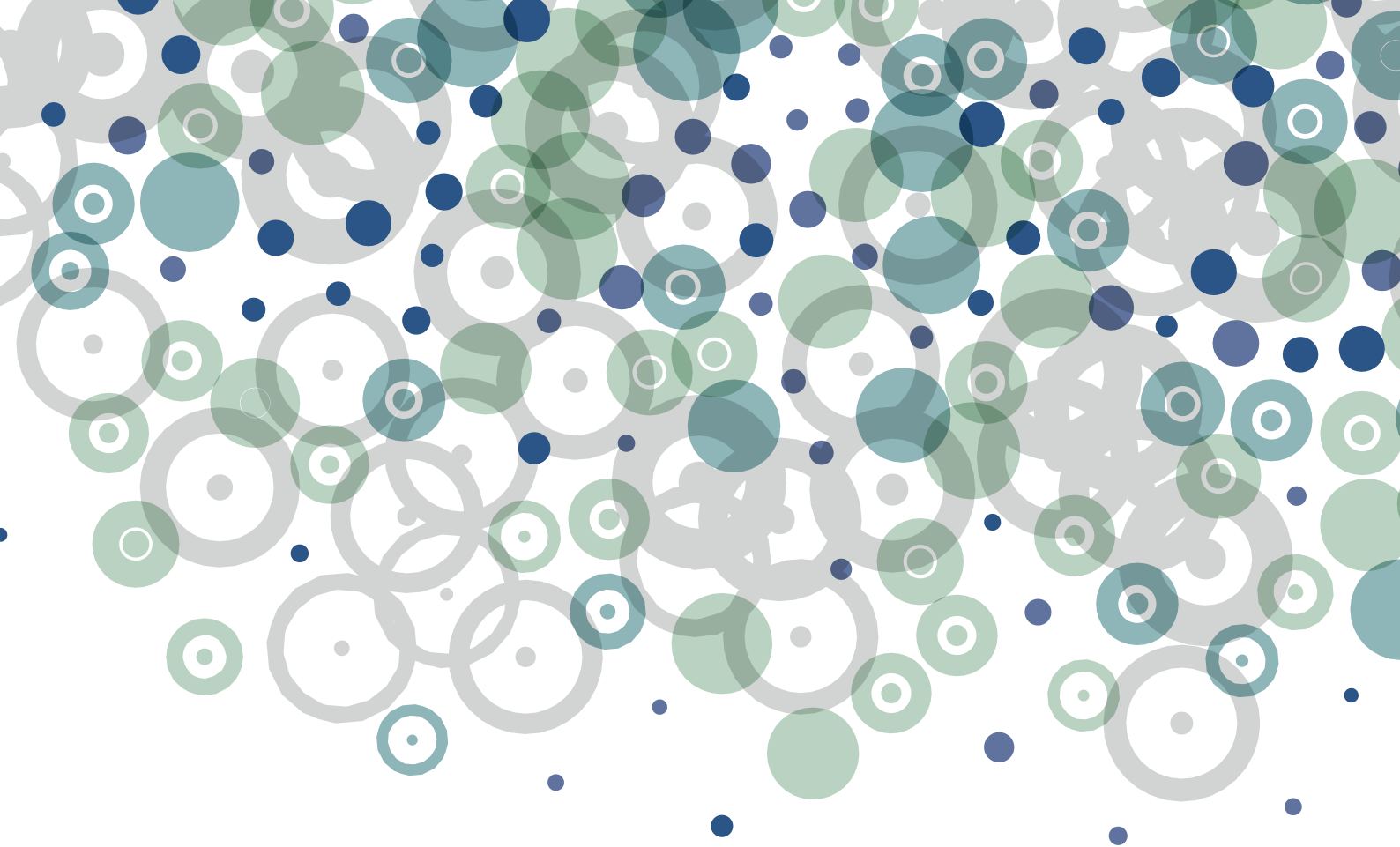
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