Discussion

Care must be taken with the interpretation of these results as the sample is small and the specificity of notable factors is uncertain in the absence of any long-term population based study on suicide risk in children and young people.

Certain factors appear to be significant, including the high proportion of families affected by mental or emotional health problems (32%) and the 20% of families experiencing unemployment, financial distress and/or debt. Relationship difficulties between parents and parenting problems were frequent with domestic abuse recorded in 24% of households. In 36% of families, previous or current child protection concerns were noted. The birth father did not play a role in 36% of families.

56% of suicide victims had made good progress in school but in 28% of the sample there had been a history of being bullied. Of note was evidence that 28% of victims had some discussion within their peer group about suicide. A number of children or young people were already known to the police, the courts or (mostly) to social care.

For over half (52%) of the victims there had been concerns expressed in various settings including school or home about their emotional or mental health. In 36% of cases there was evidence for low self-worth and in 40% there had been documented relationship difficulties. 32% had previously threatened self-harm or expressed suicidal ideation, 24% had actually self-harmed and 12% had self-harmed to the extent that a fatal outcome was narrowly avoided.

The significance of a presumed trigger event can be difficult to assess in retrospect but in many cases this appeared to be a family row or the worsening of a relationship difficulty. Death was by strangulation/hanging in 84% of cases.

In a subgroup (n=12) with family mental health problems, including alcohol and substance misuse and previous self-harming by family members, the totals accounted for 80% of families with financial distress, debt or unemployment, 66% of absent fathers, 46% of parental separation, 66% of the domestic abuse and 78% of the current/previous child protection concerns in the study.

The literature on suicide risks in young people is limited with a lack of prospective long-term population studies. Research on notable risk factors has not included studies based on CDOP data. A population based study (3) of 6,043 children in the Avon Longitudinal Study of Parents and Children (ALSPAC), assessed involvement in bullying between 4 and 10 years and suicide related behavior at 11.7 years. Peer victimization (victim, bully/victim) was significantly associated with suicide ideation and suicidal/self-injurious behaviour after adjusting for confounders.

A study on a cluster of suicide deaths in South Wales (4) demonstrated how a combination of factors increased the risk of suicide in young people. The factors were: clearly deprived circumstances, a history of self-harm, a history of abuse, drugs and alcohol, bullying, and links with other cases.

Nationally, despite the number of child deaths falling by 70 per cent over the past 30 years, there has been no decline in national mortality rates due to injuries caused by self-harm, assault or undetermined injuries (5). There are around 800 children and young people who die each year in the UK, with deaths related to assault, self-harm or undetermined injuries accounting for 34 and 37 per cent respectively of injury deaths in boys and girls aged 10 to 18. Boys aged between 10 and 18 are the most at-risk group and are almost three times more likely than girls of the same age to sustain fatal injuries.

The risk factors that contribute to deaths due to suicide or assault in children are complex and often accumulate over childhood. They include combinations of factors such as deprivation, alcohol or drug misuse and other mental health problems in children and their parents (5). The present study confirms these findings. Agencies may focus on the problems of the adults, services may lack co-ordination and the needs of the children or young people are often missed.

Strengths and Limitations of this study

Strengths

- Good cooperation from those CDOPs who did participate
- Opportunity to use data from multi-agency sources

Limitations:

- Incomplete return of data from CDOPs in second part of study
- Enquiry form used as a secondary information gathering tool
- Not all enquiry forms completed by author, some by individual CDOP managers so risk of different interpretation of agency returns on Form Bs
- Difficult to be consistent in some areas e.g. definition of mental or emotional problems.
- Perceptions and memories of actions and behaviours may have been coloured by subsequent events

Recommendations

1. Clearly it is impossible to police a young person's use of texting, the internet and social media but parents should be aware of risks and could ask if there are any concerns about cyber-bullying or whether a young person has shared feelings about suicide with peers or searched for suicide advice sites (depending on parents' relationship with the young person, but especially if there are concerns re emotional/mental health). Peer group leaders in schools/colleges could play a part in the prevention of cyber-bullying.
2. If young person expresses suicidal intent, within or outside of the family, then there should be urgent dialogue with Child and Adolescent Mental Health Services (CAMHS). There may be occasions when a referral should be made in the absence of consent and a failure to attend a consultation may be a safeguarding issue.
3. As well as being a diagnostic agency, CAMHS should develop resources to provide coordinated support for a suicide mitigation approach. CAMHS may be able support an agency that is working with a young person. A protocol should be devised for supporting young people after a serious suicide attempt.
4. There is a need to promote coping skills in young people who come from chaotic families especially if there are co-existent adult mental health problems, alcohol or substance misuse or self-harming. These families will be known to local services. Local agencies should sign up to this provision and agree on joined-up working.
5. Teachers and Learning Support Assistants should be familiar with the warning signs of emotional distress in young people and consider initiating a Common Assessment Framework (CAF) if appropriate. Any expression of suicidal ideation with peers must be reported.
6. The role of services such as outreach Samaritans in schools (Somerset model), and a "virtual" CAMHS provision, e.g. a Facebook page, to be evaluated
7. Promote the use of the information-gathering instrument employed in this study as a primary CDOP resource, to be used by the police who often take the agency lead in suspected suicide. Form B12 is not adequate.
8. Clear guidance to be issued to first responders/ambulance teams re resuscitation techniques (**Appendix D**)