National Children’s Commissioner examines intentional self-harm and suicidal behaviour in children

This submission on intentional self-harm and suicidal behaviour will focus on young people under 18 years from refugee and migrant backgrounds. The submission has been prepared by staff from the Phoenix Centre, a Tasmanian organisation which supports people from refugee and migrant backgrounds who are survivors of torture and trauma. The Phoenix Centre is a member agency of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) and is auspiced by the Migrant Resource Centre Southern Tasmania.

The Phoenix Centre has chosen to focus on the following because staff experience and expertise are greater in these areas:

- Why children and young people engage in intentional self-harm and suicidal behaviour
- The incidence and factors contributing to contagion and clustering involving children and young people
- The barriers which prevent children and young people from seeking help
- The types of programs and practices that effectively target and support children and young people who are engaging in the range of intentional self-harm and suicidal behaviours.

The Phoenix Centre provides counselling and advocacy to young people through the State-funded Department of Health and Human Services (DHHS) Early Intervention Project and the Department of Health’s Program of Assistance for Survivors of Torture and Trauma (PASTT). Suicide prevention in culturally and linguistically diverse communities is also a focus through the Community Connections Suicide Prevention Project.

In the period from July 2013 to June 2014, Phoenix centre counsellors assessed for suicidal ideation as a presenting issue in 127 clients, 18 years and under: suicidal ideation was absent in 102, mild in 15, moderate in 7 and severe in 3 clients. Data is not collected on self- harm.

Definition of terms:

Because the Human Rights Commission is investigating both intentional self-harm and suicidal behaviour, it is essential that stakeholders have a shared understanding of terminology. Self-harm and suicidal behaviour are phenomena with differing characteristics. Confusion arises when ‘self-harm’ and ‘suicide’ is used synonymously. The terms ‘non-suicidal self-injurious behaviour’ or ‘non-suicidal self-injury’ (NSSI) are used to clarify the distinction.

Why children engage in intentional self-harm and suicidal behaviour:

Counsellors observe that young people self harm (NSSI) to reduce overwhelming states of distress. Self harm is a maladaptive coping mechanism which may become habitual because it can have the effect of reducing distress. Young people may not be able to articulate why they self harm but when this is explored with the counsellor, they identify with what others have said. Cutting, head banging, scratching releases building tension; physical pain distracts from emotional pain; physical pain is preferable to numbing; inflicting pain is a form of self punishment; cuts or scratches are an external expression of inner turmoil.

Self harm is in young people's awareness. Their peers may talk about it or do it themselves; self harm is present on social media.

Engaging in self harm may be a source of shame. One young person felt ashamed when he self-harmed, expressing concern that his siblings would find out and tell his parents. His parents had fled from war with the family. The young person did not want to add to his parents' psychological burdens and knew 'that they would not understand'. He said that he self-harmed because he was lonely at school. Scratching himself with scissors occurred when he felt most distressed about his aloneness.

Most people from refugee backgrounds have experienced pre-migration trauma – war, persecution, rape, flight, separation, witnessing the death of family members. Long periods of time may be spent in refugee camps where the basic necessities are scarce, sexual and domestic violence is widespread and education disrupted and inadequate.

Many of our clients under 18 were born in refugee camps, never knowing their parents' country of origin. They grew up in camps, speaking the language of the host country. For example, young Afghani children who have grown up in camps in Iran speak Farsi rather than Dari, the language of their parents.

Clients report that they have witnessed suicide in the camps. Bhutanese refugees, the largest cohort in Tasmania, have spent long periods of time in camps in Nepal. Because suicide rates were so high in the camps and after third country resettlement, an investigation was launched by the International Organisation for Migration (IOM 2011). Among the findings is the observation that even though suicide is familiar to individuals, the issue of suicide is usually not verbalized and discussed in the family and among peers to a preventative end.

Clients have reported that they regularly experience racism at school and in the broader community. One young person talked about how sad she felt when college peers taunted her with anti-Muslim remarks, causing her to feel more isolated and triggering reminders of pre-migration persecution. Racism needs to be more actively addressed in the Tasmanian community by public education campaigns. State and local government, sporting, educational and community organisations and the media need to be firm in their condemnation of racism and celebrate the strengths and resources that diversity brings to Tasmania.

The incidence and factors contributing to contagion and clustering:

Communities are small and members are known to each other. Following the suicide of a young woman in 2012, other young women in the same community showed at risk behaviour. The young woman had posted a suicide note on a social media platform, which many saw after her death.

Although each community is small, members are connected by community and family ties to the mainland and to other countries in which family members have been resettled. For example, the Bhutanese Nepali community were aware of the high suicide rates for Bhutanese Nepali in the United States through their networks, which contributed to key individuals in the community here becoming involved with the Community Connections Suicide Prevention Project.

Social media is widely used by clients. It can encourage connection and also be the context for cyberbullying. Many parents from refugee backgrounds may not be literate in their own language, have limited English and computer skills. They would benefit from targeted programs which enable them to support their children in this space.

The Community Connections Suicide Prevention Project has delivered sessions in colleges which encourage young people to use social media as a means to identify at risk individuals (young people are made aware of what to look for) and as a means to educate and inform.

The Project makes young people aware of websites that they may find useful such as ReachOut and headspace, Kidshelpline, RUOK, Youth Beyond Blue and Bite Back.

The barriers which prevent children and young people from seeking help

In 2012, Foundation House, the University of Melbourne, the Royal Children's Hospital and the Centre for Multicultural Youth released a report, 'Barriers to and facilitators of utilisation of mental health services by young people of refugee background' (Colucci et al. 2012). Practitioners in mental health services or in contact with mental health services gave their views on 'what works' and 'what does not work'. The report recommends that services are accessible by public transport, confidentiality is assured, the referral process is easy and clear, the appointment system is non-rigid, drop-in and outreach services are provided, interpreters are used appropriately and that the young person's priorities are attended to, including practical needs. These findings are supported by our experience.

If young people access mainstream services (as opposed to specialist services working with people from culturally and linguistically diverse backgrounds), their needs may not be met. Many services do not use interpreters or provide translated materials. There is often the assumption that 'using an interpreter' means providing an onsite interpreter, whereas young people prefer telephone interpreters for confidentiality reasons. This is especially the case in Tasmania, where communities are small and groups connected. Service providers need support to learn how to access telephone interpreting in order to use organisations such as the Translating and Interpreting Service (TIS) and to work effectively with telephone interpreters. Some service providers may be reluctant to use interpreting services because of the cost.

Most counselling sessions occur by arrangement with schools, which means that the client is on site and able to attend sessions at school. Outreach, which may also include home visits, is essential to service delivery as young people prefer this to making their own way to a service. Meeting with students in the school environment also works well with very young clients.

Phoenix Centre counsellors are advocates as well. The advocacy role is an important one because responding to the client's priorities is essential to building rapport and trust. One counsellor describes responding to a newly arrived client's concerns about school notices he had received and which he could not understand. The telephone interpreter engaged for the counselling session was used regularly to translate the notices, discuss what was required and thus, ease the client's anxiety and enable participation. Schools need to take responsibility for providing translated forms or providing access to an interpreter. Staff members need to be trained to use a telephone interpreting service such as TIS so that access to information is assured for students.

A young person may not share their distress with their parents for a range of reasons: personal sharing between parent and child may not be culturally appropriate, family issues such as intergenerational conflict or unrealistic expectations may be contributing to the young person's distress, as well as a reluctance to add to the psychological distress and burdens of the family.

The young person may not be aware that school support staff or counsellors are available. The role of a counsellor is an unfamiliar one and there may be fears about confidentiality.

There is often stigma attached to mental illness; young people may fear being seen as 'crazy' if they see a counsellor or school social worker. Many young people's conception of mental health issues comes from exposure to severe untreated mental illness, experienced in the country of origin or in refugee camps.

In many communities, there is stigma associated with suicidal behaviour and suicide. There is a belief in the Bhutanese Nepali community, for example, that a family becomes tainted by suicide, which may affect a young person's opportunities for a good marriage.

Young people lack knowledge of services. They may not know where to go for help. Young people are more likely to disclose their distress to their peers who also may not know what to do.

A young person may approach a service provider for help but be discouraged by the way in which the service works. Language barriers may prevent reception from ascertaining the young person's needs, the forms may be too difficult to fill out; there may be no signs that the service is welcoming such as diverse staff members, multicultural posters, and brochures in a range of languages.

There is a tendency for service providers to 'hand over' young people from refugee and migrant backgrounds to specialist services which overloads these services and means that the mainstream services do not develop the cultural competency to support young people. All services should be inclusive and culturally sensitive. For example, a counsellor reports making a notification to Child and Family Services which CFS decided not to follow up because specialist services have the 'cultural knowledge' to best the support the client, when a CFS intervention may be more effective to keep the child safe.

Young asylum seekers –many of whom are unaccompanied minors released into the community from detention to live in group homes– carry with them an accumulation of risk factors: pre-migration trauma, flight, separation from family with little or no prospect of reunification, persecution in countries of refuge, dangerous voyages by boat, long periods of time spent in detention centres, continuing uncertainty about their visa status and fear of being sent back to danger. The broad-ranging requirements of the Code of Conduct, introduced by the Department of Immigration and Border Protection has given rise to further anxiety for young asylum seekers.

The Phoenix Centre has become aware that there is a belief among some of these young asylum seekers that attending counselling may prejudice their application for refugee status.

In addition to asylum seekers, another vulnerable group has come to the attention of the Phoenix Centre. These are most often humanitarian entrants aged from 16 to 18 years who have experienced disrupted education, with no English and a trauma background who enter the school system in age appropriate grades. For example, a 16 year old enters a high school at Grade 10. His challenges

include learning the language, coping with a new culture, supporting family members who have less access to learning systems than he does, living with the impacts of trauma on his well-being and his capacity to learn, as well as negotiating the tasks of adolescence. Unable to cope with the overwhelming challenges, he becomes irregular in his school attendance. The risk of disengagement and negative behaviours is high. This is a group which needs targeted assistance.

The types of programs and practices that effectively target and support children and young people who are engaging in the range of intentional self-harm and suicidal behaviours:

Phoenix Centre counsellors receive referrals from a range of sources and work closely with other services to support young people. Young people to the age of 25 may self-refer.

The EAL network in schools provides a focus and hands on support for young people. EAL staff members are attuned to their students' needs and most referrals for young people to the Phoenix Centre are from EAL teachers. Similar advocacy is practised by staff from TasTAFE and YMEP (Young Migrant English Program).

In collaboration with YMEP, the Community Connections Suicide Prevention Project has delivered programs to reduce stigma in the areas of mental illness and sexual and gender diversity. Evaluations indicate that young people were better informed about supporting their peers to find appropriate help and better informed about the issues facing LGBTI young people after the sessions.

The Project has worked in colleges to provide life skills programs covering topics such as coping skills, relationship issues and conflict resolution. In the near future, the BRITA Futures program, which promotes resilience and positive acculturation, will also be offered. BRITA (Building Resilience in Transcultural Australians) Futures, which addresses a gap in service, is being evaluated by the Queensland Transcultural Mental Health Centre and is showing some positive initial results (Mitchelson et al. 2010).

Community Connections Suicide Prevention Project has also delivered sessions to young people from refugee backgrounds based on the RUOK? approach to suicide prevention, which encourages peer support. Following the sessions, a counsellor was invited to attend a meeting which was called to support a student expressing suicidal ideation which she disclosed to her peers, who with the student's agreement, took their concern to staff. Her peers made it clear that they were prompted to act by the RUOK? message: 1. Ask RUOK? 2. Listen without judgement 3. Encourage action 4. Follow up, as well as remembering, it's ok to say, 'I'm not ok'.

The Project has encouraged a community-led approach to suicide prevention by employing Community Consultants from communities in the north and south of the state: Sudanese, Chinese, Bhutanese, Hazara, Congolese and Chin. The consultants work within their communities to explore understandings about suicide, warning signs, risk and protective factors, likely help-seeking and support behaviours, as well as recommendations to service providers on how best to support community members who are at risk of suicide. The community consultant then delivers suicide awareness training to the community tailored to the needs of the community and in a way which is culturally appropriate. Using this gatekeeper approach, communities build capacity around the issue of suicide and are more able to support their young people who are at risk.

Many young people who have been consulted are concerned about conflict with parents. Conflict may arise when the power balance shifts in the family as the young person acculturates and learns English more quickly than the parents. Often, the level of responsibility is experienced as a burden as the young person is expected to access services for the family, take family members to appointments, care for sick family members, look after siblings as well as do well at school.

Children and young people witness and are victims of family violence, which has often been part of their lives before coming to Australia. Counsellor/advocates support young people by making notifications to Child and Family Services, developing safety plans, providing psychoeducation about the impacts of family violence and referring to specialist services as appropriate. Children and young people often report a safer home environment after police intervention has occurred.

Children talk with relief in many contexts, about 'the rule of law' in Australia. Many arrive, having experienced physical punishment at home and at school. Some parents find it difficult to change their approaches to parenting. As one Congolese community member stated, government laws about how you raise your children are experienced as an 'imposition on our culture'.

Intergenerational conflict whether about religion, relationship issues, the use of drugs and alcohol, cultural expectations or marriage, points to the need to engage families when supporting young people. This can be challenging because the young person may be reluctant for family to be involved. With the young person's consent, community or religious leaders or trusted individuals may be useful to advocate or mediate.

A more holistic approach in the form of culturally appropriate parenting skills training would also be useful. Many parents are very concerned about their children but feel that they are unable to understand or help them because they live in 'different worlds'.

When counselling is provided, as indicated earlier, outreach and telephone interpreting are used. Psychosocial and suicide assessments are completed. When self harm and suicidal behaviour are present, counsellors develop a safety plan with the client and have found the following practices effective: first and foremost, the building of a therapeutic relationship with the client, emotional regulation, psychoeducation, coping skills, goal setting, mindfulness techniques, narrative therapy, play therapy and art therapy. If mental illness is apparent, the client is supported to see a General Practitioner; if the risk of suicide is immediate, the client is taken to the Department of Emergency Medicine or guidance is sought from the Mental Health Helpline.

Case study:

is a 12 year old Afghani boy who has been in Australia for three years. disclosed to his peers that he had been cutting himself and had taken a rope with the intention of hanging himself. His peers spoke to a trusted EAL (English as an Additional Language) teacher. The teacher spoke to the school social worker who spoke to said that he did not want to speak to anyone from the school. He agreed, however, to be visited at school by a counsellor from the Phoenix Centre, acceptable to him because of its association with the Migrant Resource Centre, with which he was familiar. also insisted that his parents and siblings not be informed about his situation or that he was receiving counselling. He did not wish to upset his parents who were already upset by his older brother's behaviour.

The counsellor conducted a suicide assessment which indicated that the client was not in immediate danger. The incident with the rope had occurred several months ago and there had been no similar incidents since then. The client described the context in which this incident occurred. The client said he had difficulty controlling his emotions; as he said, his emotions went 'whoosh'. He would break items nearby, hit out at others, flick light switches on and off, scream and shout. The suicidal behaviour occurred after such an episode of emotional dysregulation, following an argument with his siblings about access to a computer game. His mother intervened, seemingly in favour of his siblings. ran outside and into the garage where he saw a rope which he threw over a beam. He stood there with the rope around his neck. He thought about if he hanged himself how badly that would impact on his parents. He thought about a favourite teacher at school and how upset she would be if he killed himself. Feeling ashamed, hid the rope, went inside and did not speak about the incident until he disclosed it to two classmates.

spoke about the suicidal behaviour when two classmates saw scratches on his arms. He was feeling lonely and confirmed that he had been scratching himself and told them about the incident with the rope. explained to the counsellor that he did not scratch himself often but did so when he had no one to be with at school. He would feel alone and upset and would scratch himself with scissors. He felt ashamed about doing this. He said it did not hurt and he wasn't sure why he did it.

The counsellor and worked first on a safety plan: how to keep safe if he felt suicidal again. The counsellor provided psychoeducation around suicidal behaviour, e.g. that many people attempt suicide because they are looking for a solution to their pain rather than wishing to end their lives, about impulsivity which is an issue for young people because developmentally they may not be able to grasp the finality of death. The counsellor explored the many reasons why young people might self-harm, identifying it as a maladaptive coping mechanism and looking at other positive coping strategies to use when feeling overwhelmed.

The counsellor created an opportunity for to talk about the experiences he and his family had had before coming to Australia. chose not to disclose the details of his experience, only saying that it had been 'hard' and that there were aspects of his old life that he missed. He spoke about friends who were still in the refugee camp.

The counsellor and looked at the impacts of trauma on the developing brain in an age appropriate way, and how the brain could establish new pathways, so that he wouldn't go 'whoosh' so often. learnt to identify emotions, to recognise triggers, body signs for emotions, anger management techniques, and mindfulness techniques such as deep breathing or imagining a calming space which he could go to when feeling distressed.

priority was to make friends so that issue was explored, using a strengths based approach.

The counsellor worked with for six months, seeing the client during term on a weekly basis. During that time, reported no further self-harm or suicidal behaviour. He made friends, one of them 'Australian', and had been supported by staff to join one of the school soccer teams. The counsellor and worked on goal setting, providing a future orientation. made the goal that he wanted to become a sports teacher.

As part of the exit strategy, the counsellor encouraged to speak with the School Social worker who had referred him whenever he felt in need of support, or contact the counsellor again if in need for further assistance. The counsellor showed websites that he might find useful: Reach Out, RUOK, Kidshelpline, Youth Beyond Blue and Bite Back.

Other key elements of recovery included a supportive and inclusive school environment and his spiritual beliefs. He identified participation in the Moslem faith as a source of comfort and strength, feeling very proud when he received a certificate for fasting during Ramadan for the first time.

Recommendations

1. Service providers need to be culturally sensitive and inclusive in their delivery of services to young people from migrant and refugee backgrounds. They need to be aware of the pre-migration and resettlement challenges which young people experience so that they can be effective in their support. Providing outreach, employing bicultural workers, using interpreters and translated materials, involving families and working with community leaders are central to improving access to services for young people.

2. Service providers and community organisations need to consult with communities to find out the kinds of assistance that community members need to best support their young people. Community members may point to parenting courses, opportunities to celebrate culture, ways to join sporting clubs or information on sexual health.

3. Community-led solutions to suicide prevention show positive outcomes. Community Connections Suicide Prevention Project's engagement of community consultants has facilitated conversations about the issue of suicide, raised awareness of warning signs, risk and protective factors and how best to support community members at risk of suicide. Young adults contributed to consultations, attended training and took leadership roles.

4. Partnerships are an effective first step in supporting service providers to address the risk factors for suicide. The Phoenix Centre has worked in collaboration with Sexual Health Services, Gamblers Help and Working It Out in educational settings to provide information for young people in a way which is relevant and accessible.

5. Opportunities for young people to develop leadership skills and to exercise those skills need to be provided. Young leaders provide role models and mentors to their peers, especially when they are at different stages of the settlement journey.

6. Young asylum seekers are at risk, particularly because they have either self-harmed or engaged in suicidal behaviour while in detention. Current immigration policies create a climate of uncertainty, hopelessness and xenophobia increasing risk of harm for this vulnerable group. A more humane policy position is required so that Australia fulfils its responsibilities as signatory to the Refugee Convention and the United Nations Convention on the Rights of the Child.

7. Enhancing protective factors is an approach to suicide prevention which requires greater attention. Young people need to be supported to 'fit in' and if they choose, to celebrate their culture and religious practice in ways that they find life-enhancing.

8. The refugee journey is an expression of resilience. That resilience can be built on by offering young people further life and coping skills to promote social and emotional well-being, thus reducing the risk of suicide.

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