Youth Affairs Council of Western Australia

Submission to the National Children's Commissioner examination into intentional self-harm and suicidal behaviour in children

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INTRODUCTION

The Youth Affairs Council of Western Australia (YACWA) is the peak non-government youth organisation in Western Australia with a membership of over 300 youth service organisations, community organisations, academics, individuals and most importantly young people themselves. Established in 1980, YACWA has worked tirelessly for 30 years to deliver high-level representation and advocacy for the Western Australian youth sector and young people.

Our role is to:

- Act as a lobbying group for the non-government youth sector and Western Australian young people aged 12-25
- Provide information and support to the non-government youth sector
- Work to promote fair and positive outcomes for young people in our community
- Promote equity, equality, access and participation for young people in Western Australia
- Advocate to all levels of government on the best interests of Western Australia's young people
- Encourage the active participation of young people in identifying and dealing with issues that are important to them
- Improve youth services by exchanging ideas, information, skills and resources
- Provide a strong, united and informed voice capable of effectively advocating for the non-government youth sector and the young people with whom they work

YACWA is thankful for the opportunity to submit to this critically important examination. Self-harm and suicide are at epidemic levels in Australia, with mental health illness impacting greatly throughout our communities.

However, these are not at all new phenomena, with many inquiries and reports conducted both at a state, national and international level. Without immediate action, we will continue to see the lives of many young people in Australia lost as stigma, lack of services and a lack of funding prevent them from accessing help. The true impact of this examination will not be in the revealing of new information, but in the changes we see to the lives of young people at risk of self-harm and suicidal behaviour, through change to the way we support their needs.

EXECUTIVE SUMMARY

Our submission assesses the high prevalence of self-harm and suicidal behaviours affecting children and young people in Western Australia. Youth suicide and self-harm are arguably the most preventable public health problems facing our communities nationally, and require immediate attention and further funding support.

Scope of YACWA's Submission

Western Australia is geographically extremely diverse, with a large population of children and young people living away from metropolitan areas. This presents unique issues to young people in rural, regional and remote areas, where incidences of self-harm and suicide are at much greater levels than when compared to their prevalence in metropolitan areas.

With this knowledge in mind and to inform our approach, we have conducted consultations in Broome and online via Google Hangout, a live video conferencing program. These consultations involved discussing the terms of reference with young people, youth services and other youth organisations from across Western Australia.

However, more broadly we wanted to hear the unique experiences of young people in our communities relating to self-harm and suicidal behaviour. Whilst methods such as these are effective in hearing concerns and developing strategies to reduce these incidences, the situation of young people will only improve through direct action, which we urge the Commissioner to immediately advocate for.

YACWA has also recently released our *Lost your happy place? A guide for the Western Australian youth sector in responding to young people who are homeless and at risk of suicide* report. This project was developed by YACWA in response to the high rate of suicidal behaviours amongst homeless young people (aged 12-25 years) and qualitative data collected as part of a youth sector survey in 2012. The report includes the findings from a literature review and information gained through consultation with a number of Youth Service Providers located in the Perth Metropolitan region. Whilst the report specifically identifies the vulnerabilities experienced by homeless young people, there are many that similarly reflect the challenges all at-risk young people encounter with regards to self-harm and suicidal behaviour. For the Commissioner's convenience we have placed this report in our Appendix (see *Appendix A*).

Summary of Terms of Reference

Our submission examines all of the terms of reference outlined by this examination. Our summary of which is:

(1) The reasons why young people engage in self-harm and suicidal behaviour are complex. It is important that we recognise differences between the two behaviours, and implement programs that identify a young persons risk, aimed at intervention and prevention.
(2) Contagion and clustering are impacting our communities significantly. Children and young people are extremely susceptible, and we must ensure that we are responsible

in our reporting of suicide in the media and provide wide and continued support to children and young people affected by suicide.

(3) Children and young people experience significant barriers when help seeking for self-harm and suicidal behaviours. These are further compounded by vulnerabilities that exist due to connection with a particularly at-risk group. We must seek to remove these barriers through targeted approaches at young people, those who support them, and the wider community.

(4) Whilst the collection of comprehensive information is important, the scale of self-harm and suicidal behaviours requires immediate action through programs and practices.

(5) There are serious impediments that exist pertaining to the accurate identification and recording of self-harm and suicide in children and young people, resulting in a significant gap in knowledge. We must utilise current research and recommendations to immediately reduce these impediments.

(6) YACWA recommends that a national child and death database be created, along with a national reporting function. However, we also reiterate the need to urgently implement programs and practices that will immediately reduce self-harm and suicidal behaviour in children and young people.

(7) Currently, there is a vast amount of evidence that can guide the effective targeting and support of children and young people engaging in self-harm and suicidal behaviour. We must continue these and implement new-targeted methods that will further reduce incidences in specific groups that are significantly more at risk.

(8) The effectiveness of public education campaigns is often debated. However, if applied correctly through a thorough evidence base, success can be achieved. These campaigns must be implemented in conjunction with widespread training initiatives in self-harm and suicidal behaviours for young people, those who support them and the wider community.

(9) Digital technologies and media offer many pathways to engaging with children and young people engaging in self-harm and suicidal behaviours. Whilst we must be aware of increased access to potentially dangerous information, we have a great opportunity to connect with young people in the technological age and this needs to be expanded.

Failing international obligations

Children and young people in our country are not being protected sufficiently from self-harm and suicidal behaviours. Australia has signed and ratified numerous international human rights instruments that seek to ensure the protection of the lives of every human being.[1] This also extends to the highest possible standard of mental health care. Specifically relating to children and young people, the *Convention on the Rights of the Child* provides that every child must be ensured the highest attainable standard of health and access to facilities for the treatment of illness and rehabilitation of health.[2] Further, the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (MI Principles), provide more specific obligations that our government needs to be recognising and addressing.

[1] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: http://www.refworld.org/docid/3ae6b36c0.html [accessed 22 May 2014], Article 12.

[2] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at: http://www.refworld.org/docid/3ae6b38f0.html [accessed 22 May 2014] Article 24

The premise of these instruments require signatories to implement health services, goods and facilities that are available, accessible, acceptable and of good quality. In terms of at-risk groups and their specific vulnerabilities to self-harm and suicidal behaviour, there are further legislative protections referring to young people who are indigenous[3], from a refugee background, disabled and those who are gender variant or sexually diverse[4].

Governments at state and federal level must take positive action to secure the rights of young people and their access to health. Whilst these actions may require the application of significant and substantial resources, we cannot let the lives of young Australian's diminish through preventable health issues such as self-harm and suicidal behaviour.

[3] UN General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples : resolution / adopted by the General Assembly*, 2 October 2007, A/RES/61/295, available at: http://www.refworld.org/docid/471355a82.html [accessed 2 June 2014]

[4] International Commission of Jurists (ICJ), *Yogyakarta Principles - Principles on the application of international human rights law in relation to sexual orientation and gender identity*, March 2007, available at: http://www.refworld.org/docid/48244e602.html [accessed 22 May 2014]

Causes of self-harm and suicidal behaviour

Why children and young people engage in self-harm and suicidal behaviour

The reasons why children and young people engage in self-harm and suicidal behaviour are complex. These are unique to each individual and can be influenced by a number of differing physical, psychological and environmental conditions and associated risks. However, research, statistics and evidence clearly provide that young people are more vulnerable to engaging in these behaviours than the wider population. Suicide was the 15th leading cause of death in Australia, however it was the leading cause of death among young people aged 15-24.[5] The increasing occurrences of these behaviours are a major health concern at a state, national and international level.

Self-harm and suicidal behaviour are still poorly understood in Australia even among teachers, social workers, police, prison officers and even nurses and doctors. The factors that contribute to young people engaging in these behaviours are varied and complex. Further, they are not usually triggered by one isolated event, but rather as a set of circumstances that leave young people feeling overwhelmed and unable to manage their feelings.[6]

Also see *Appendix A, section 6.0*, which outlines the risk factors, protective factors and warning signs that expose young people to becoming more vulnerable to engaging in self-harm and suicidal behaviours. As provided in this section, risk factors should be interpreted with caution as they continually change and do not provide information about an individual or their definitive risk of suicide.[7]

The importance of distinguishing between the two

Self-harm arises in many different forms and often involves things other than physically harming oneself on the outside.[8] Research and evidence conclude that many young people who engage in self-harm do so mainly as a coping strategy, which allows them to continue to live rather than an attempt to end their life.[9] It is thus critical to distinguish that often the motivation is not the intention to die, but rather an instant relief for the pain they are experiencing internally. However, whilst the relief is temporary, the circumstances leading to these behaviours usually remain.

Suicidal behaviour is more closely linked to depression,[10] with other contributing factors including psychosis and alcohol and other drugs. We have seen increasing statistics regarding the numbers of young people experiencing depression, and with social stigma still impacting a young person's ability to access help these will continue rise. There is also a growing correlation between exposure to others killing themselves in this way similarly increasing the risk for young people[11]. This will be further analysed in *Term of Reference 2*.

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[5] Australian Bureau of Statistics, Suicides, Australia (2010) ABS Publication 3309.0.

[6] MHC: CF, 2006

[7] Rudd MD, Mallet S, Myers Pa, Rosenthal D, Living Well? *Homeless young people in Melbourne. Melbourne: The Australian Research Centre in Sex, Health and Society* (2003) La Trobe University.

[8] Inspire Foundation, *What is self-harm,* Fact Sheet <http://au.reachout.com/What-is-self-harm>.

[9] Nock MK, Jorm AF, et al. *Development of mental health first aid guidelines for deliberate non-suicidal self-injury: a Delphi study,* (BMC Psychiatry. 2008 Jul 23;8: 62).

[10] State Government of Victoria, Suicide and Mental Illness (2014) <http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Suicide_and_mental_illness>.

[11] (Hawthorn et al, 2012)

Where to from here?

The factors that contribute to why children and young people engage in these behaviours are clearly complex, unique to each person and constantly changing. First, it is clear that children and young people are at greater risk than the wider population. Second, there are factors that can compound this risk for children and young people. However, through research and evidence we are getting a clearer and more precise picture of how to address these. Whilst it is necessary to distinguish what constitutes self-harm and suicidal behaviour, and why young people engage in these behaviours, a stark similarity exists with the associated substantial disability and loss of years of healthy life. It is imperative that we continue current programs and practices that are effective in addressing these behaviours and reducing barriers to help seeking, and further continue to develop new methods relating to prevention and intervention.

Factors contributing to clustering and contagion

It is evident that children and young people who are exposed to suicidal behaviour are more likely to similarly exhibit these behaviours after this initial exposure. Suicide contagion refers to the process whereby one suicide or suicidal act within a school, community, or geographic area increases the likelihood that others will attempt or complete suicide.[12] The clustering of suicides is said to occur when multiple suicidal behaviours or suicides fall within an accelerated time frame, and sometimes within a defined geographical area. It is a concerning reality that children and young people are the most vulnerable to suicide contagion and clustering.[13]

Age

There appears to be a direct correlation between age and vulnerability to suicide contagion and clustering. It is widely understood that incidences of self-harm and suicidal behaviours can spread quickly and spontaneously through a group of children and young people.[14] Studies indicate that that the relative risk of suicide following exposure to another individual's suicide was 2 to 4 times higher among 15-19 year olds than among other age groups.[15] Recently, a Canadian study found that 12-13 year old children were at greatest risk and were five times more likely to have suicidal thoughts than teens that had been exposed to a death.[16] This indicates that the younger a child is, the less resilient they may be to suicidal behaviour.

Media and the Internet

It is also widely held that the media can impact a young person's perception of suicide and self-harm.[17] This has been consistently reflected in studies that have found a strong relationship between reports of suicide in newspapers or on television and subsequent increases in the suicide rate. Whilst it is important to not continue the stigmatisation of self-harm and suicide (which can occur if we avoid covering these issues altogether), we must avoid any glamourising or romanticising of suicide that can occur in the process of communicating about a suicide death.[18] This should also include removing methods of suicide or reports that remain in the media for long periods of time. Further, the emergence of digital media has enabled reports of suicide to become more accessible. We must be careful that when giving positive attention to a young person who has taken their life in the media, that we conversely do not encourage suicidal thoughts and behaviour in young people.

Other factors

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[12] National Youth Mental Health Foundation (Headspace), *Suicide Contagion* <http://www.headspace.org.au/media/9992/Suicide_Contagion.pdf>.

[13] Zenere, F., 'Suicide clusters and contagion' (2009) *Principal Leadership* 10(2), 12-16.

[14] Gould, M. S., *Suicide clusters and media exposure*. In S. J. Blumenthal & D. J. Kupfer (Eds.), Suicide over the life cycle: Risk factors, assessment, and treatment of suicidal patients (1990) (Washington, DC: American Psychiatric Press) 517-532.

[15] Gould, M. S., Wallenstein, S., Kleinman, M. H., O'Carroll, P., & Mercy, J. 'Suicide clusters: An examination of age-specific effects' (1990) 80 *American Journal of Public Health*, 211-212.

[16] Sonja A. Swanson, ScM, Ian Colman, PhD, 'Association between exposure to suicide and suicidality outcomes in youth' (2013) CMAJ July 9, 2013 vol. 185 no. 10.

[17] Hawton, K and Williams, K. 'Influences of the media on suicide: researchers, policy and media personnel need to collaborate on guidelines' (2002) *British Medical Journal* 325, 1374-1375.

[18] Feteke S, Schmidtke A, Takahashi Y, Etzersdorfer E, Upanne M, Osvath P, 'Mass media, cultural attitudes, and suicide. Results of an international comparative study' (2001) 22(4):170-2.

Headspace provide that following a suicide, those most at risk include young people who:[19]

- Have attempted suicide in the past;
- Were close friends or family members of the person who died;
- Witnessed the death;
- Are already dealing with stressful life events;
- Had contact with the person shortly before they died;
- Had argued or fought with the person before they died;
- Are preoccupied with thoughts of death and dying; and
- Have experienced other losses or suicides in the past.

Previously, support is often given to the immediate friends and family of young people who have ended their life. However, research suggests that the risk of suicide was magnified even if the child did not know the deceased personally.[20] Exposure to a suicide generally appears to be strongly associated with suicidal ideation and behaviour, and we must ensure that young people are adequately supported when impacted in this way.

How can we reduce the risk?

Reducing contagion and clustering in young people can occur in several ways. Of primary importance is ensuring that children and young people feel comfortable when seeking help for suicidal thoughts. For children and young people attending school, university and other educational pursuits, sustained crisis intervention programs and services are recommended. In our consultations, young people in Broome reflected on the severe lack of services and support in rural and remote areas in the aftermath of suicide, leading to continual contagion and clustering in their communities. It is also critically important to ensure that those who have direct contact with young people are effectively trained in suicide prevention training (see *Appendix A, section 10.0*). One of our members further provided that:

> "In regards to contagion, there needs to be post-vention programs developed to empower communities (schools, rural and remote, cultural, agencies, etc) to respond to incidences of suicide in an immediate and planned way"

Avoiding discussion of suicide with young people similarly does not deter the risk of contagion and clustering. Conversely, the media can play a powerful role in educating the public about suicide prevention, and any reports or stories they publish should inform its audience of the likely causes of suicide, its warning signs, trends in suicide rates, recent treatment advances, and highlight opportunities to prevent suicide.[21] There is a vast array of research providing guidance as to how we can effectively minimise contagion and clustering when reporting suicide in the media. Further, whilst it is responsibility of the media to communicate information on suicide in a way that has the lowest risk of fostering these behaviours, they can be guided on how they approach the issue by engaging with those working directly with young people and policy makers. For more information on appropriate ways of communicating and reporting in relation to suicide, we recommend visiting **http://mindframe-media.info**.

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[19] National Youth Mental Health Foundation (Headspace), *Suicide Contagion* <http://www.headspace.org.au/media/9992/Suicide_Contagion.pdf>.

[20] Sonja A. Swanson, ScM, Ian Colman, PhD, 'Association between exposure to suicide and suicidality outcomes in youth' (2013) CMAJ July 9, 2013 vol. 185 no. 10.

[21] Etzersdorfer, E., & Sonneck, G. 'Preventing suicide by influencing mass-media reporting. The Viennese experience 1980-1996' (1998) *Archives of Suicide Research* 4, 67-74.

Barriers preventing young people from seeking help

Young people are more likely to be poorly informed about mental health[22], despite help-seeking practices becoming a key governmental strategy tied to risk reducing imperatives of current Australian suicide prevention policy.[23] The establishment of helpline phone numbers, Internet information and support services and school based mental health promotion programs have all grown in number recently. However, statistically young people are more vulnerable than ever before to experiencing adverse mental health outcomes, and experience significant barriers relating to help seeking.

The barriers to help seeking are outlined extensively through a number of different sources. Some of the barriers are:

- Stigma and embarrassment;
- Problems recognising symptoms;
- Preference for self-reliance;
- Confidentiality and trust;
- Hopelessness;
- Lack of parental/adult support;
- Lack of knowledge regarding services and support; and
- Lack of support in schools.

Specifically within schools, YACWA and its members reiterate that whilst teachers are currently not equipped to deal with these issues, chaplains are associated with religion which itself has created stigma. It is thus vital that youth workers trained in suicide intervention are supported in these spaces as we believe they are best placed to support young people at-risk.

Compounding the above issues for many young people are a number of vulnerabilities that multiply the likelihood of experiencing mental health problems. Some of these unique barriers to help-seeking include being Aboriginal or Torres Strait Islander, living in rural or remote communities, identifying as LGBTI, being culturally or linguistically diverse, or those who are experiencing homelessness. The specific barriers impacting these particularly at-risk young people will be assessed in more depth later in our submission (see *Term of Reference 7*).

How can we address these barriers?

In addressing the existence of the more common barriers impacting upon a young persons ability to help seek, there is a vast amount of research and literature that indicates the following ways to be effective:

- Studies suggest using positive past experiences to increase mental health literacy and service knowledge;
- Creating strong support networks such as parents and friends who are open to professional support as a factor in good health and wellbeing. Studies have found that

[22] Jorm AF[1], Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P., (1997) 'Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment' 166(4) *Medical Journal Australia.*182-6.

[23] Commonwealth Department of Health and Aged Care, *Living Is For Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia. Areas for Action* (2000) Commonwealth Government, Canberra.

young people are more likely to recommend help for a friend, than to seek help themselves[24]; and

- Research concludes that ensuring young people have the ability and confidence to identify and articulate their emotions, and their ability to recognise and understand the symptoms of a mental health illness, promotes help seeking.[25]

Specifically regarding the significant number of young people who live away from metropolitan areas in Western Australia, one of the most significant barriers preventing help seeking is access to appropriate services. It is also important to acknowledge the vital role of schools, primary health care networks, youth-friendly services, family and friends and creating caring communities in supporting young people to seek help.

Further information pertaining to how we can enhance protective factors affecting young people at risk of self-harm and suicidal behaviour can be found in *Appendix A, section 6.0*.

[24] Rickwood, D., Deane, F.P., Wilson, C.J. & Ciarrochi, J., 'Young people's help-seeking for mental health problems' (2005).
[25] Ibid.

Conditions necessary to collect information

Currently, comprehensive information is not reported in a regular and timely way, reducing the ability of agencies such as the *Australian Bureau of Statistics ('ABS')* and the *Australian Institute of Health and Welfare ('AIHW')* to inform policy, programs and practice.

In terms of what conditions are necessary, legislative measures allowing cross-governmental agencies to share information should be reassessed. Further, standardising reporting across a national spectrum would enhance effectiveness and efficiency of information used to inform policy, programs and practice. Methods increasing public and professional access to information about all aspects of preventing suicidal behaviour should also be assessed and introduced.

Impediments have limited the role of the '*ABS'* and '*AIHW*' to report accurately on incidences of self-harm and suicidal behaviour, consequently we will assess these limitations in *Terms of References 5 and 6*.

Impediments to accurately identifying and recording self-harm and suicide

Accurately identifying and recording incidents of self-harm and suicidal behaviour have been reoccurring problems both in Australia and abroad. These difficulties have been described as paramount concerns of health researchers and survey research methodologists,[26] and were identified in our *Lost Your Happy Place? Report* (see *Appendix A, section 4.0*) as contributing significantly to underestimating the issues at hand. *The Australian Institute of Health and Welfare* provides that examining patterns and trends in deaths can help explain differences and changes in the health of a population, contribute to the evaluation of health strategies and interventions, and guide planning and policy-making.[27] However, the majority of people who engage in self-harm conceal their injuries and may never come into contact with medical or other services, and as a result no information is recorded. Previous surveys indicate that only 10% of adolescents who self-harm were admitted to hospital.[28]

The difficulties in identifying and recording incidences of suicide in children and young people are compounded by discrepancies and delays in data collection. The *Australian Institute of Health and Welfare* also acknowledges that their records potentially underestimate the number of suicides in young people due to the delay between the coroner certifying the death as a suicide and coding the final cause of death.[29] As a result, these may instead be recorded in the database as undetermined intent.[30] The *Australian Bureau of Statistics* has also highlighted that the length of time in filing coronial reports usually results in data not being recorded in annual reports.[31] Further, state recognition of the ability to form the intent to commit suicide differs and differences in admission and treatment practices exist, similarly impeding the accuracy of identifying and recording suicide. Other difficulties arise in identifying deaths from suicide, such as those involving single vehicle transport accidents, drowning's, drug overdoses and other methods of suicide which are difficult to classify.[32] Accordingly care must be taken when making use of data.

A Senate Inquiry initiated by the *Federal Australian Government* in 2008 raised concerns about the accuracy of suicide reporting in Australia and outlined the factors that may impede accurate identification and recording of possible suicides noting the consequences of any under-reporting on understanding risk factors and providing services to those at risk.[33] Recommendations released in *June 2010* (Titled the *'The Hidden Toll'*) included standardising coronial legislation and practices among providing extra training to staff in coronial offices, changes to the reporting of young people aged under 15 years, and more regular reporting.

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[26] Taylor et al., 'Methodological issues associated with collecting sensitive information over the telephone-experience from an Australian non-suicidal self-injury (NSSI) prevalence study' (2011) *BMC Medical Research Methodology* 11:20.

[27] Australian Institute of Health and Welfare (Cth), Risk factors, diseases & death. (2013) <http://www.aihw.gov.au/deaths/>.

[28] Diego De Leo and Travis Heller, 'Who are the kids who self-harm? An Australian self-report school survey' (2004) MJA 181: 140-144.
<http://ec.europa.eu/justice_home/daphnetoolkit/files/projects/1997_174/int_self_harm_survey_australia.pdf >

[29] Australian Institute of Health and Welfare (Cth), *Young Australians: Their Health and Wellbeing* (2011) <http://www.aihw.gov.au/publication-detail/?id=10737419261>.

[30] Australian Bureau of Statistics, Suicides, Australia (2010) ABS Publication 3309.0

[31] Community Affairs References Committee (Cth), *The Hidden Toll: Suicide in Australia* (2010) <http://www.suicideprevention.ca/wp-content/uploads/2010/05/Australian-Senate-report-on-suicide-2010.pdf>.

[32] Australian Institute of Health and Welfare (Cth), *Young Australians: Their Health and Wellbeing* (2011) <http://www.aihw.gov.au/publication-detail/?id=10737419261>.

[33] Commonwealth of Australia (Cth), *Commonwealth response to The Hidden Toll: Suicide in Australia Report of the Senate Community Affairs Reference Committee* (2010), 2.

However, nearly four years on and we are yet to see any significant progress on its recommendations.

In response to this lack of action, the *Commission for Children and Young People and Child Guardian* (QLD) noted in their *Trends and Issues paper: Child Deaths,* that the absence of national reporting on the number of children and young people under the age of 15 who suicide has resulted in under-appreciating the real extent of the issue.[34] The reasons for this absence are said to be due to the sensitive nature of suicide, however this impediment to accurate identification is impacting effective intervention and prevention from taking place. This in turn will impact upon our ability to allocate appropriate resources in developing policies and programs.

In terms of where reform can be made, there are already Commonwealth reports outlining necessary alterations in current data collection and methodology, and a vast amount of supporting literature providing further guidance. However little has been implemented. In our response we have mentioned several ways this can be improved, however YACWA urges the Commissioner to ensure that recommendations from previous inquiries to these matters are advocated for within her role and positive change occurs.

[34] Commission for Children and Young people and Child Guardian (Qld), *Trends and Issues paper: Child deaths – under-reporting of youth suicide* (2013) 13.

Do we need a national child death and injury database, and a national reporting function?

YACWA recommends that a national child death and injury database be created, and that a regular and consistent national reporting mechanism is introduced. Cause-specific death statistics provide insights into the events that contribute to deaths and to the burden of disease, providing evidence of patterns and trends if used correctly. These in turn can contribute to the evaluation of health strategies and interventions, whilst guiding planning and policy-making.[35] However, we stress that the current support and continued implementation of effective programs and practices must remain a priority ahead of the need to collect more statistical data.

Currently, the ABS compiles and reports on all deaths in Australia through information provided to them via state and territory registrars. The *Commission for Children and Young People and Child Guardian* in Queensland recently reported on the ongoing disparity between state and Commonwealth datasets resulting in the under-reporting of youth suicide in Australia.[36] The existence of this under-reporting can greatly impact the ability of services to identify patterns nationally, possibly hindering early intervention and preventative action from taking place within a reasonable time. With multiple agencies across Australia apparently capable of providing comparable levels of child death data[37], there appears little to hindering its creation other than bureaucratic delays.

Several other countries have created national recording databases to provide additional information to assist in understanding and preventing child deaths. However, it is important to note that many of these countries still have high youth suicide rates. Indicating that whilst national databases and reporting may assist in responding to the issue, prevention and intervention will only occur through action.

YACWA believes that there are benefits in establishing a national child death and injury database, and in creating a national reporting function. Youth suicide is a key cause of preventable death throughout our states and territories. This examination highlights a significant issue that requires accurate and comprehensive reporting, which is currently not being undertaken. This clearly affects the design of policy, programs and action in preventing, responding to and supporting young people at risk of self-harm and suicidal behaviour. However, we also reiterate the importance of immediately implementing programs and services that utilise current knowledge to reduce the incidence of self-harm and suicide amongst our young people.

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[35] Australian Institute of Health and Welfare (Cth), *Risk factors, diseases & death* (2013) <http://www.aihw.gov.au/deaths/>.

[36] Commission for Children and Young people and Child Guardian (Qld), *Trends and Issues paper: Child deaths – under-reporting of youth suicide* (2013) 13 <http://www.ccypcg.qld.gov.au/pdf/publications/papers/trends-and-issues/Issues-Paper-no-13-under-reporting-of-youth-suicide.pdf>.

[37] Commission for Children and Youth People and Child Guardian (Qld), *Annual Report: Deaths of children and young people Queensland 2010-11* (2011) < https://www.ccypcg.qld.gov.au/pdf/publications/reports/annual_report_dcyp_2010-2011/11-773_AR_Deaths-of_CandYP_2010-11_WEB.pdf>.

Effective programs and practices for engaging with young people

Self-harm and suicidal behaviour in children and young people are extremely complicated issues that require targeted intervention and prevention programs and practices. These must take into account the highly distinct and individual risk and protective combinations to which children and young people are exposed to. Young people need long-term specific support and consistency in the implementation of these to provide them with hope and recovery for the future. It is evident that they are more susceptible to these behaviours than the wider population, with this vulnerability exponentially compounded if they identify as Aboriginal and Torres Strait Islanders, live in regional or remote communities, identify as having diverse sexuality, sex and gender, from a diverse, culturally and linguistically diverse background, are living with disabilities, experiencing or have experienced homelessness, or are refugees.

In our *Lost your happy place? Report* (see *Appendix A, section 9.0*), we identified the importance of taking a recovery-orientated approach to mental health. This presents a shift away from the view of treating illness, towards promoting individual strengths and well-being.[38] Although this approach is widely endorsed in literature, many mental health services are yet to genuinely adopt a recovery orientated approach.[39] Also, it is vital that people who work with individuals at risk of suicide have appropriate training to be able to respond effectively in a crisis to ensure the best possible outcome for the suicidal person.[40] For further information regarding effective training practices and programs, see *Appendix A, section 10.0*.

In Western Australia, our main programs or education campaigns include the National Suicide Prevention Strategy (whole community), the Mind Matters Initiative (high school students), the Peer Support Program (high school students) and Reach Out Pro (health professionals and youth workers). However, we are lacking significant support in implementing specific programs that effectively target at-risk groups.

In responding to the unique vulnerabilities of children and young people from the aforementioned groups, the following practices have been found to be effective in targeting and supporting them.

Young people who are Aboriginal and Torres Strait Islander

Statistics indicate that young people who identify as Aboriginal are significantly more at risk of self-harm and suicidal behaviour, with young Aboriginal men three times more likely to commit suicide than non-Aboriginal men.[41] The recently published '*Elders' Report into Preventing Indigenous Self-harm & Youth Suicide*' provided substantial guidance as to what practices are effective in reducing self-harm and youth suicide among young Indigenous people. The report highlighted the role that culture can play in healing and protecting young people, and for this to be facilitated by those within the community. There currently appears to be a severe lack of community consultation in implementing successful programs and practices, and similarly ensuring funding of successful programs beyond this financial year.

[38] Shepherd G, Boardman J, Slade M,. 'Making recovery a reality' (2008) Sainsbury Centre for Mental Health, London.
[39] Mental Health Council of Australia, 'Perspectives: Mental health & wellbeing in Australia' (2013) Deakin West MHCA.
[40] Youth Affairs Council of WA, Youth Work Code of Ethics (2003).
[41] Department of Health and Ageing*, Mental health* (2013) <http://www.health.gov.au>.

Similarly, the importance of providing peer support and recovery is also vital, and was evidenced often in our consultations. In our *Lost your happy place? Report* (see *Appendix A, section 9*), we provide insight into the benefits of programs and practices that facilitate support through this way. A fundamental aspect of the recovery process is establishing connections with others and many individuals describe the important role that connecting with others played in their personal recovery. This element applies to all young people engaging in self-harm and suicidal behaviour, and internationally there is a movement to promote recovery in mental health services through utilising peer support workers in service delivery. [42]

In our consultations, young people in Broome provided that not having a safe space, a lack of support in the Kimberly region, and greater shame within the community where further significant barriers other than those identified above, in help seeking. In particular, young people told of the added pressure placed on them by family and community expectations. We also heard that confidentiality and trust were often complicated when family or friends were staff at local health services.

> *"You've got your aunty, your uncle, your nana…they are Aboriginal Health workers. You've got your whole family on the board, you know, are you going to go to a private health provider who charges you know god knows what?" age 18* (In relation to the difficulties in visiting community health services)

The existence of limitations in accessing specific services often meant that young people where taken away from their families and to Perth. Young people involved in our consultation process also expressed the need for services to be flexibly open to respond to their issues effectively.

> *"Kids are committing suicide at 2am in the morning, where are services or safe spaces for them?" , Young person (Broome, WA).*

Young people who identify as Aboriginal and Torres Strait Islander are more vulnerable to engaging in self-harm and suicidal behaviours. Catastrophic rates exist in some Kimberley Aboriginal communities such as those in Balgo, Fitzroy Crossing, Mowanjum and Derby, where suicides occur at rates of up to 20 times the state average.[43] For the purpose of the submission, we will provide two case examples of successful programs being implemented in Western Australia.

Case Study: Alive and Kicking Goals Program (Kimberley Region, WA)

Through our consultations, we spoke with services that operate in and around Broome (Kimberly Region, WA). Specifically, the *Alive and Kicking Goals* program has been vital in supporting young people in remote communities. This program aims to reduce the high suicide rate through peer education workshops, one-on-one mentoring, and counseling. The project is initiated, managed and led by Aboriginal people in the Kimberly. The success of the program provides many positive examples of how programs can be effective. These include the value of one-on-one client work and training existing members of the community with the skills to implement the program

[42] Bradstreet S. 'Harnessing the 'Lived Experience': Formalising Peer Support Approaches to Promote Recovery' (2006) 11(2) *The Mental Health Review* 33-7.
[43] Office of the Auditor General (WA), *The Implementation and Initial Outcomes of the Suicide Prevention Strategy* (2014) Report 7: May 2014, 5. <https://audit.wa.gov.au/wp-content/uploads/2014/05/report2014_08-Suicide.pdf>.

and ensuring services are culturally appropriate. These have fostered proper connections within the community, have built trust, and provide confidentiality. They have also provided leadership pathways to young people in their community, which is not easily accessible in regional and remote areas. However, funding for the program has not been guaranteed past June 2014. It is vital that this program, and others like it are immediately extended to ensure sustainability, consistency and most importantly significant reductions in rates of young people at-risk self-harming and suicide.

Case Study: Yiriman Project (south central and west Kimberley Region, WA)

The Yiriman Project is a suicide prevention initiative that works with Aboriginal community and families in the south central and west Kimberley region in Western Australia for a 'whole of community' approach to support positive social change. Attention is focused on young Aboriginal people (aged 12-30 years) within an immersion style cultural framework as they learn strategies to address problems such as substance abuse, self-harm and contact with the justice system. It aims to generate intergenerational relationships, strong cultural leadership and governance processes. The Yiriman Project is auspiced and strongly supported by one of our members the Kimberley Aboriginal Law and Culture Centre (KALACC), one of three peak Indigenous organisations in the Kimberley. It has recently won an IGA Reconciliation Australia Award in 2012 for the program's successes.

The many successes of these programs are premised upon a whole community approach that value traditional Aboriginal culture, and more importantly are led by elders and peers within communities. They are best placed to understand the real situation of Aboriginal Youth Suicide, and we have heard conclusively that children and young people, youth services and organisations, all believe that programs like those above are best placed to make a positive impact on the devastating phenomena impacting our indigenous communities.

Young people in rural, regional WA

Young people in regional, rural and remote areas are twice as likely to commit suicide as young people in metropolitan areas. The reduction of access to essential services is also worsening due to the gradual depopulation of rural and remote communities, acting as a severe barrier to young people who are seeking support. The barriers that exist to implementing programs and practices that reduce self-harm and suicidal behaviour include limited access to mental health care programs and practices, stigma, and lack of media reporting on the issue. Personal vulnerability must also be targeted, such as loneliness, alienation, unrecognised or untreated depression and alcohol and other drug misuse.

It is integral that a whole community approach is adopted in programs and practices initiated in rural and remote areas, effectively strengthening community networks. These should include programs that promote positive community attitudes towards help seeking and health. The *Young and Well Towns* project (by Young and Well CRC) is currently assessing effective models of e-mental health services that can reach and improve outcomes for young people in rural areas. YACWA believes that services must be continued and expanded to young people in rural and regional Australia. Australia is a signatory to several international treaties outlining our obligation in providing equal and consistent services to children and young people, despite geographical location.

Young people who identify as Lesbian, Gay, Bisexual, Transgender or Inter-sex (LGBTI)

Young people who identify as LGBTI are significantly more at-risk of engaging in self-harm and suicidal behaviour than those who do not. The issues regarding this vulnerable group of young people are complex and compounded by experiences of stigma and discrimination. 20 per cent of transgender (Couch et al., 2007) and 15.7 per cent of gay, lesbian and bisexual (Pitts et al., 2006) people living in Australia are said to be currently reporting feelings of suicidal ideation.

Successful practices include the *Open Doors Service Providers* website, which aims to provide service providers with awareness and access to LGBTI resources and information with a single point of entry to an information space. When creating programs, research shows that creating safe spaces where they can access information, support and form friendships are vital. Currently, there is a scarcity of support services that identifies and responds to their individual needs.[44] Encouraging social inclusion is also of value, as families and friends may not be supportive. Current barriers exist relating to marginalisation and discrimination by young people who identify as LGBTI.[45] *Suicide Prevention Australia* recommends increasing the availability of health and community support services through activities, such as cultural awareness and competency skills training and development.[46] This requires integrating a range of health promotion suicide prevention and crisis intervention efforts to reduce exposure to risk and promote factors known to protect and strengthen mental health. YACWA recommends that current evidence bases can be used to develop more specific initiatives and interventions.

Young people from culturally and linguistically diverse backgrounds (CaLD)

Young people from non-English speaking or CaLD backgrounds are close to six times more likely to experience homelessness than the general Australian population.[47] Specific barriers include accessing services that are language and culturally appropriate. Further, many young people may be escaping war, conflict or famine, and may be doing so with some of their family members or by themselves.[48] These can clearly be evidenced to create stress and accompanying emotional and behavioural problems such as depression and anxiety, feelings of marginalisation and alienation, heightened psychosomatic symptoms, low self-esteem and identity confusion.[49] *Mental Health in Multicultural Australia* recommends that programs and practices for CALD people should primarily aim to reduce stigma and increase mental health literacy. To do this, they recommend providing culturally appropriate early intervention and

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[44] Open Doors Youth Service Inc, *Lesbian, Gay, Bisexual and Transgender Youth Suicide Prevention Project*, August 2008 to August 2009 Evaluation Report (2009) <http://www.opendoors.net.au/wp-content/uploads/2009/11/Open-Doors-Suicide-Prevention-Project-Final-Report.pdf>.

[45]Joint Submission from Lifeline Australia, Suicide Prevention Australia, The Inspire Foundation, Ozhelp Foundation, The Salvation Army, The Mental Health Council of Australia and the Brain and Mind Research Institute, University of Sydney, Submission to the Senate Community Affairs Committee Inquiry into Suicide in Australia (2009) <http://suicidepreventionaust.org/wp-content/uploads/2012/05/Submission-to-the-Senate-Community-Affairs-Committee-FINAL-221109-all-logos.pdf>.

[46] Suicide Prevention Australia, Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities (2009) Position Statement <http://suicidepreventionaust.org/wp-content/uploads/2012/01/SPA-GayLesbian-PositionStatement.pdf>.

[47] Department of Health (WA), Western Australian suicide prevention strategy 2009-2013 (2009), Government of Western Australia.

[48] Mason, D., *The experiences of Homelessness for CALD young people in Melbourne's West Footscray Housing Group* (2008) 21 Parity 4.

[49] Selvamanickam, Sumathy et al., *Coping in a new world : the social and emotional wellbeing of young people from culturally and linguistically diverse backgrounds* (2001) Transcultural Mental Health Centre. < http://www.health.qld.gov.au/metrosouthmentalhealth/qtmhc/docs/new_world_1.pdf>

responsive mental health care.[50] There is also evidence pertaining to the low voluntary use of mental health services by young people who are from CaLD backgrounds. This is said to be due to a lack of information about services, as well as associated cultural and community stigma. Further, parents or carers may be unaware of youth services or view them with suspicion. Practices and programs need to be developed that identify these barriers to successfully engage with young people of CaLD backgrounds who are at-risk of self-harm and suicidal behaviour.

Young people living with a disability

Young people living with a disability are at greater risk of developing many of the mental health concerns that affect the general population.[51] Anxiety and depression are under recognised by health professionals and service providers. We need to ensure that young people living with a disability who are at risk of self-harm and suicidal behaviour have positive coping mechanisms, that reduce or relieve underlying stress and improve communication skills.[52] These can be enhanced through trust, targeted treatment and support from family members and friends.[53]

Young people who are refugees

Research has indicated that "detention is a powerful direct contributor to the severity of psychological distress in asylum seekers", and that detained asylum seekers "exhibit a significantly higher level of depression, posttraumatic stress, anxiety, panic and physical symptoms", compared to those residing in the community."[54] Targeted successful strategies regarding language and communication have been identified as barriers to effective programs and practices.

Young people experiencing homelessness

Young people experiencing homelessness are at far greater risk of self-harm and suicidal behaviour. In our *Lost Your Happy Place? Report*, we outlined the unique challenges faced by homeless young people complicated significantly by their vulnerability to poor mental health. They are a particularly difficult group to engage with, due to a myriad of compounding factors including unpredictable living arrangements and the absence of trust in both people and services.[55] To be able to successfully engage with this group it is important that services employ approaches that encourage and support positive and lasting relationships amongst other initiatives.[56] For further information on how to effectively meet the service needs of young

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[50]Mental Health in Multicultural Australia (MHMA), *Workers Implementation Guide - Promotion, prevention & early intervention*
<http://www.mhima.org.au/Default.aspx?PageID=10436545&A=SearchResult&SearchID=34031102&ObjectID=10436545&ObjectType=1#tab3>.

[51] Curran, P. J., Atkinson, P. M., Foody, G. M., et al. Linking Remote sensing, land cover and disease (2000) Advances in Parasitology 47, 27-80.

[52] Fortune S, Sinclair J, Hawton K., 'Adolescents' views on preventing self-harm. A large community study' (2008) *Soc Psychiatry Psychiatr Epidemiol* 43:96-104.

[53] Skegg K. Self-harm. Lancet. 2005;366:1471-1483.

[54] Hutchinson, Terry & Martin, Fiona 'Australia's human rights obligations relating to the mental health of refugee children in detention' (2004) *International Journal of Law and Psychiatry*, *27*(6), pp. 529-547.

[55] Barker J, Humphries P, McArthur M, Thomson L. *Literature Review: effective interventions for working with young people who are homeless or at risk of homelessness* (2012) Canberra (ACT): Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

[56] Ibid.

homeless people, see *Appendix A, section 11.0*. For information outlining how best to respond to a young homeless person at risk of suicide see *Appendix A, section 13.0.*

Are public education campaigns effective and feasible in reducing self-harm and suicidal behaviour?

Historically, public education campaigns aimed at reducing the number of children who engage in self-harm and suicidal behaviour can be best described as being 'hit or miss'. As identified in our *Lost your happy place? Report (*see *Appendix A, section 7.0*), general awareness-raising campaigns have typically shown only moderate effectiveness in improving attitudes towards self-harm and suicide. This effectiveness is further reduced when assessing their impact in reducing suicidal behaviours.[57] However, YACWA believes that these still play a role in creating awareness and education of these behaviours, and in reducing stigma and other barriers preventing effective help seeking and support.

The feasibility of conducting public education campaigns

With the rapid and ever-increasing development of digital technologies and media, conducting public education campaigns are extremely feasible. The stark reality facing many government organisations, NGO's and not-for-profits are that they are operating on little to no budget. Whilst this is clearly unfavourable and should urgently be addressed, public education campaigns don't always require a lot of money to succeed. With digital technologies and social media sites such as Facebook and Twitter, print media is not the only means of impacting positive change.

The effectiveness of public education campaigns

Generally, public education campaigns attempt to change behaviours and provide awareness and/or education regarding self harm and suicidal behaviour. It is imperative that to effectively remove many of the barriers relating to help seeking, we create greater awareness of these issues and alternatives for support. The importance of which is underlined in the *Commonwealth Department of Health and Ageing's National Suicide Prevention Strategy (LIFE – Living is for everyone)*. This strategy identifies that a shared understanding of the problem is essential to developing effective suicide prevention activities.

Several sources provide guidance as to how to effectively implement public education campaigns regarding self-harm and suicide. The *World Health Organisation (WHO)* recommends targeting education campaigns to the general public to improve awareness of suicidal crises and, more broadly, to improve awareness of depression,[58] previously identified as being a major risk factor for self-harm and suicidal behaviour.[59] Research concludes that the lack of available public information and stigmatisation of self-harm and suicide are major barriers to care,[60] as identified previously in our submission (see *Term of Reference 3*). Also, high visibility campaigns in relation to other issues such as smoking appear to have had positive impacts, and similar resource intensive sustainable approaches should be encouraged.

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[57] Fountoulakis KN, Gonda X, Rihmer Z., Suicide Prevention programs through community intervention (2001) 130 (1-2) *Journal of Affective Disorders* 10-6.
[58] WHO Health Report Mental Health, *New Understanding, New Hope* (2001) Geneva, World Health Organization.
[59] Nock MK, Borges G, Bromet EJ, et al, 'Cross-national prevalence and risk factors for suicidal ideation, plans and attempts' (2008) *British Journal of Psychiatry* 192:98–105, 2008
[60] Corrigan P, Kerr A, Knudsen L, 'The stigma of mental illness: explanatory models and methods for change' (2005) *Applied and Preventive Psychology* 11:179–190.

However, the true impact of public education campaigns has been extremely difficult to define. International studies assessing the impact of public education campaigns in the sphere of self-harm and suicidal behaviour indicate that the effects have tended to be modest at best. This appears to be compounded by education strategies aimed at children and young people that are often not evidence based, do not reflect the current state of knowledge in suicide prevention, or properly evaluate effectiveness and safety for preventing these behaviours.[61]

Similarly, the use of media campaigns are frequently undertaken despite limited evidence pertaining to their effectiveness. Contradicting the *World Health Organisations* guidelines[62], evidence suggests that campaigns targeting populations generally have not shown any detectable reduction of suicide rates or increasing treatment seeking or drug prescribing in suicide rates or any increase in accessing help-seeking services.[63] In instances where decreases have occurred, attitudes remain relatively unchanged.[64] Despite this we believe that the media can play a critical role in public education campaigns, by providing vital information relating to prevention and intervention, and ensuring that any depiction or reporting by them of a suicide or suicidal behaviour is undertaken sensitively and appropriately.

The future of public education campaigns

There is hope for the future of public education campaigns in the space of self-harm and suicidal behaviour. The *United States Air force* implemented a prevention program that sought to educate the Air Force community about prevention services, targeting high-risk service men and women, promoting early identification, referring people for help at the first signs of emotional troubles, counteracting the perception that getting help is bad, and eliminating barriers and discrimination associated with needing care. 90% of the Air Force personnel had received suicide prevention training and education shortly after the campaigns implementation, resulting in suicides falling by more than 37%.[65] This case example also strengthens the need for specific education awareness for young people and those working with them regarding self-harm and suicidal behaviours.

Recent evidence provides that broadly targeted public education campaigns do little to impact positive change regarding attitude and behaviour to self-harm and suicidal behaviour. However, in further strengthening these campaigns targeting the language used by the media, and creating awareness of the issue for those working in health, social and education services should be prioritized.[66] Whilst there is a need to focus on developing and community connectedness, and to constantly challenge and identify ways to remove cultural values and beliefs that unfairly expose certain groups to self-harm and suicidal behaviours, targeted

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[61] J. John Mann; Alan Apter; Jose Bertolote, et al., 'Suicide Prevention Strategies: A Systematic Review' (2005) <http://healthymarathoncounty.org/staging/wp-content/uploads/Suicide-Prevention-Strategies-a-systematic-review.pdf>.

[62] WHO Health Report Mental Health, *New Understanding, New Hope* (2001) Geneva, World Health Organization.

[63] J. John Mann; Alan Apter; Jose Bertolote, et al., 'Suicide Prevention Strategies: A Systematic Review' (2005) <http://healthymarathoncounty.org/staging/wp-content/uploads/Suicide-Prevention-Strategies-a-systematic-review.pdf>.

[64] Lehfeld et al., 'Suicide attempts: results and experiences from the German Competency Network on Depression' (2004) *Adv Psychosom Med* 26:137-43.

[65] Knesper, D. J., *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit* (2010) American Association of Suicidology, & Suicide Prevention Resource Center MA: Education Development Center, Inc.

[66] Health Service Executive (IRE) *Irish National Strategy for Action on Suicide Prevention 2005-2014*, Reach Out (2005) <http://www.nosp.ie/reach_out.pdf>.

suicide intervention training such as gatekeeper and Applied Suicide Intervention Skills training (ASIST) (see *Appendix A, section 10*) have demonstrated more contextual positive outcomes.[67]

[67] Isaac M, Elias B, Katz LY, Belik S-L, Deane FP, Enns MW, et al. Gatekeeper training as a preventative intervention for suicide: a systematic review (2009) La Revue Canadienne de Psychiatre 54(4): 260-8.

Utilising digital technology and media to improve mental health outcomes

There is little doubt that children and young people are spending more time consuming media and using digital technologies than ever before. This has impacted significantly on how they socialise, pursue education and entertain themselves. However, whilst the digital world provides new pathways to engage, share ideas, form communities, and become friends. We must also ensure that growing concerns around cyber-bullying are effectively addressed, and for these technologies not to become easy methods for harassing and harming others. The opportunity to effectively harness these technologies is great, and is still underutilised by government agencies and service providers.

Role of digital technologies and media

The role of digital technologies and media in preventing and responding to self-harm and suicidal behaviour must be expanded upon current methods. Services such as *ReachOut.com.au* have effectively grasped this opportunity, and should be used as a model for other services in effectively addressing these complex issues. Traditional methods such as public education campaigns have largely been ineffective in addressing mental health outcomes in children and young people. However, pathways in digital technologies appear to be offering more effective solutions, via the offering of specific information and support to those in need.

Management of digital technologies and media

There is a wealth of research pertaining to the increasing phenomenon of cyber-bullying amongst children and young people, and the extremely damaging impact that it can have on a young person's health. *Young and Well CRC* provides that 91% of young people aged 14-17 spend time online weekly. Further, sites available for access by young people that actively encourage self-harm contain instructions of successful techniques,[68] and present the opportunity to network with people who also may encourage self-harm and suicide[69] are worryingly prevalent on the Internet. Research has also revealed strong correlations existing between youth who reported self-harm and high Internet use, use of chat rooms, having close online relationships, engaging in sexual behaviour online, and a willingness to send personal information about themselves online.

In our consultations, young people spoke of their growing concerns around cyber-bullying and the damaging effects resulting from being a victim to this behaviour. The impact of which is often magnified when the young victim lives in a small community. Legislation does exist criminalising cyber-bullying and the encouragement of suicide. However, whilst policies of this nature may deter some children and young people from engaging in negative online behaviour, the focus must be on education and fostering safe online spaces for young people to seek support.

Establishing effective ways to manage digital technologies and media will no doubt be challenging, due to the constantly changing nature of their use and the development of new

[68] Becker, K., & Schmidt, M.H. *When kids seek help on-line: Internet chat rooms and suicide* (2005) Reclaiming Children and Youth, 13, 229 – 230.
[69] Fortune, S., Hawton, K., 'Deliberate self-harm in children and adolescents: a research update' (2005) *Current Opinion in Psychiatry*, 18, 401-406.

technologies. Currently, in responding to these concerns researchers suggest that 'service providers pursue website optimization strategies to maximize the likelihood that children and young people exhibiting these behaviours, access helpful rather than potentially harmful sites in terms of crisis'.[70]

Utilisation of digital technologies and media

Whilst digital technologies and media can be used to the detriment of children and young people, there are clear opportunities for successfully reaching and intervening online with young people who are engaging in these behaviours. We are constantly seeing these technologies become an ever-increasing medium for young people to express their emotions, whereby they often reveal warning signs. There is an abundance of research providing guidance as to the benefits of digital technologies and media for young people engaging in self-harm and suicidal behaviour. These include support[71], opportunities for self-help[72], prevention[73] and intervention[74]. Further, digital technologies now promote access among many platforms, can provide information directly to young people who can remain anonymous, and can address issues such as isolation amongst many others.

With regards to using the Internet, online crisis support and suicide prevention services such as *Lifeline*, *ReachOut* and *Headspace* provide comprehensive online chat and telephone support for young people who access their site. Children and young people now have greater access to prevention and intervention information and services, online support forums and advice.

Specifically regarding young people using chat rooms to discuss self-harm and suicidal behaviour, studies have revealed positive effects on their self-behaviour. This may duly be in part to the need for young people to feel connected with their families and communities, and ultimately young people who feel connected are less likely to engage in self-harm or suicidal behaviours.[75] There is also a belief that being informed of a young person's recent Internet habits could provide a beneficial indicator in clinical assessments. Oxford researchers based in the United Kingdom similarly found that up to 70 percent of young people who engaged in self-harm used the Internet to find out about techniques.[76] However, consensus appears to indicate that further research should be undertaken to examine the exact impact.[77]

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[70] University of Oxford. 'How internet affects young people at risk of self-harm, suicide' (2013) *ScienceDaily* <www.sciencedaily.com/releases/2013/10/131030185706.htm>.
[71] Becker, K., & Schmidt, M.H. *When kids seek help on-line: Internet chat rooms and suicide* (2005) Reclaiming Children and Youth, 13, 229 – 230.
[72] Whitlock, J., Eckenrode, J., & Silverman, D., 'Self-injurious behaviors in a college population' (2006) *Pediatrics* 117, 1939-1948.
[73] Baume, P., Rolfe, A., Clinton, M., 'Suicide on the Internet: a focus for nursing intervention?' (1998) *Aust. N. Z. J. Ment. Health Nurs.* 7 (4),134.
[74] Hoffmann, W.A., 'Telematic technologies in mental health caring: a web-based psychoeducational program for adolescent suicide survivors' (2006) *Issues Ment. Health Nurs*. 27, 461–474.
[75] Centers for Disease Control and Prevention (USA) (n.d). *Strategic Direction for the Prevention of Suicidal Behavior: Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior*. <http://www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf>.
[76] Kate Daine, Keith Hawton, Vinod Singaravelu, Anne Stewart, Sue Simkin, Paul Montgomery, T'he Power of the Web: A Systematic Review of Studies of the Influence of the Internet on Self-Harm and Suicide in Young People' (2013) *PLoS ONE*; 8 (10) <10.1371/journal.pone.0077555>.
[77] Ibid.

Lastly, with the growth of phones and tablets that provide incredible capabilities, services now are looking at innovative ways to connect with children and young people. Applications and online tools are already being utilised by *ReachOut.com* to engage more effectively with children and young people. The *Alive and Kicking Goals* program that is based in the Kimberly region in Western Australia has recently released their phone and tablet compatible app *ibobbly*. The app was created in partnership with the *Black Dog Institute* and is the world's first suicide prevention app designed primarily for use by indigenous people. It effectively delivers its messages via the use of indigenous metaphors, images and stories drawn from local Aboriginal artists and performers, bypassing two of the major barriers to help-seeking in indigenous communities in perceived stigma and isolation. They have further strengthened the apps accessibility by not needing ongoing Internet access and creating individual password access to allow for multiple users on one device (ensuring confidentiality of information). The app clearly indicates the targeted and innovative responses that digital technology can offer children and young people at-risk of self-harm and suicidal behaviour.

There is no risk to suicide by talking about it; there is a risk of ignoring it if the topic is avoided.[78] Whilst the Internet has facilitated phenomena such as cyber-bullying and enabled greater access to information and spaces encouraging self-harm and suicide, the opportunities to address these behaviours far out-weigh the negatives. Developing technology and changing patterns in user-activity provides vast opportunities for engaging with children and young people at-risk. Specifically, the *Alive and Kicking Goals App* reflects the ability of technology to specifically address barriers faced by specific groups of young people and developing resources in culturally relevant ways. These technologies can be used safely and effectively to promote young people's wellbeing, and supporting providers to engage with young people via this medium must be continued and improved.

[78] Jans T, Taneli Y, Warnke A. *Suicide and self-harming behaviour*. In Rey JM (ed), IACAPAP e-Textbook of Child and Adolescent Mental Health (2012) Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions <http://iacapap.org/wp-content/uploads/E.4-SUICIDE-072012.pdf>.

CONCLUSION

It is clear that children and young people are more at-risk of engaging in self-harm and suicidal behaviours. Whilst we are not alone in our difficulties in attempting to reduce these avoidable health outcomes, the specific vulnerabilities that exist regarding particular groups of young people (as evidenced in our submission) require significant investment into policy, programs and practice. There are already vast amounts of research and evidence from current practices that can effectively guide these required outcomes. Further, we largely know what barriers are preventing help-seeking. Whilst the need to create more consistent and responsive ways of collecting data regarding these incidences is important, we must act now. This will require a whole community approach, and specifically in relation to the unique vulnerabilities of young Aboriginal and Torres Strait Islanders, we must utilise information in the *Elder's Report* that places control of the situation in the hands of community leaders and young people themselves. We need to take action locally and nationally to build skills, improve knowledge and awareness of what 'works', and provide opportunities to prevent these devastating incidences from occurring in the future.