National Children's Commissioner Examines Intentional Self-harm and Suicidal Behaviour in Children Submission

The Commission recognizes that intentional self-harm and suicide is most likely to occur at a much higher level amongst groups of 'vulnerable' children and young people, including children and young people in out-of-home care, children who have died and were known to Child Protection, children and young people in youth justice facilities, Aboriginal children and young people, children in immigration detention facilities and gender variant and sexuality diverse children and young people.

It is important to commence with defining what is meant by intentional self-harm and suicide. Intentional self-harm is taken to mean when the behaviour of the child or young person deliberately causes pain or injury to their body. The most common type of self-harm among young people is cutting, with other types including burning the skin until it marks or bleeds, picking at wounds or scars, self-hitting or pulling out hair by the roots (known as trichotillomania), and the most extreme kinds being breaking bones, hanging and deliberately overdosing on medication. The other forms of intentional self-harm that are not generally included as self-harm include starving or binge eating, abuse of drugs or alcohol and dangerous driving. 'Suicidal ideation' refers to thoughts that life is not worth living, which may range in intensity from fleeting thoughts through to concrete, well thought through plans for killing oneself, to a complete preoccupation with self-destruction *(Headspace, 2009; SANE, 2013).*

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

Self-harm is usually a response to intense pain, distress, or overwhelming negative feelings, thoughts or memories. The distress being experienced is often associated with mental illness or trauma, and is usually an accumulation of negative experiences of stresses rather than being in relation to a single event or experience that triggers the self-harm in the young person. The individual may feel that it provides temporary relief from their psychological distress in the short term, but the sense of relief often does not last because the underlying problems that have caused the distress have not been resolved. Although the young person who self-harms says that they wish to die, the motivation for their behaviour is more often related to expressing their distress and a desire to escape from difficult circumstances. Although for some young people self-harm is a "once-off" event, for others (over 50% of those who self-harm) it becomes repetitive. In fact, most of these young people who repeatedly self-harm state that they never believed they would come to rely upon it as a way to cope with their feelings. Over the longer term, they may come to realize that self-harm is not an effective coping mechanism, but find it hard to stop doing the behaviour as they can't find other ways to cope with their distress (such as talking to a trusted other).

Self-harming can become additive behaviour for the young person and for them it may not be simply a case of just stopping the behaviour. This may not be possible until they have developed more effective ways of managing their distress, which can take some time. A harm minimization approach may need to be adopted to reduce the severity of the self-harm and work towards cessation of the behaviour, which can be a way of staying alive rather than being a means to end their life *(Headspace, 2010; Orygen Youth Health, 2014)*. Therefore, although the person who is self-harming may not mean to kill themselves, it can

often become a compulsive and dangerous activity that requires careful professional help, as it may result in their death *(SANE, 2010).*

For those young people who are experiencing suicidal ideation, if it is mild and only being reported in relation to a single occasion, it has been found to be associated with clinically significant symptoms of depression *(Headspace, 2009).* Young people who experience persistent and severe suicidal ideation are at increased risk of attempting suicide. This risk is mediated by the weight of the burden of psychosocial risk factors that the young person is subject to. The risk factors applicable for suicidal behaviour in the general population of young people are:

- a previous suicide attempt
- mental health and substance use disorders
- physical illness: terminal, painful or debilitating illness
- family history of suicide, alcoholism and/or other psychiatric disorders
- social isolation and/or loving alone
- bereavement in childhood
- family disturbances
- unemployment, change in occupational or financial status
- rejection by a significant person e.g. relationship break-up
- recent discharge from psychiatric hospital
  (Headspace, 2009).

The factors described above may be seen as generally applicable also for vulnerable groups of young people, but with an increased likelihood for particular factors and potentially combined with some additional factors.

Vulnerable Groups

Children Involved with Child Protection and Out-of-Home Care

By definition, those children and young people who are involved with Child Protection services and may be placed in out-of-home care have experienced abuse and/or neglect, which has resulted in trauma. For many of these children they will have experienced a lack of attachment with a primary caregiver during their early years and beyond. Following on from their early trauma experiences, some children may also be revictimized through experiencing sexual abuse and sexual exploitation whilst in out-of-home care. These intrapersonal factors which predispose the child or young person to undertake intentional self-harm and/or increased risk of suicide, can be compounded by environmental factors. In addition to the stigma associated with being involved with Child Protection or residing in out-of-home care, there is exposure to peers who self-harm, express suicidal ideation or attempt suicide. This situation is greatly exacerbated for young people placed in the Secure Welfare Service (SWS), which is a service for young people who are at risk of harming themselves or others, and where they will be exposed to other young people who are very distressed and may be expressing this through self-harming behaviour.

Children in Youth Justice Facilities

Many children and young people in youth justice facilities can be expected to have abuse history characteristics in common with those involved with Child Protection and placed in out-of-home care and may be dual clients. Similar to those young people in the environment of SWS, young people in youth justice facilities are subject to the culture of a custodial environment which is notorious

for the prevalence of self-harming and suicidal behaviour. Custodial environments have also been synonymous with sexual assault among the detainees, which combined with the social disconnection, stigma and exposure to aggressive behaviour and violence can be expected to have deleterious impacts upon the mental health of young people in custody.

Aboriginal Children and Young People

Aboriginal children and young people are at much higher risk of self-harm and suicide, with the general risk factors believed to be further compounded in the Aboriginal population by broader situational and sociocultural factors. These situational and sociocultural factors may differ considerably in their application between urban, regional, rural and remote settings.

It is also important to understand the cultural differences in how Aboriginal people may view mental health and suicidal behaviours. Aboriginal people usually have a more holistic understanding of health, whereby spiritual and cultural wellbeing not only affects the individual, but the community as a whole.

Suicide remains a significant social issue in Aboriginal communities within Victoria, linked with both chronic and cyclical disadvantage, and incorporating socioeconomic aspects, disproportionate rates of contact with the justice system, imprisonment, family violence and alcohol and drug misuse. Chronic disadvantage is further compounded by the historic injustice of dispossession, cultural disruption and dislocation from family and culture experienced by the Stolen Generations and their children (Department of Human Services, 2006).

Professor Colin Tatz has identified eight factors that contribute to suicidal or high risk behaviour:

- lack of sense of purpose in life
- lack of publicly recognized role models and mentors outside of the sporting realm
- disintegration of the family and lack of meaningful support networks within the community
- sexual assault
- drug and alcohol misuse
- animosity and jealousy
- the persistent cycle of grief
- illiteracy, which results in exclusion and alienation.

Aboriginal young people experience high rates in each of these risk factors.

The Victorian Aboriginal Suicide Prevention and Response Action Plan 2010 -2015 considers a range of risk factors that specifically apply to Aboriginal young people, including lack of expectation for the future, boredom, family breakdown and family rejection, poor educational attainment or attendance, racism, poor health and/or mental health, previous suicide attempts, being bereaved by suicide, exposure to family violence, lack of parental support and relative social disadvantaged compared to the mainstream population.

Adoption

Children and young people who have been adopted may have experienced early trauma as a result of abuse or neglect, and may have subsequent developmental issues. Given their history, children who have been adopted can experience attachment and bonding issues, with particular difficulties related to identity

which may emerge most forcefully during adolescence given the process of identity formation that occurs during this period. The challenges may become particularly complex for children with an intercountry adoption background whose families grapple with issues relating to language and cultural connection as well.

Children and Young People in Immigration Detention

Asylum seeker children and young people, especially those who are unaccompanied minors, in immigration detention are highly likely to have experienced trauma during their journey and potentially abuse and neglect. They will also have experienced loss related to their community connection to their land, loss of and separation from family members. They will be concerned for the safety and support of family members left behind in their country of origin and transit, which may remain areas of current conflict. These stressors may be compounded by feelings of powerlessness as they cannot achieve their family's aim that they will support the family financially, as they do not have work or vocational study rights and can no longer make split family applications for their parents to come to Australia. The impact of indefinite detention means children and young people in immigration detention are also exposed to mental health issues that can escalate to self-harm and suicidal behaviour by family members and others in the centre, increasing the risk that they will also undertake this behaviour.

Gender Diverse and Sexuality Variant Children and Young People

Those children and young people who identify as gender diverse or sexuality variant also have very high rates of intentional self-harm, suicidal ideation and suicide attempts *(Suicide Prevention Australia, 2009).* Self-harm and suicide risk among LGBTIQ youth is not a consequence of their sexual or gender identity itself, but is attributable to their social experience of their identity, including stigmatization and bullying which result from entrenched transphobia and homophobia. These attitudes and behaviour contribute to isolation, poor social and emotional wellbeing *(Suicide Prevention Australia, 2010).* Young people who are struggling to endure a culture and climate that stigmatizes difference are often left without the essential support they need from their family or community *(Bagley and Tremblay, 2000).*

Students may witness discrimination being inflicted upon others who have come out, leading them to keep their own identity secret, resulting in ongoing impacts for their own mental health and wellbeing. This secrecy and isolation is often compounded by poor quality sexual health education in schools, which does not respond to the experiences or needs of LGBTIQ young people and may even perpetuate myths and stereotypes. When young people subsequently come out or are outed, they may experience rejection by family members and/or their community, especially when this is justified on the basis of cultural or religious affiliations. This lack of social support is likely to place the young person at risk of homelessness, economic instability and destitution. The young person may find that service provision is not inclusive and especially difficult to access in rural areas, given the lack of services available. These factors can combine to heighten the young person's psychological distress as they experience discrimination in many aspects of their lives *(Growing Up Queer, 2014).*

2. The incidence and factors contributing to contagion and clustering involving children and young people

Suicide contagion is a reference to a process whereby one suicide or a suicidal act within a school, community, or geographic area increases the likelihood that others will attempt or complete suicide *(Headspace, 2010)* which can be known

as copycat behaviour *(Suicide Prevention Australia, 2010)*. Of great concern is that suicide contagion can lead to a cluster of suicides, in which a number of suicides follow an initial death. Suicidality in family members or friends increases youth depression and reported suicidal thoughts *(Barksdale, Walrath, Compton and Goldston, 2008; Liu, 2006)*, with the phenomenon more prevalent for girls *(De Leo and Heller, 2004)*. Younger people are more susceptible than older people *(Zenere, 2009)* and it is believed that this is a consequence of young people identifying more strongly with the actions of their peers, which is part of the normal process of development during adolescence. Adolescence is also known to be a period of increased vulnerability to mental health problems, which increase the risk of suicide *(Headspace, 2010)*. The personal grief and distress of experiencing suicidality in a loved one, combined with exposure to self-harming behaviours, heightens the risk *(Suicide Prevention Australia, 2010)*, with 43% of child suicides in Queensland thought to contain contagion properties *(Queensland Commission for Children and Young People and Child Guardian, 2009)*. Unfortunately, comparison statistics have not been readily available for Victoria, but the Commission for Children and Young People is seeking this data.

There are a number of factors that have been identified as increasing the risk of suicide in young people:

- attempted suicide previously
- being a close friend or family member of the person who has died
- witnessed the death
- already dealing with stressful life events
- contact with the person shortly before they died
- argued or fought with the person before they died
- preoccupied with thoughts of death and dying
- experienced other losses or suicides in the past *(Headspace, 2010)*.

Dr Michael Carr-Gregg has argued that it is very important for young people to feel that they have a positive social identity and that they feel socially integrated. However, the evidence was that more and more young people did not feel safe, valued and listened to, making them increasingly vulnerable. He described these young people who don't believe in themselves and don't have a basic sense of meaning, purpose or belonging as 'spiritual anorexics'. The young people also had "an absolutely prurient interest in what the media tells them to be interested in", giving negative stories greater impact on increasing their vulnerability *(Gregor, 2004)*.

It has been proposed that the most significant factor that contributes to suicide contagion is the glamourizing or romanticising of suicide and sanitizing and normalizing this behaviour *(Gregor, 2004; Headspace, 2010; Suicide Prevention Australia, 2010)* which can occur in communication of a suicide death. This can be an indirect consequence of the social norm of focussing on the positive qualities of a person who has recently died and not dwell upon the mental health or relationship difficulties they may have been experiencing. Although such behaviour is quite understandable, it has the potential to encourage suicidal thoughts in other vulnerable young people *(Headspace, 2010)*.

Dr Stephen Stack has offered three explanations for the media's impact on suicide rates based on his research. The first explanation is based upon a simple copycat or imitation perspective, whereby media stories provide an illustration of how a troubled person was able to opt out of their difficulties, which other troubled people are able to identify with. The second explanation relates to a

differential identification with models, with imitation theory suggesting people model their behaviour after "superior" people such as celebrities more than average people. Dr Stack found media stories about celebrity suicide were 14 times more likely to generate a copycat effect. The third explanation relates to audience receptiveness, whereby different genders, cultural background and age groups may be more primed for suicide than others. The younger age group of those under 35 years were found to be particularly sensitive to copycat effects. However, the strongest indicator of a copycat effect was found to be the volume of media coverage an individual suicide received *(Gregor, 2004).* Although story presentation is not thought to play a major role, problematic stories tended to be based on information gathered from courts, coroners' reports or police and it was suggested that reporting of explicit details of the method or location should be avoided *(Gregor, 2004; Suicide Prevention Australia, 2010).*

It has been proposed that there are two types of suicide clusters, a "mass cluster" which involves a cluster in time, irrespective of geography, and thought to be associated with the influence of media reports such as in the case of celebrity suicides. On the other hand, "point clusters" involve suicides that are close in time and/or space and can consequently be more simply identified. These clusters will often occur within institutional settings such as hospitals, prisons, schools, or within distinct communities. Canadian research suggests that point clusters are a major problem in some native communities where native reserves accommodate communities of closely related individuals who share the same social disadvantage issues, and so the impact of a single suicide is felt by the entire community. The closeness of the residents creates a greater risk of a cascading effect leading to a cluster of suicides which can continue over an extended time period in a phenomenon known as "echo clusters" *(Olson, 2013).*

Of the Vulnerable Groups discussed previously, it can be seen that three clearly fall within institutional settings, being residential units providing out-of-home care, youth justice facilities and immigration detention centres. These settings provide an environment where young people with trauma histories are housed together, dealing with stressful relationship disconnections and exposed daily to the distressed behaviour of peers, with limited personal coping skills and often very restricted access to external mental health and other supports. Young people in out-of-home care have little influence on their living and family situation, whilst those in youth justice facilities are subject to a custodial sentence and young people in immigration detention are subject to indefinite detention and frequent policy changes.

There are a number of techniques that have been formulated to reduce the risk of suicide contagion in a school or community that should be applied generally:

- identification and monitoring of people at increased risk
- appropriate support and treatment for people at risk, including initial one-to-one support for distressed young people, as well as ongoing treatment by mental health clinicians
- appropriate reporting of suicide in the media
- careful consideration of the provision of information that is age and culturally appropriate, including;
    - clear, concise and timely delivery to minimize misinformation and distress
    - factual information, without unnecessary detail, provided immediately

- announcements made to small groups and close friends, with family members being told individually beforehand.

Aboriginal communities would appear to reflect the experience of their Canadian native counterparts, with point clusters being observed in over ten Australian Aboriginal Communities *(Victorian Government Aboriginal Affairs Report, 2013)*. It is acknowledged that this risk of clustering means suicide prevention strategies must include critical responses in communities after a suicide to support family, friends and the community in the wake of a death. Ensuring culturally sensitive responses both at the place of death, as well as during funeral ceremonies, is essential for grief support. Therefore the potential for cluster suicides will need to be considered, particularly in the development of culturally appropriate post incident management or crisis management.

The town of Mildura in Victoria, near the border of South Australia and NSW, has experienced a point cluster over the period of 2013 -2014.

Children and young people who identify as gender diverse and sexuality variant tend to congregate more as an online community seeking support and acceptance to overcome geographical distance. There would not appear to be formal research highlighting the regular incidence of suicide clusters for this vulnerable group, although there have apparently been sporadic instances of clusters in the US, with a famous example being a school district that had adopted very repressive policies which allowed homophobic and transphobic bullying to flourish *(Erdely, 2012)*.

3. The barriers which prevent children and young people from seeking help

There would appear to be a number of barriers which prevent children and young people seeking help, including:

- feelings of guilt, shame and fear
- inappropriate response of the person approached for support
- myths about the nature of self-harm and suicidal behaviour
- lack of a trusted other
- lack of awareness about where to seek support
- format of the service being provided
- cultural appropriateness of the service
- accessibility of the support service.

Feelings of Guilt, Shame and Fear

Children and young people involved in self-harming behaviour will usually be experiencing great guilt, shame and fear. They are very aware if others find out about their behaviour they may be labelled as an "attention seeker", "crazy" or "stupid" by others. Such fears can lead them to go to extraordinary lengths to keep their behaviour secret, such as only self-harming in private and harming parts of their body that are not visible to others. Daily life is also affected as young people wear clothes that conceal cuts and scars, limit activities such as swimming and avoid physical or intimate relationships. Even those who are closest to the young person may be unaware of their self-harming behaviour *(Headspace, 2010)*. Research found the rates of self-harm reported by young people were three times higher than that estimated by their parents *(Meltzer, Harrington, Goodman & Jenkins, 2001)*. Feelings of guilt and shame may also prevent the young person from acknowledging the issue and acting to seek

information and the support they need to better manage their emotional distress and problems *(Headspace, 2010).*

Inappropriate Response of the Person Approached for Support

It has been suggested that young people who do seek support to address their self-harming behaviour are most likely to first approach their friends or family members. This makes the response given by this person critically important and it is therefore imperative that common myths about self-harm are dispelled. Such myths include the attitude that the self-harm should not be taken seriously, viewing it as "just a phase" or "attention seeking". Alternatively, getting angry with the young person or panicking and jumping to the unwarranted conclusion that the young person is suicidal are not helpful. It is also a myth that self-harm is associated with a particular subculture amongst young people such as the 'emo' trend, when in reality self-harm has been an observable behaviour for decades *(Mental Health Foundation, 2006).* It is also a myth that if a young person self-harms they must have a mental illness or personality disorder. Although self-harming behaviour is strongly suggestive of an underlying psychological or emotional problem, many affected young people would not meet the criteria for diagnosis of a specific mental illness. If the young person's initial attempts to seek support receive a negative or unhelpful response, their distress may be increased and self-harming may become more frequent or serious *(Orygen Youth Health, 2014).*

Myths about Self-harm and Suicidal Behaviour

Parents will often experience intense emotional responses upon learning that their child is self-harming, including shock, embarrassment, shame, guilt and confusion. Many parents report that they feel they have "failed" their child in some way, or fear how the behaviour will reflect upon them as being "poor parents" or that their "child is crazy". This belief can make parents reluctant to confide in friends or family members about what they are going through. As a consequence, their social isolation may be exacerbated leading them to feel overwhelmed. Parents may then delay seeking help for their child until the self-harm escalates and a crisis occurs. However, such delays in seeking help can have serious consequences both for the young person and their family. It is best for help to be sought early to enable appropriate support and treatment to be provided *(Headspace, 2010).*

In general, when a child or young person is experiencing mental health problems they will be reluctant to seek professional help, and as their suicidal ideation increases, their intention to seek help will decrease further. Despite this, many young people do seek general medical care prior to suicidal behaviour. Therefore health and other professionals who have ongoing contact with young people are in a good position to be able to detect and assess risk. Although young people are unlikely to disclose suicidal thoughts without prompting, they may do so if asked specifically about it *(McKelvey, Davies, Pfaff et al, 1998).* Professionals must therefore be alert to the warning signs and ask young people about suicidal behaviour and ideation rather than waiting for the young person to bring it up. If the subject is approached sensitively, only a minority of young people will deny suicidal intent when they are actually planning to suicide. It must be remembered though, that although for the majority of cases a suicide attempt will be preceded by at least one warning sign, this is not always the case. For this reason, not every suicide is preventable *(Headspace, 2009).*

Professionals working with young people need to feel confident that they are capable of a sensitive and effective approach to the discussion of suicidal ideation with young people. This requires training that addresses any personal discomfort

professionals may have with this topic or fears relating to adherence to the myth that discussion of suicide may "put ideas in their head". This myth is still common and can contribute to low detection rates of suicidal young people across a variety of settings *(Coombs, Miller, Alarcon et al, 1992; Hahn & Marks, 1996; Michel, 2000,).* Surprisingly, even GPs, mental health professionals and university counsellors do not routinely ask about suicidal risk factors or behaviour among high-risk clients. Yet in an age of saturation usage of social media and high prevalence of suicidal behaviour in their age group, young people will already be very familiar with the topic of suicide and discussing it will simply not be introducing something they are unaware of.

Lack of a Trusted Other

The lack of a trustworthy other that the young person could approach to discuss self-harm or suicidal ideation is particularly an issue among Vulnerable Groups in institutional settings. For example, children and young people in out-of-home care have trauma histories relating to their experience of abuse or neglect from family members, which will affect their ability to trust and form close relationships with others. For children and young people in youth justice facilities with similar trauma histories, coupled with a custodial setting, the capacity to trust others is unlikely to be high. Children and young people in immigration detention are highly likely to have experienced or been exposed to trauma, conflict and displacement, may lack contact with family members, and have additional cultural and language barriers to being able to build a trusting relationship. Gender diverse and sexuality variant children and young people may experience being ostracized from their family upon coming out, creating an additional barrier to being able to trust confidences to others.

Lack of Awareness about where to seek Help

Children and young people generally may not know where to seek information and support about self-harm or suicidal ideation. For this reason, professionals are encouraged to provide information on support services including helpline contact details as a condition of all media articles covering the topic *(Gregor, 2004).* Services may not be visible and the low level of literacy among most Vulnerable Groups means that some young people are reliant upon word of mouth *(Accessibility of Mainstream Services for Aboriginal Victorians, VAGO Report, 2014, p.47).* Institutional settings will usually have some form of welfare support program, but this sole source of support may lack professionals trained in the detection, assessment and support of self-harm or suicidal behaviour in children and young people. Children and young people who are gender diverse and sexuality variant tend to seek information and support through their online community networks. However, although this is generally positive, young people also report exposure to very negative material that has been planted by anti-gay individuals and organizations.

Format and Cultural Appropriateness of the Service being Provided

The format of service provision is clearly quite important, depending upon whether the child or young person is held in a custodial setting, or in the community and able to access online resources. Low literacy may mean that the administrative procedures to access the service may need to be modified. There may also be a lack of culturally safe services which are not equipped to manage the cultural needs of Aboriginal people, as staff have a lack of expertise in this area and require cultural awareness training *(Accessibility of Mainstream Services for Aboriginal Victorians, VAGO Report, 2014, p.47).* The adaptation of mainstream prevention approaches that have been derived from non-Aboriginal understandings of suicide and health have, to date, been less effective in addressing Aboriginal suicide, particularly for those most in need. Key

requirements for long term success in suicide prevention strategies for Aboriginal people are that programs must be developed for and by the communities they are intended for, they must foster empowerment and Aboriginal communities must be involved in the consultation, programming, delivery and control of services as part of self determination (*Victorian Government Aboriginal Affairs Report, 2013).*

For children and young people in immigration detention there will be a similar lack of understanding of the cultural needs of a range of refugee communities of diverse cultural and religious backgrounds, who may not even have language equivalents to cover the concepts.

Accessibility of the Support Service

For all groups outside custodial settings, there are practical logistical issues that may reduce the ability of children and young people to seek help. They may lack transport, especially in regional areas, and be unable to afford any costs associated with support sessions. Children and young people may also be concerned about confidentiality, given their age group and parental consent issues. There may also be an age barrier, in that children would seem to be engaging in self-harming behaviour at a much younger age and support services are designed to cater for youth. This fits with the myth that younger children are incapable of self-harm or suicidal ideation, despite regular media reports of children as young as six apparently suiciding.

4. The conditions necessary to collect comprehensive information which can be reported in a regular and timely way and used to inform policy, programs and practice. This may include consideration of the role of Australian Government agencies, such as the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

In order to collect comprehensive information about self-harm and suicide amongst children and young people for use in guiding policy, programs and practice, there are a number of areas that need development.

1. Standardized definitions of what is to be classified as self-harm, suicidal ideation, suicide attempts and completed suicide.

2. Methodology that explores the issue of suicide attempts and completed suicides that may at first appear to be accidental injuries or deaths. It could be questioned whether a number of deaths amongst young people, especially through methods such as drug overdose, may actually be a result of intention rather than accident.

3. Standardized data set development that covers issues such as:
    - the method of self-harm or suicide attempt (including railway suicide attempts)
    - the age of the child or young person
    - the cultural and/or religious group with which the child or young person identified
    - whether the child or young person had an asylum seeker or refugee background
    - whether the child or young person was of Aboriginal or Torres Strait Islander background
    - whether the child or young person was involved with Child Protection at the time, or had been previously

- whether the child or young person was in out-of-home care, and if so, what type
- whether the child or young person was involved with Youth Justice at the time, or had been previously
- whether the child or young person had been involved with mental health services, or had been previously
- whether the child or young person was subject to permanent care or adoption
- whether the child or young person was in immigration detention (held or community), located on the Australian mainland or an alternative, or had been previously
- whether the child or young person was an unaccompanied minor, and if so, whether classified as a ward or non-ward
- whether the child or young person identified as gender diverse or sexuality variant (or alternatively using LGBTIQ classification groups).

4. Detailed budget modelling which demonstrates the financial and social costs to the community, in terms of the burden of disease model, of self-harm, suicide attempts and completed suicides.

5. It might be expected that the ABS (Australian Bureau of Statistics) would develop and implement the common data set described above, in consultation with a range of stakeholders including the federal Department of Health, Department of Immigration and Border Protection, Aboriginal and Torres Strait Islander communities, the Refugee Minor Program, Headspace, the Department of Education and Human Services for each of the States and the National Safe Schools Coalition.

6. The Australian Institute of Health and Welfare (AIHW) also has an important role to play in providing a more comprehensive analysis of the data collected in relation to self-harm and suicide amongst children and young people. The AIHW could explore whether there are other previously unidentified groups of especially vulnerable children and young people, any patterns in the method of harm chosen, models of good practice for supporting children and young people at risk, both in the community and institutional settings, and when and how to prevent a suicide cluster.

5. The impediments to the accurate identification and recording of intentional self-harm and suicide in children and young people, the consequences of this, and suggestions for reform

There are a number of challenges to the accurate identification and recording of intentional self-harm and suicide in children and young people.

- Given the lack of comprehensive data and community misconceptions about the nature and context of self-harm and suicide, the impact upon the broader community of this behaviour in children and young people is largely unknown, but is likely to be greatly under-estimated.
- Community attitudes towards self-harm and suicide, with the issue being especially difficult to discuss within some religious and cultural groups which have strong taboos about such behaviour.
- Myths about self-harm and suicide which prevent those engaging in the behaviour from seeking support and fostering inappropriate responses by those who might have been asked to give this support.

- Unwillingness of professionals to initiate discussion with children and young people about self-harm or suicidal ideation because of their own discomfort, lack of training and confidence, and mistaken belief that they might introduce the concept to the child or young person.

To address these challenges, there are a range of initiatives that could be undertaken:

- The development of systems for accurate recording of data, and especially the analysis of patterns of particularly high vulnerability, would allow the scoping of the social and financial costs of self-harm and suicidal behaviour among children and young people. This results of this scoping would allow the issue to be given priority in terms of the cost to the community of not undertaking prevention and early intervention work and remaining reliant on crisis intervention work.
- A community and professional awareness campaign regarding the role of trauma and mental health issues in self-harm and suicidal behaviour, how to recognize the behavioural indicators and what steps to take to support the child or young person.
- A separate education campaign using social media and other technologies should be developed for young people to encourage discussion and support strategies for peers involved in self-harm and/or experiencing suicidal ideation. This could be modelled on the work of the RUOK? Organization.
- Joint training for professionals and cultural and religious community group leaders to explore culturally appropriate responses for detecting, assessing and intervening when self-harming or suicidal behaviour is present amongst children or young people within the community.

6. The benefit of a national child death and injury database, and a national reporting function

There would seem to be a great number of benefits of establishing a national child death and injury database, and an associated national reporting function. This would ensure that consistency in data collection is developed across jurisdictions and analysis of comprehensive data on a national basis.
By ensuring that all deaths of children are reported to the database operator, it would become possible to explore and analyze any trends that may emerge, with a view to development of effective, targeted interventions. It is clearly in the public interest to treat self-harm and suicide of children and young people as a public health problem that is amenable to treatment. The database operator would be responsible for providing an annual report on child deaths and injuries, but also quarterly and/or monthly statistics which would allow for the detection of emerging patterns and timely intervention.

Upon consideration of the data relating to cause of death for children subject to inquiry by the Commission for Children and Young People (CCYP), it was found that 22 children died from suicide/self-harm during the period 1996 to 2013 and 25 from drug/substance related issues (VCDRC Annual Report 2013). This number may include accidental and intentional overdoses.

7. **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. Submissions about specific groups are encouraged, including children and young people who are Aboriginal and Torres Strait islanders, those who are living in regional and remote communities, those who are gender variant and sexually diverse, those from culturally diverse backgrounds, those living with disabilities, and refugee children and young people seeking asylum. De-identified case studies are welcome.**

Aboriginal and Torres Strait Islanders

Suicide prevention responses for Aboriginal communities often include community strengthening and education programs, personal development, youth activity programs, re-orienting health services and accompanying policies. The adaptation of mainstream prevention approaches that have been derived from non-Aboriginal understandings of suicide and health have, to date, been less effective in addressing Aboriginal suicide, particularly those people most in need. Whilst there may be a lack of documented evidence on the effect of suicide prevention strategies for Aboriginal people, there are some key identified requirements for long term success found in the *Victorian Aboriginal Suicide Prevention and Response Action Plan 201-2015*:

- the programs must be developed by and for the communities they are intended for
- they must foster empowerment
- Aboriginal communities must be involved in the consultation, programming, delivery and control of services (self determination).

Gender Diverse and Sexuality Variant

There would seem to be five main areas that need to be addressed to prevent self-harm and suicide amongst LGBTIQ children and young people. The first relates to the use of terminology, which was the subject canvassed with young people themselves during the consultation process for the Australian Human Rights Commission's exploration of *Protection from discrimination on the basis of sexual orientation and sex and/or gender identity* in 2010. Young people focussed on the need for terminology to be inclusive and how it was often not understood in the broader community or used to make them separate *(OUTthere, 2010).* As the former OCSC (Office of the Child Safety Commissioner) argued in detail in their submission to this inquiry, great care needs to be taken when using such terminology which is a highly contested area, and different terms may be more appropriate in various contexts until a broader understanding and acceptance is achieved (OCSC, 2010). This is especially important as inappropriate terminology can be disempowering when it is linked with bullying and discrimination.

Sexual health education in schools is an area that has long been neglected, despite the transformative role it can play in educating the broader school community about LGBTIQ children and young people. At worst, schools have no effective sexual health education program, or it is of poor quality with poorly trained staff delivering a program they feel uncomfortable about teaching. In the worst instances, the staff member will express or condone discriminatory or inappropriate attitudes regarding LGBTIQ identifying students or community members, thus further entrenching discrimination and bullying *(OUTthere, 2010).* The current debate about the school chaplaincy program highlights the dangers of individual's views undermining the work of programs in schools such as the Safe

Schools program which affirms the normality and acceptance of homosexuality *(Stark, The Age, 08.06.14).*

Sexual health education has been included in curriculums for a substantial period, having also been included in the National Curriculum, and is expected to be taught to a consistently high standard. An example of good practice is the exemplary program at Northern Bay College in Geelong which has been widely publicized *(Building Capacity in Sexuality Education: The Northern Bay College Experience, 2012).* There are ample, well written resources to assist staff, such as *Catching On Early* for the primary years, *Catching On* and most recently *Safe Landing* for secondary schools and *Talk Soon, Talk Often,* a much lauded resource to assist parents. Although these resources are produced with the support of government departments and training is available for teaching staff, consistent engagement has simply not occurred, and education about and sanctions against inappropriate behaviour by staff remains a challenging issue.

The challenges experienced in the consistent provision of high quality sexual health education are perhaps simply a reflection of the community's fear about discussing sexuality generally. This is despite comprehensive research such as the *Writing Themselves In* (1992, 1997, 2002, 2008, 2013) reports based on national surveys of the sexual health and wellbeing of same sex attracted and gender questioning young people, showing that discrimination in schools was the greatest source of abuse they faced. In the most recent edition, students themselves were found to be advocating for the inclusion of LGBTIQ content in sexual health education as right, more were questioning of sexuality and gender binaries and wanted to know about the mechanics of sex, not reproductive processes. Within schools a broader community education campaign is required that ensures sexuality education is closely linked with anti-bullying programs and strategies. At some schools, a nominated teacher who can provide a safe space and support for young people who are being bullied may be allocated, however this initiative alone does not address the perception of an unsafe environment within the school.

As well as experiencing a safe and supportive environment within their school, LGBTIQ children and young people need to know that when they are provided with other services they will not experience discrimination, which may be based on ignorance. The OUTthere submission (2010) details many examples from young people of their experiences of discrimination in service provision which demonstrate their awareness of how those involved feel protected by community attitudes and various sections of legislation. For such pervasive discrimination to become extinct, broader societal attitude change is required and it seems this may be led by popular culture. Interestingly, in a recent presentation of her research findings, Professor Kerry Robinson explained how 5 year old children told her that they knew all about gay people and had no concerns because they watched *Modern Family* (May, 2014), a popular television show, which comes after *Glee*, another television show which depicted gay students and their challenges. Professor Robinson felt these social influences might help to explain the much more progressive attitudes of children relative to their parents.

Finally, GLBTIQ young people and others have pointed out the importance of their members being integrated within the mainstream community and treated equally *(OUTthere, 2010).* Groups such as the Rainbow Families Network have argued that children, siblings and grandparents have been subjected to discrimination and harassment on the basis of the sexual orientation of their member parents. They seek to have an interconnected community where the threat of discrimination on the basis of sexual orientation and sex and/or gender identity is removed. The importance of this for LGBTIQ children and young people to

observe as they grow up and contemplate their own future life course should not be under estimated.

Educationally Disengaged

The vulnerability of young people who had been disengaged from education and were attending the CAE (Council for Adult Education) for VCAL, VCE and New Pathways programs was highlighted when staff observed that there were some cases of suicide during the term holidays. For these young people, their success was thought to be measured purely through their attendance and participation in class a few times per week, a routine disrupted during holidays. The staff then created a Youth Holiday Program called Beak Out, which involved attendance twice per week, including activities such as going on tours, sharing meals and working on creative projects which were devised by the participants, including FACE-UP, a photo portrait paste up, and Projection, an exhibit forming part of the Northern Exposure Visual Arts Festival.

Child Protection and Out of Home Care

Whilst there are not specific programs to address self-harm or suicidal behaviour in children and young people involved with Child Protection or placed in out-of-home care in Victoria, referrals can be made to in-house counselling services that may be provided by the specific child and family service agency. Alternatively, the child or young person may be referred to a CAMHS (Child and Adolescent Mental Health Service) or to Take Two, a state-wide developmental therapeutic program for children and young people in the Child Protection system.

Please see **Appendix 1** for a de-identified case study of a young person who suicided after a long history of cumulative trauma.

Youth Justice

The Victorian Commission for Children and Young People provides an Independent Visitor Program (IVP) where trained volunteers visit young people in custody in the Youth Justice Centres. The volunteers are available for the young people to talk with about issues of concern to them and this provides an avenue for relationship building and the capacity to support emotional wellbeing.

The African Youth Justice Program provided by VICSEG (Victorian Co-operative on Children's Services for Ethnic Groups) provides an African support team to mentor youth justice clients through court and in custody. This unfunded program is critically important as it provides specialist support to isolated and vulnerable young men to adjust to detention and isolation, through providing both cultural and religious support, especially during significant religious celebrations. Youth Justice Familiarization Training is provided to volunteers who become mentors to the young men, with the main topics being conflict resolution, anger management, offending behaviour, suicide prevention and professional and ethical procedures.

Railway Safety

A specific intervention program has also been launched in Victoria which has the highest rate of deaths by suicide on railways. The program is run by the TrackSafe Foundation and has included posters at stations encouraging vulnerable people to contact support services *(Gough, 2012)*, training staff to detect warning signs that a person intends to self-harm and appropriate ways to intervene. Early research has revealed that there are distinctive behavioural patterns and prompted the discussion about copycat behaviour and the importance of open discussion of the topic to highlight the frequency and severity of the issue *(Carey, 2014).*

8. The feasibility and effectiveness of conducting public education campaigns aimed at reducing the number of children who engage in intentional self-harm and suicidal behaviour

By their very nature, public education campaigns can only be feasibly considered for targeting the reduction of self-harm and suicidal behaviour by children and young people outside institutional settings. Those within such settings require more specialized interventions, although the whole community benefits when a public health approach is adopted and awareness of the precipitating factors, risk indicators and appropriate interventions is improved. The crude data collection that has occurred in the past that has not enabled analysis of trends relating to age, method of self-harm or suicide attempt, or whether the individual is a member of one of the identified vulnerable groups, must be improved before public campaigns that will be effective can be developed. A corollary of this work is the accompanying budget modelling that demonstrates that the emotional, health and financial costs for the individual, their family and the community as a whole when spent on prevention and early intervention are much lower than the very high social and financial costs associated with self-harm, suicide attempts and suicide completions.

A broader public education campaign might also tailor messaging and/or methodology for specific vulnerable groups such as Aboriginal and Torres Strait Islander children and young people, LGBTIQ children and young people, CALD background children and young people, children and young people with disability and those in regional and remote communities. Given the importance of peer networks and support for children and young people, it is critical that peers are knowledgeable and confident to be the powerful and effective first responders that they may be called upon to become. Parents also need to be aware of behavioural risk indicators and how to intervene and seek appropriate support, whether it is for their own child or on behalf of their child's peer.

9. The role, management and utilization of digital technologies and media in preventing and responding to intentional self-harm and suicidal behaviour among children and young people

The important role that media has to play in the appropriate and responsible reporting of suicide, given the potential negative consequences for vulnerable populations *(Pirkis, 2010),* has been discussed previously in response to Question 2. There are a range of ways that social media and digital technologies can also be used to prevent and respond, but also in some cases promote intentional self-harm and suicidal behaviour among children and young people. For example, LGBTIQ young people described the importance of online groups, chat sites and websites for provision of social interaction, acceptance and information that could assist in overcoming their social and physical isolation in the *Growing Up Queer* report (2014). At the recent Family Planning Victoria launch of the Safe Landing sexual health education resource (03.06.14), Professor Anne Mitchell spoke about her research finding that children and young people see social media as their territory for discussion of sexual, and all other health and wellbeing matters which fits with their saturation level of access to online technology. The growth in this access and usage is exponential, now forming an integral part of youth culture, being a vital part of their social life and method for expression of their identity *(McGrath, 2009).*

This presents opportunities that have been exploited by programs such as ReachOut, Kids Helpline and SECASA (South East Centre Against Sexual Assault) who provide web based counselling to utilize the potential to reach more

individuals by providing easily accessible, confidential, free and convenient services to those young people who need them, even though the individual may have originally accessed the service simply seeking information *(Suicide Prevention Australia, 2010).* Online counselling also offers even greater anonymity than phone counselling, which may make it even more appropriate for self-harming or suicidal young people given the shame and fear usually present *(Urbis Keys Young, 2002).* Online access is especially important for those isolated children and young people living in regional and rural areas who may have access to quite limited community support services and infrastructure. Online resources can also support improved mental health literacy as young people use materials to assist their peers *(Metcalf and Stephens-Reicher, 2010),* which may become a powerful weapon in combatting suicide contagion and clusters.

However, there must also be recognition that some websites contain content which advocates self-harm as a lifestyle. Pro self-harm websites promote messages encouraging self-harm, photographic depictions of self-harm, techniques for engaging in the behaviour and discussions whose intent is to validate self-harm practices. Such websites encourage participants to share their own stories as a way of belonging. Although there is evidence that some individuals found participation in self-harm communities assisted them to regain control of their lives, there was concern that it may also normalize and encourage dangerous behaviour via concealment and sharing of techniques *(Boyd, Ryan and Leavitt, 2010).* It is proposed that professionals should learn from what is being made visible online, which is largely content generated by young women, and use this to develop evidence based programs that leverage off the content and the communities of people who engage in self-harming behaviour to develop proactive interventions (*Boyd, Ryan and Leavitt, 2010).*

Appendix 1 De-identified Case Study based on Child Death Inquiry

was subject to a Child Death Inquiry under section 34 of the *Commission for Children and Young People Act 2012.*

died as a result of hanging when he was aged 15 years. At the time of his death, he was residing with his father and younger sibling.

came to the attention of child protection services a total of 20 times, commencing when he was an infant. Of these 20 reports, most were closed at intake, with the last report being closed shortly before his death. Protective issues had not been effectively resolved at the point of closure of the case on a number of occasions.

resided with his parents until he was school aged, at which time they separated. initially remained in the care of his father, with no known protective concerns. During his first year of school went to live with his mother, commencing a pattern of moving between his parents, which continued throughout his life. appeared to be fairly settled whilst in the care of his father. However, when he would move to his mother's care, his behaviour was difficult to manage and he was rejected by her. Whilst father appeared to be the more capable parent, he was never thoroughly assessed and presented several risk factors.

For the last year of life, he resided with his father and was exposed to an acrimonious relationship between his father and his stepfather. In the last report to child protection services, was alleged to have sexually abused his sibling, and whilst the assessment of child protection services and the police was that these allegations were malicious, it is unclear whether had been informed of this.

During his life, experienced many traumatic events, including ongoing rejection by his mother. Many supports were put in place, however, they were often not maintained whilst moved between residing with each of his parents. Child protection services appeared to form the view that was difficult and that his mother was doing her best with a challenging child. Mental health professionals considered that during early years his mother was incapable of love and that his behaviours were a result of his environment.

The Inquiry found that there were missed opportunities for assessment and intervention which could have altered trajectory. A thorough and holistic assessment, which included the historical information, could have led to a decrease in harm to throughout his life.

Cumulative harm legislation was introduced in 2007, five years before died in 2012, however opportunities to conduct a cumulative harm review were not acted upon.

A cumulative risk-of-harm approach could have highlighted the overall risk, and identified the pattern of rejection and failure of his mother to meet his needs. was repeatedly subjected to emotional harm and his behaviours were never adequately considered in the context of the harm he was experiencing.

References

Bagley, C & Tremblay, P (2000) Elevated rates of suicidal behaviour in Gay, Lesbian and Bisexual Youth. *Crisis, 21,* 3.

Barksdale, C, Walrath, C, Compton, J & Goldston, D (2008) Assessing the effects of peer suicide on youth suicide. *Suicide 7 Life – Threatening Behaviour, 39,* 2, 152 – 160.

Boyd, D, Ryan, J & Leavitt, A (2010) PRO-Self-Harm and the Visibility of Youth-Generated Problematic Content. *Journal of Law and Policy for the Information Society, 7 (1),* 1 -32.

Carey, A (2014) Rail staff to train in self-harm awareness. The Age, 9 June 2014.

Commission for Children and Young People Act 2012

Coombs, D W, Miller, H L, Alarcan, R et al (1992) Presuicide attempt communications between parasuicides and consulted caregivers. *Suicide and Life-threatening Behaviour, 22,* 289 – 302.

De Leo, D & Heller, T (2004) Who are the kids who self-harm? An Australian self-report school survey. *Medical Journal of Australia, 1818,* 3, 140 – 144.

Department of Human Services (2006) Next Steps: Victoria's suicide prevention forward action plan. A public statement, Victorian Government, Melbourne.

Erdely, S R (2012) One Town's War on Gay Teens, *Rolling Stone, 2 February 2012.*

Gough, D (2012) Suicide main cause of rail deaths. The Age, 1 November 2012.

Gregor, S (2004) Copycat suicide: The influence of the media. *InPsych, August.*

Hahn, W K & marks, L I (1996) Client Receptiveness to the Routine Assessment of Past Suicide Attempts. *Professional Psychology: Research Practice, 27 (6),* 592 – 594.

Headspace (2009) MythBuster: Suicidal Ideation, Orygen Youth Health Research Centre.

Headspace (2010) MythBuster: Sorting fact from fiction on self-harm, Orygen Youth Health Research Centre.

Liu, R (2006) 'Vulnerability to Friends' Suicide Influence: The Moderating Effects of Gender and Adolescent Depression. *Journal of Youth and Adolescence, 35,* 3, 479 – 489.

McGrath, H (2009) Young people and Technology: A review of the current literature (2nd edition) Alannah and Madeline Foundation.

McKelvey, R S, Davies, L C, Pfaff, J J et al (1998) psychological distress and suicidal ideation among 15-24 year olds presenting to general practice: a pilot study. *Aust NZ J Psychiatry, 32,* 344 - 348.

Meltzer, H, Harrington, R, Goodman, R & Jenkins, R (2001) Chidlren and adolescents who try to harm, hurt or kill themselves: A report of further analysis of the national survey of the mental health of children and adolescents in Great Britain in 1999. Office for National Statistics, London.

Mental Health Foundation (2006) Truth Hurts: Report of the National Inquiry into Self-harm among Young People. Cameron Foundation.

Metcalf, A & Stephens-Reicher, J (2010) ReachOut.com user profiling insights 2010, report for Inspire Foundation, Sydney.

Michel, K (2000) Suicide prevention and primary care. In K Hawton and K van Heeringen (Eds.) International handbook of suicide and attempted suicide. Chichester, England: Wiley, 661 - 674.

Office of the Child Safety Commissioner (2010) Submission to Protection from discrimination on the basis of sexual orientation and sex and/or gender identity Consultation. Office of the Child Safety Commissioner.

Olson, R (2013) Suicide Contagion & Suicide Clusters. *Infoxchange 10,* Centre for Suicide Prevention.

Orygen Youth Health (Website accessed 27.05.14) Self Harm, Orygen Youth Health.

OUTthere (2010) Submission to Protection from discrimination on the basis of sexual orientation and sex and/or gender identity Consultation. Rural Victorian Youth Council for Sexual Diversity.

Pirkis, J (2010) Suicide and the news and information media. A Critical Review. Hunter Institute of Mental Health, Newcastle.

Queensland Commission for Children and Young People and Child Guardian (2009) Reducing Youth suicide in Queensland Discussion Paper, Commission for Children and Young People and Child Guardian, Brisbane.

SANE (2010) Self-harm fact Sheet, SANE Australia.

SANE (2013) Suicidal behaviour Fact Sheet, SANE Australia.

Stack, S (2003) Media coverage as a risk factor in suicide. *Journal of Epidemiology and Community Health, 57,* 238 - 240.

Stark, J (2014) Safe Schools program, chaplaincy scheme don't mix: experts. The Age, 8 June 2014.

Suicide Prevention Australia (2009) Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities Position Statement. Leichhardt, Sydney.

Suicide Prevention Australia (2010) Youth Suicide Prevention Draft Position Statement, Leichhardt, Sydney.

Urbis Keys Young (2002) National review of the tele counselling and web counselling services. Department of Health and Ageing, Canberra.

Victorian Aboriginal Affairs Report (2013) Victorian Government, Melbourne.
Victorian Aboriginal Suicide Prevention and Response Action Plan 2010-2015 (2010) Department of Health, Victorian Government, Melbourne.

Victorian Aboriginal Suicide prevention and Response Action Plan 2010 – 2015 (2010) Department of Health, Melbourne.

Victorian Auditor General (2014) Accessibility of Mainstream Services for Aboriginal Victorians. Victorian Government, Melbourne.

Victorian Child Death Review Committee (2013) Annual report of inquiries into the deaths of children known to Child Protection. Commission for children and Young People, Melbourne.

Working with Children Act 2005

Writing Themselves In (2010) The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people. Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.

Young and Well Cooperative Research Centre (2014) Growing Up Queer: Issues Facing Young Australian Who Are Gender Variant and Sexuality Diverse, Young and Well CRC, Melbourne.

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