ACT Government
Health

Ms Megan Mitchell
National Children's Commissioner
Australian Human Rights Commission

Dear Ms Mitchell

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

Thank you for the opportunity to make a submission to your examination into intentional self-harm and suicidal behaviour in children.

Please find attached a joint submission from ACT Health and the Education and Training Directorate. I apologise for its delay.

ACT Health looks forward to the findings from your examination.

Yours sincerely

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ACT Health response to the National Children's Commissioner's call for submissions examining intentional self-harm and suicidal behaviour in children

Introduction

ACT Health has prepared this submission in partnership with the Education and Training Directorate (ETD) and understands that the Community Services Directorate (CSD) will be making a separate submission. All Directorates welcome the Commissioner's examination of the important issues of intentional self-harm and suicide in children.

The ACT Government urges all levels of government to work collaboratively to understand the precipitants of intentional self-harm and suicide in children and to work across portfolio boundaries to address risk factors and enhance protective factors in order to reduce the incidence of intentional self-harm and suicide in children. This has been the approach taken in the ACT Governments suicide prevention strategy *Managing the Risk of Suicide: A Suicide Strategy for the ACT 2009-2014*, which has taken a whole of government, whole of community approach.

It needs to be recognised that intentional self-harm and suicide can be separate, but interrelated behaviours. That is, a child or young person may engage in intentional self-harming behaviours without the intent of suicide. Conversely, intentional self-harm may be a precursor, and is well recognised in the literature, as a risk factor for future completed suicide (Hawton & Harris, 2007). The remainder of this response provides comments against the call for submissions criteria, where the participating Directorates believe that they have particular expertise or are able to provide a unique perspective. Responses have not been provided to criteria where the Directorates feel that a literature review methodology would more appropriately address them.

1. **Why children and young people engage in intentional self-harm and suicidal behaviour.**
   n/a

2. **The incidence and factors contributing to contagion and clustering involving children and young people.**
   n/a

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

There are numerous reasons why children and young people are reluctant to seek help. These include fears about confidentiality; shame and stigma associated with self-harm and feeling suicidal; fear of being seen as 'crazy' or 'weird;' difficulties accessing care, including not knowing where and how to seek care; and the attitudes of parents. It also needs to be recognised that, for many young people, intentional self-harm is seen as a normal part of belonging, and even a 'rite of passage' or 'badge of honour'. Young people with this view do not see that they have a problem and, therefore, do not want help. Moreover, young people who experience feelings of shame and embarrassment about their self-harming behaviour often endeavour to hide it and thus also do not seek help.

For those who do want help, fears about perceived breach of confidentiality can be a significant problem. These fears can exist at several levels. The main areas of concern are that the young person not wanting their parents to know that they are seeking help and not wanting their peers to know that they are seeking help. There is a considerable stigma attached to help-seeking behaviours

associated with mental illness and distress. This stigma is a major deterrent to people seeking treatment for any mental disorder.

A General Practitioner (GP) will not be the first person that many young people go to for help, however those who may consider this option are likely to be put off by the fact that they may be going to their family GP and therefore concerned that the GP will talk to their parents.
It is possible that this concern may be ameliorated by the new 'super clinics', where the business model makes it less likely that the young person or their family has an established relationship with the GP. However, the lack of continuity of care, with there being no guarantee of seeing the same GP at the next visit, makes it difficult to provide care to these vulnerable young people. Young people may also face practical barriers in seeing a GP, including the need to have a Medicare card and to make a co-payment.

The prominence of community based services is also a deterrent for some young people. Staff within the ACT Health Child and Adolescent Mental Health Service (CAMHS) report that some young people tell them that the reason that they did not attend their appointment was because their peers would see them getting off the bus and walking over to the CAMHS offices. Some have described this as a 'walk of shame', as a lot of adolescents are aware that the particular building is the location for CAMHS. It is suggested that more anonymous services, perhaps within shopping centres may reduce this problem.

Long lag times between making a decision to seek help, or being referred to a service, and getting an appointment are also problematic. For instance, the wait time for an appointment at headspace ACT can be between eight and twelve weeks. For young people who are really struggling, this can seem like a lifetime. In addition, a lack of clear and defined information sources mean that 77 per cent of young people feel that they don't know who to turn to with questions about self-harm. This is a view that is shared by parents, teachers and GPs (Cello Group).

The attitudes and behaviours of parents and carers can also be a barrier to young people seeking help. Clinicians report that some parents are reluctant to seek help for their young person, or to encourage them to seek help, as they do not see self-harm as a serious problem, some view self-harm as something that happens to other people's children. Some parents feel that self–harm is associated with failed parenting and shame and some see self-harm as 'bad behaviour'. Some parents believe that talking with their children is important, but others would prefer someone else to have the conversation with their child.

Family dysfunction may be both a contributing factor towards intentional self-harm and suicidal ideation and a barrier to young people seeking help. Within the ACT, a lack of transport can also present a barrier to young people accessing help. There are additional barriers for young people from an Aboriginal and Torres Strait Islander background. A study by Price and Dalgleish (2013) identified the following barriers specific to Indigenous adolescents:

- fear of government intervention and being ostracised by the community; and
- intergenerational stigma and feelings of shame associated with help seeking particularly regarding mental illness.

Recommendations

It is necessary to run visible promotion campaigns that aim to reduce stigma and to education children and young people and their parents/carers about where and how and when to seek help. These need to be developed cautiously to ensure that they are evidence-based and thus do not cause harm.

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.**

Two significant issues impacting on the ability to collect comprehensive information about intentional self-harm are:

i. Technical data issues, including definitions; and
ii. The variety of people who may become aware of a young person's self-harming behaviour.

i. Technical data issues

Intentional self-harm occurs across a continuum but can be invisible in a clinical reporting context. Within the health setting, there are currently no nationally consistent guidelines or pathways for the diagnosis or recording of intentional self-harm presentations. The International Statistical Coding of Diseases (ICD) is used in hospitals and collects data about hospital presentations; however, there is no central data collection system to gather information about those who seek help in a community setting, via a GP, community support agency, youth centres, etc. Use of the ICD can also be problematic as there are different codes for mental health disorders, drug and alcohol disorders and intentional self-harm. Anecdotal review of data collected in the ACT suggests an inconsistent use of the ICD system. For example, an individual may present to the Emergency Department after an episode of intentional self-harm involving cutting. The wound may be sutured and the individual discharged. Technically both codes for suture and for intentional self-harm should be reported, but this may not always be the case. Clear definitions of exactly what constitutes intentional self-harm are required to assist accurate data recording and subsequent clinical responses.

ii. The variety of people who may become aware of a young person's self-harming behaviour

Clear and consistent mechanisms for the identification and reporting of intentional self-harm are required across all services. There are a myriad of specialist and general services that support families, children and young people, some of who may engage in intentional self-harm or have high suicide risk factors. The collection of accurate information from these services will be influenced by a variety of factors including: skill level of staff, recording processes within the agency, privacy and confidentiality concerns at an agency level, and the ethical stance of professionals (e.g. whether wanting to break the confidentiality of a young person). It may be beneficial for the Privacy Commissioner to provide direction to agencies on the keeping and sharing of confidential information to enable a workable, consistent mechanism for data collection. Similarly, professional ethical concerns would need to be addressed via collaboration with professional bodies and higher education providers.

Recommendation

It is necessary to have a whole of government response to the identification and reporting of intentional self-harm, suicidal ideation and attempts. Children and young people may present with self-harm, suicidal ideation and suicide attempts in a number of settings and those working with these young people struggle to know how to respond, without the additional need to report and track such behaviours. We suggest that consideration be given to how those working with this population can be better supported to respond to young people and mechanisms be developed to accurately identify and report the prevalence of self-harm, suicidal ideation and suicide attempts.

It is also recommended that attention be given to developing a nationally consistent pathway and guidelines for the diagnosis and recording of intentional self-harm. Once these guidelines have been developed, an online training package be developed to assist jurisdictions in the provision of training to all clinicians with diagnostic, referral, recording and coding responsibilities.

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.**

It is well recognised that the number of children and young people engaging in self-harming behaviours is under-reported.
Four primary reasons for this are:

i. The fact that many young people do not seek professional help;
ii. Young people perceive the need to ask for help as a sign of weakness and value self-reliance;
iii. A lack of consistent pathways for data collection; and
iv. Delays in the Coronial process.

i. Many young people who self-harm do not seek professional help

It is well recognised that the majority of young people who self-harm and those at risk of suicide do not seek any form of professional help. The vast majority of young people with these issues who do seek help, do so from informal sources. This was illustrated by an Australian study by De Leo and Heller (2004). The results of this study found that among a sample of school students (average age 15.4 years), less than half of those who had engaged in deliberate self-harm sought help. Of those who did seek help, 81% approached a friend for advice. The finding that young people prefer to seek help from informal sources has been replicated by many (See Curtis, 2010; Rickwood, Deane, Wilson, et al, 2005). Young people can prefer to use technological modalities for assistance. The internet is a frequent source of information and psychological help used by young people (Neal, Campbell, Williams, et al, 2011; Feng & Campbell, 2011; Mission Australia, 2011).

ii. Perceiving the need to ask for help as a sign of weakness and/or feeling of the need for self-reliance

Young people often report feeling that asking for help is an indication of weakness or that it is not socially acceptable among their peers. Others believe that their problems are not severe enough to warrant needing help (Curtis, 2010; Moskos, Olsen, Halbern, et al, 2007). Similarly, young people report that they feel they should be able to manage their problems themselves (Wilson, Deane, & Ciarrochi, 2005). There is a desire for self-reliance as they find their independence as young adults.

iii. A lack of consistent pathways for data collection

There are currently no nationally consistent guidelines or pathways for the diagnosis and recording of intentional self-harm presentations. The development and implementation of such guidelines in the first step in allowing the consistent collection of data that will allow for reporting to agencies such as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW).

iv. Delays in the Coronial process

Initiatives such as the National Coroners Information System (NCIS) have improved data collection regarding deaths by suicide. However, there can be long delays in cases being finalised and thus data being made available. The data adjustment processes that have been adopted by the ABS in recent years have improved the reporting deaths by suicide. However, discrepancies in data reported by

the ABS for Queensland and that collected through the Queensland Suicide Register indicate that there continues to be an underreporting in ABS data regarding suicide. ACT Health is unable to provide an explanation for this discrepancy but suggests that further consideration may need to be given to uniform data coding and collection mechanisms to identify sources of inconsistency and take steps to remedy any gaps. The stigma associated with suicide possible repercussions for families may lead some Coroners to be reluctant to give a finding of suicide, particularly where the deceased is from certain religious or cultural backgrounds that condemns suicide. The reluctance of Coroners to give a finding of suicide again results in an underreporting of suicide deaths among children and young people.

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

ACT Health strongly supports the establishment of a national child death and injury database. This would allow for the standardised collection of information concerning suicide in children and young people. The establishment of a national child death and injury database would enable the distribution of findings and possible learnings from the database.

Within the ACT Government, the Community Services Directorate (CSD) currently runs a Death Review Committee for Children and Young People. CSD will provide more detail about this committee and its impacts on the ACT in its submission.

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.

This section is divided into three sections. Firstly, theoretical underpinning deemed most effective in providing suitable interventions. Secondly, current services within the ACT which are working well and may potentially benefit from additional resources. Finally, existing gaps in services will be explored in more detail.

i. Theoretical underpinning

The type of programs and practices that target intentional self-harm and suicidal behaviours are influenced by the conceptualisation of why children and young people engage in these behaviours. The conceptualisation of intentional self-harm and suicide is most effectively viewed as essentially multi-faceted and ecological in nature, requiring an ecological approach. While there are intra-personal factors (genes, disposition, disability etc) that are likely to contribute to self-harming behaviours, using a medical model that does not address these factors is not sufficient.
An ecological understanding includes intra-personal factors as well as factors that include the family, peers, school, local community, society, and economic factors.

Adopting an ecological conceptualisation increases the sectors of the community that can be involved in prevention and thus increases the number and types of interventions available. For example, enhancing the ability to comprehensively address developmental trauma, which contributes significantly to the internal distress of children and young people, means that increasing family supports, both economic and therapeutic, needs to occur. This would also require a review of laws and practices that guide the care and protection of children and young people by appropriate agencies.

ii. Existing ACT Government Health and Education Services

Health Services

The Child and Adolescent Mental Health Service, within Mental Health, Justice Health, Alcohol and Other Drug Service, provides a comprehensive suite of tertiary mental health services for children and young people. One program of particular note is the Dialectical Behaviour Therapy (DBT) Program. This program is being delivered to adolescents aged 13 to 18 years experiencing serious emotional difficulties (or emotional dysregulation) and who display intentional self-harming and suicidal behaviours. The DBT program has four major treatment components: weekly individual therapy; weekly parent and adolescent psycho-education skills group; phone coaching between appointments to support skills use and family therapy as needed to resolve conflict using DBT skills.DBT also has a specific treatment target hierarchy which informs the content of individual sessions, this hierarchy is:

- decreasing life threatening behaviours such as suicide attempts and self harm;
- decreasing therapy interfering behaviours;
- decreasing behaviours that interfere with quality of life, and
- increasing behavioural skills.

DBT is the recommended evidence based practice for self harm and emotionally disregulated behaviours as per National Health and Medical Research Council (2012).

There are other ACT services such as headspace and The Junction Youth Health Service which provide psychological support for young people. Increasing the capacity of these existing services, rather than establishing further services to meet the needs of specific groups, would provide more effective support for all young people accessing services. Services could be expanded to provide:

- extensive outreach/mobile services to schools and/or community centres;
- extended hours so that young people can access services easily after school;
- sufficient resources to provide a timely service; and
- multidisciplinary and targeted services with case management support.

Education and Training Services

The School Youth Health Nurse program is a primary health care program providing early intervention services to young people attending school and their families. The program has been found successful in engaging young people, providing interim support and referral to treatment services. The School Youth Health Nurses also undertake health promotion activities to groups, classes and whole school projects. However, the service is not sufficiently resourced to provide a nurse in all schools or for sufficient time to meet the needs of the school community. In the ACT Youth Feasibility Study, young people in Canberra identified the School Youth Health Nurse program as one of two programs that effectively met their needs.

In addition to the School Youth Health Nurse program, the ACT Education and Training Directorate (EDT) provides a number of interventions. These are summarised as follows:

Universal interventions in education

- Social Emotional Learning programs (refer www.casel.org for an understanding of SEL) in which all students participate.
- The Australian Curriculum contains elements that develop the social and emotional skills of children and young people. http://www.australiancurriculum.edu.au/
- MindMatters/KidsMatter adopts a whole school approach to mental health and resilience building.
- Whole school training for teachers to respond to depressed, suicidal and self-harming students

- Strategies to enhance the connection/belonging to schools. A positive school climate is protective of student from disadvantaged backgrounds and those with mental health difficulties.

Selected interventions in education

- Anxiety and depression group programs (eg RAP and FRIENDS).
- Social skills group programs.
- Programs for groups of students developed by youth support workers and pastoral care co-ordinators.
- Good practice guides that provide direction to groups of specialist staff (eg School Psychologist GPG on Self Harm, Depression and Suicide).

Targeted interventions in education

- Access to specialist support staff (eg School psychologists, nurses). Processes to support practitioners eg Good Practice Guides.
- Referrals to support agencies for family support, counselling etc.

iii. Service Gaps

Much is known about the importance of the early years in the laying down of appropriate neural pathways as foundations for psychological health. In light of this, Health services have responded to the needs of the 0-2 year olds and their families. However, the need continues through the early primary school years where there is a significant gap in services for children and their families. Services in these years are sparse and acutely focussed. A need exists for an early intervention school based program for years P-6 that includes effective parenting support programs.

Psychosocial Education

An opportunity exists for the inclusion of psychosocial education/emotional intelligence development during the school years. Difficulties in delivering these programs at present include:

- Competition for curriculum space. These programs are considered a lower priority and are used to fill small timeslots, resulting in the program not being delivered in the manner and timeframe in which it was designed and tested.
- Existing programs tend to target at-risk small groups rather than a preventative measure for the whole cohort of students.

There is need for teaching staff to have a greater understanding of adolescent development, adolescent issues and emotional distress, as these factors may drive unsociable and oppositional behaviours. Secondary to this is the need for schools to develop psychologically supportive strategies for managing student discipline.

Recommendations

The Triple P Parenting program is an evidence based program that has been accessed by many families with reported high efficacy. This program could be modified to include information about intentional self-harm and suicide to assist parents in identifying and responding appropriately. Similarly, programs that support parents of adolescents, such as the Resourceful Adolescent Parent Program (RAP-P) could be promoted more prominently to encourage parent attendance. These actions could increase parent's knowledge about normal adolescent development, areas of particular challenge, and include self-harm and suicide.

Emotional regulation and related skills such as mindfulness and anger management have been proven to be addressed through programs such as DBT. Consideration could be given to developing programs that could be delivered in high schools and colleges to ensure that all young people develop these skills. Aligning the goals of such programs with the Australian curriculum would maximise uptake within schools and colleges.

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.

ACT Health does not have the expertise to comment on the effectiveness of a public education campaign of this type

However, in response to community feedback regarding the need for mental health and wellbeing campaigns, the ACT Government developed the *Let's Talk for Suicide Prevention* (Let's Talk) campaign.

The campaign commenced in 2010 and aims to:

- raise awareness about suicide and suicide prevention for residents of the ACT;
- provide information about where residents of the ACT can obtain assistance if they, or someone they know, is at risk of suicide; and
- reduce the stigma associated with suicide.

The overall message of the campaign is that it is 'OK to Talk' about suicide and suicide prevention. *Let's Talk* runs over the four weeks leading up to World Suicide Prevention day on 10 September.

The four sub-themes of the campaign are:

- It's OK to talk about suicide and feeling suicidal;
- You can help someone who is feeling suicidal;
- You can recognise the signs; and
- How to help a friend bereaved by suicide.

The 2013 campaign focused on suicide prevention amongst young people aged 15-25.
ACT Health and the ETD worked in partnership to:

- develop and disseminate information about risk and protective factors, warnings signs, how to support someone at risk of suicide and where to seek help for students, parents, teachers and school counsellors;

- host a public forum, where an eminent Australian researcher in the area of youth suicide prevention, Professor Leo De Leo provided information for parents and others who care for children.

Anecdotal feedback from those who attended the public forum and others working in the area of suicide prevention indicate that the campaign was well received. However, it has not been possible to formally evaluate the campaign's effectiveness. One of the barriers faced in delivering this type of campaign to students, parents and teachers was the concern from some schools that presenting information about suicide will 'plant the idea' and increase the likelihood that a young person may consider suicide. For example, some schools were unwilling to display posters and promotional material containing the word 'suicide'. Research, particularly with people who have experienced an episode of suicidal ideation, indicates that this fear is unfounded and discussing suicide does not lead to an increase in attempts (Commonwealth of Australia, 2005). This fear, although incorrect, is

common and therefore education campaigns aim to address such myths and provide information for parents, teachers and other caregivers about risk and protective factors, warning signs, how to speak to a young person who may be at risk along with information about where to seek help and support in times of need.

Recommendation

Further education is required for education gatekeepers, including teachers and parents about suicide risk factors and to dispel myths around suicide, including addressing the common belief that speaking about suicide may lead a young person to consider suicide.

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

Social media and intentional self-harm and/or suicide prevention can be described as a double edged sword. There are some positive and negative factors at play. On the upside, there are some educational websites available that provide children and young people with evidence based information about how to manage feelings related to intentional self-harm and suicide. Conversely there are also very dangerous sites that tell young people 'how to' self-harm or take your own life and openly encourage these types of behaviour.

ACT Health manages a Facebook page as one component of the *Let's Talk* campaign and has used Twitter to disseminate campaign messages. The ACT Government has been reluctant to expand the use of digital technologies and media in suicide prevention and responding to intentional self-harm and suicidal behaviour among children and young people for four primary reasons:

i. A lack of national guidance concerning safety and protocols for the use of digital technologies. The ACT Government has procedures and protocols in place governing the appropriate use of digital media. However, being a small jurisdiction, the ACT does not have the resources to independently undertake the research to develop protocols regarding the safe use of digital technologies to promote suicide prevention messages and welcomes the work being undertaken by the Hunter Institute for Mental Health and other organisations.
ii. Medical-legal concerns around ACT Health's ability to ensure the safety of the users of these ACT Health sites.
iii. Lac k of evidence regarding the efficacy of digital technologies in the prevention of self-harm and suicidal behaviour – As this is a new, and fast growing field, there has been limited evaluation of the effectiveness of some technologies, in particular mobile applications. A number of papers have been prepared describing the development and content of a wide range of mobile applications and social media. However, efficacy evaluations are scarce.
iv. A lack of resources to provide continuous monitoring and moderation of digital sites to ensure that inappropriate information is not posted.

Recommendation

We recommended that consideration be given to working with internet search engine providers to include a hyperlink to counselling and support services from any site that provides information about how to self-harm or end one's life.

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