NSW GOVERNMENT Health

INQ14/11

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

Dear Ms Mitchell

National Children's Commissioner's examination of self-harm and suicidal behaviour in children aged under 18 years.

Please accept the NSW Government's submission in relation to your examination of self-harm and suicidal behaviour in children aged under 18 years.

The Government's response is enclosed. I apologise for the delay in providing our response.

Yours sincerely

Dr Kerry Chant
Chief Health Officer and Deputy Secretary
Population and Public Health
23/6/14

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

Submission from NSW Government agencies

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

NSW Health – Mental Health and Drug and Alcohol Office

The Mental Health and Drug & Alcohol Office of the NSW Ministry of Health is aware that the Commissioner has consulted a number of internationally-recognised experts in the field in the process of this examination and therefore NSW Health has not compiled a comprehensive review of the scientific literature.

Although many risk associations have been identified, no direct "causes" of intentional self-harm or suicidal behaviour exist in the scientific sense.

Intentional self-harm

The self-harm literature is sometimes complicated by differing definitions. For example, Ougrin et al. (2012, p.37) noted that UK and European authors more typically use "self-harm" broadly, irrespective of the intent, in contrast to the USA, where "the usual approach is to distinguish between self-harm episodes with and without suicidal intent, the former referred to as suicide attempts and the latter as non-suicidal self-injury." For some young people, suicidal intent may be difficult to ascertain.

Not all young people who intentionally self-harm have contact with health services, so studies involving clinical samples may produce a different range of results from community-based samples.

The community-based Australian National Epidemiological Study of Self-Injury (Martin et al., 2010) found that non-suicidal self-injury peaked for females at 18-24 years but for males the peak was earlier at 10-17 years.

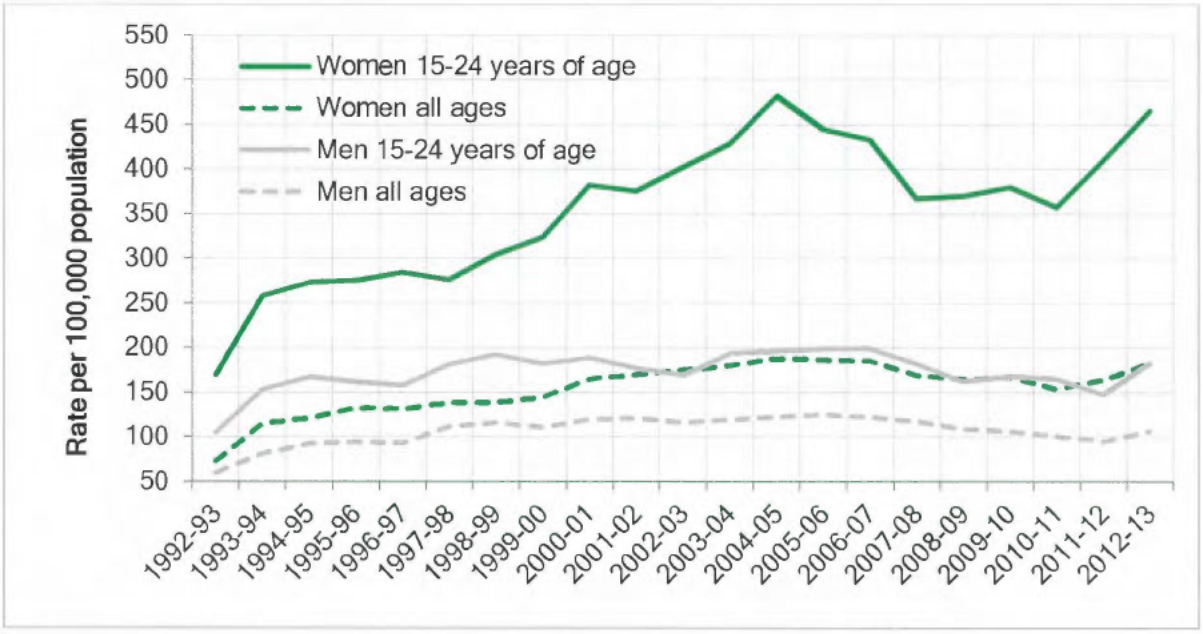
From an international perspective, Moran et al. (2012, p.236) noted that self-harm "is especially common in 15-24 year old women, a group in whom rates of serious self-harm seem to be rising".

The following extract from NSW Health Statistics describes patterns of youth hospitalisation for self-harm from 1989-90 to 2012-13.
http://www.healthstats.nsw.gov.au/Indicator/men_suihos/men_suihos?filter1ValueId=

> "The self-harm hospitalisation rate in females aged 15-24 years reached a peak in 2004-05 (488.5 per 100,000 population) and then declined to 2010-11 but has increased over the last two years to peak levels. In 2012-13 the rate of hospitalisation for self-harm in young women aged 15-24 years was 465.8 per 100,000 population (2.5 times higher than all females) compared to 182.8 in young men (1.7 times higher than in all males). There were 2,141 hospitalisations for self-harm in young women aged 15-24 years in 2012-13 (33% of the female total) and 903 for young men (24% of the male total)."

Young women living in inner regional areas of NSW had higher rates of intentional self-harm hospitalisations than women living in major cities (577 versus 429 per 100,000 of population, respectively).

Figure 1 Hospitalisation for intentional self-harm, 1992-1993 to 2012-2013



Population: People from NSW aged 15 years and over.

Data source: Centre for Epidemiology and Evidence. Health Statistics, NSW using data from the Admitted Patient Data Collection: NSW Ministry of Health.

A large population-based study that followed Victorian adolescents from year 9 in high school (aged 14-15 years) into young adulthood found that that most adolescent self-harming behaviour resolved spontaneously (Moran et al, 2012). In this study, approximately 8% of participants reported self-harm during the adolescent phase, with less than 1% reporting self-harm with suicidal intent during this period. Self-harming reduced substantially in late adolescence, with only 1% of the sample reporting self-harm in both the adolescent and young-adult phases of the study. This drop-off was most dramatic in young males with a greater continuity in self-harm in females.

These results do not mean that intentional self-harm should be ignored. On the contrary, intentional self-harm is associated with a range of other problems, which may benefit from treatment, and is also associated with increased risk for suicidal behaviour and death by suicide.

Identified factors associated with increased risk for intentional self-harm in children and young people include:

- various mental health problems such as disruptive behaviour disorders, post-traumatic stress and other anxiety disorders, mood disorders, emerging borderline personality disorders, eating disorders, psychosis;
- substance use;
- Aboriginality;
- a history of physical and/or sexual abuse or neglect;
- being in-care, in a secure institution or an asylum-seeker;

- recent stressful events such as relationship break-ups or disciplinary/legal crises;
- family factors such as family relationship difficulties, family history of self-harm, family history of mental health problems; and
- having peers who self-harm.

(See for example Martin et al., 2010; Ougrin et al., 2012)

It is well-recognised that intentional self-harm can be a means for responding to distress and some people do not feel pain but a sense of relief.

Self-injurious behaviours are also more common in children and young people with intellectual disabilities or communication disorders, especially some specific uncommon genetic conditions, such as Cornelia de Lange syndrome.

Suicidal behaviour

Suicidal behaviour is reported as also more common in gay, lesbian and bisexual young people (e.g., Fergusson et al., 1999); in young people treated with antidepressants; or in boys taking the ADHD medication, atomoxetine (Matheson et al., personal communication, 2014). Although the evidence is not specifically for children and adolescents, the week following discharge from hospital is associated with increased risk of repeated self-harm and suicidal behaviour.

The publication of a Swedish study (Isacsson and Ahlner, 2014) has recently added complexity to earlier findings of increased suicidal behaviour in young people prescribed antidepressants by suggesting that the introduction of warnings about antidepressant medication and suicidal behaviour were associated with an increase in deaths by suicide. The authors hypothesised that young people may have avoided treatment for depression, contributing to increased suicide deaths.

The most recent NSW Child Death Review Team Annual Report recorded that 16 of the deaths of young people aged less than 18 years registered in 2012 were due to suicide or probable suicide. These deaths are grouped together as suicide in the report.

The NSW child death register includes 245 suicides over the 15 years from 1998 to 2012 and the team's assessment was that there has been no apparent change in the suicide rate in this age-group over recent years.

https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0005/12389/CDRT_Annual_Report_2012_web.pdf

The Australian Bureau of Statistics Causes of Death report records intentional self-harm as the cause of death for 75 young people (48 males and 28 females) aged 15-24 years in NSW in 2012. http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02012?OpenDocument

Department of Family and Community Services (FACS)

It is recommended that the National Children's Commissioner Report particularly explore the relationship between domestic violence and self-harm and suicide.

FACS' understanding is that self-harm is often used to try and control difficult and overwhelming feelings or to gain some kind of relief from emotional pain. It may also be used to express anger, to feel 'something' (if you're feeling numb) or to communicate a need for help. People who self-harm may have been experiencing a range of problems such as difficulty getting along with family members or friends, feeling isolated or bullied by someone, a relationship breakup, current or past physical, sexual or emotional abuse or neglect, loss of someone close such as a parent, sibling or friend and/or serious or ongoing illness or physical pain.

Children and young people may engage in self-harm as a way to help manage distress whereas suicide attempts to stop distress by ending life. Young people self-harm or contemplate suicide for many reasons and every individual's motivation will be different. Young people hurt themselves in many different ways and many of these may be completely invisible to those around them. An important factor in understanding an act of self-harm is to establish the underlying intent but most terms do not distinguish among acts where the individual has a fixed determination to die, where there is ambivalence about survival and where self-harm is a way of regulating negative emotions.

Children in care and care leavers are at increased risk of hurting themselves as a result of adverse backgrounds and continuing stress and trauma. Although there is extensive research on self-harm and suicide, very little focuses specifically on children in care and care leavers

In their review of adolescent suicide and self-harm, Hawton et al. (2012) identified three groups of young people who may go on to complete suicide: those whose previous life problems and developmental difficulties have placed them at risk; those living with what would be categorised as major mental disorders; and those for whom suicidal behaviour is a response to a more immediate stressor. The backgrounds, mental and emotional difficulties and current life experiences of many children in care and care leavers, mean that they could fit in to one or all of these groups.

In 2010, the Australian Medical Journal of Australia reported victims of child sexual abuse are at increased risk of suicide later in life. Experiences of domestic violence within the family and sexual assault are believed to be key drivers of self-harm amongst children. It is not known how many suicides in NSW are a result of the psychological effect of trauma experienced as a result of domestic and family violence and sexual assault.

FACS recommends that the project team preparing the National Children's Commissioner's 2014 Statutory Report to Parliament seek to identify and document the prevalence of child self-harm and suicide where the experience of domestic and family violence in the family, and experiences of sexual assault are key drivers.

The NSW Annual Child Death Report (2012) identifies a clear link between violent, coercive and controlling behaviour towards an adult member of the household (usually the mother) and risks to the children. Ten children known to Community Services died from suspected suicide in 2012. This is the highest number of deaths by suicide in the last five years. The cases examined within the Report illustrate the multiple risks associated with domestic violence. Family relationships are a significant driver of children and young people's mental health. The 2012 Report findings also highlight how risk for children who experienced domestic violence was often compounded by higher levels of other co-existing abuse types such as emotional abuse, physical abuse, sexual abuse and physical neglect. The co-existence of these abuses is critical in our understanding of the psychological impact of violence on children. FACS will soon commence a cohort review that focuses on vulnerable adolescents, suicide and risk taking behaviour.

FACS requests that the National Children's Commissioner's 2014 Statutory Report work with FACS, to explore the impact of domestic and family violence and child sexual abuse on children and young people's mental health (including self-harm and suicide).

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

NSW Health - Mental Health and Drug and Alcohol Office

The "Werther effect" (named after Goethe's fictional character, Werther) of an increase in imitative suicides after actual or fictional portrayals of suicide is an enduring hypothesis supported by some evidence (e.g. Schmidtke and Häfner, 1988).

The NSW Child Death Review team's 10-year summary report of deaths from 1996-2005 found that in 1997, there was "an exceptionally high suicide rate, with evidence of a high level of contagion" (2008, p.173). Although the team acknowledged that contagion is difficult to determine unless the young person had told someone about their motivation, over the 10 year period, the team assessed that contagion was evident in the deaths of 22 children and young people (11% of the suicides) and possibly implicated in a further 17 deaths. Of the contagion episodes, 20 of the 22 young people had a personal relationship with another individual who had died by suicide. In only two instances was the "primary suicide" not directly known to the young person whose suicide had followed.

A recent pilot study by Professor Philip Hazell from the University of Sydney and colleagues (personal communication, 2014) suggests that friends of adolescents who self-harm also have higher rates of self-harm and mental health problems. The likely mechanism appears to be through "assortive friendships" rather than propagating the new onset of behaviours and problems.

Department Of Education and Communities (DEC)

There are a number of studies of contagion effects for suicide and self-harm. Young people who self-harm do so for many reasons. Not all young people who self-harm do so because they wish to die. Research identifies:

- potential risk factors include male gender, being an adolescent or young adult, drug or alcohol abuse, and past history of self-harm
- far more adolescents who self-harm have friends who engaged in self-harm in the same period
- the association between engaging in self-harm and exposure to self-harm amongst peers is largely confined to girls who self-harm
- an increase in suicidal behaviour by family members is positively associated with suicidal behaviour among adolescents
- social modelling/learning of self-harm may increase risk of initial engagement in self-harm among individuals with certain individual and/or psychiatric characteristics
- important contributors to self-harm and suicide include genetic vulnerability and psychiatric, psychological, familial, social, and cultural factors.

It is important to note that a range of behaviours and motivations (including ambiguous motivations) are captured by the terms 'intentional self-harm' and 'suicidal behaviour' and that this confounds agreement on the reasons why children and young people may engage in this type of behaviour. Whitlock J (2010) *Self-Injurious Behavior in Adolescents*: PLoS Med 7(5): e1000240. doi:10.1371/journal.pmed.1000240 (http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000240) provides a useful summary of the issues including prevalence, motivating factors, relationship with suicide, 'contagion', prevention and treatment.

Research on suicidal behaviour in young people has shown that a student's attempted, completed or suspected suicide can contribute to an increased risk of suicide in other vulnerable members of the school community, including other students.

Following a suicide those at increased risk include young people who:

- have a past history of suicidal behaviour - a previous suicide attempt is considered to be the strongest predictor of future suicide attempt or suicide
- were close friends or family members of the person who died
- are dealing with significant life stressors including relationship difficulties with family, friends or partners
- misuse substances
- have a mental illness

- argued with the person before they died
- witnessed the death.

All public schools in NSW have emergency management plans which address all potential emergencies, including suicide. The plans outline how prevention, response and recovery activities will be coordinated within each school. School counsellors work closely with principals to implement a well-planned approach, which includes recognising and addressing the potential for contagion. Identifying, assessing, supporting and referring students identified at risk is an essential component of a school's work. Where the need for additional support is identified, schools work in partnership with other agencies including the NSW Ministry of Health and Headspace, a National Youth Mental Health Foundation Ltd which provides young people aged 12-25 with mental health and counselling support.

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

NSW Health - NSW Kids and Families

Young people face significant barriers in accessing primary health care including concerns about: confidentiality of health information, cost of services and treatments, convenience of access and fear of judgement by health professionals and reception staff. Inexperience with independently seeking help, previous negative experiences accessing services, and limited appointment times outside school or work hours further impact on young people's access to appropriate services.

GPs and other community based services are well placed to respond to young people's complex health problems by providing comprehensive health care, and acting as a first point of call in the problem identification, treatment, follow up and referral GPs are also in an ideal position within a youth friendly framework, to provide support, advice or referral for parents of young people who are looking for guidance in parenting their adolescents. Health professionals need to be better trained and more competent in youth health issues, including their ability to engage young people, and be familiar with common issues.

NSW Health – Mental Health and Drug and Alcohol Office

Martin et al (2010) found that only a small percentage of those who self-injure seek care.
A key priority in the UK National Institute of Health and Care Excellence guidelines on the initial management of self-harm is "people who have self-harmed should be treated with the same care, respect and privacy as any patient." (NICE, 2004, p.4)
The NICE Guidelines draw attention to the need to deliver compassionate, non-judgmental responses. The literature in this field highlights that punitive responses and delays in follow-up may deter young people and families from engaging in treatment.

Young people with emerging borderline personality disorder commonly resort to repeated self-harm and they are also a group with increased risk for suicidal behaviour. Through education and consultation, NSW Health's Project Air adolescent extension, recently delivered in partnership with the University of Wollongong, has supported mental health services across NSW to better understand and provide more compassionate and effective responses to young people with emerging borderline personality disorders and their families.
http://ihmri.uow.edu.au/projectairstrategy/index.html

NSW Health acknowledges the need to continue to enhance community-based specialist Child and Adolescent Mental Health Services (CAMHS). The 2011/12 NSW budget included

recurrent funding of $3.4 million for Assertive Community CAMHS pilots in Nepean/Blue Mountains, Northern Sydney and Southern NSW Local Health Districts. These pilot teams improve access to specialist CAMHS and provide services to young people and their families during the phase when their mental health problems require a more assertive community-based outreach response. An external evaluation by the Social Policy Research Centre of the University of NSW is in progress.

Department Of Education and Communities (DEC)

The barriers which prevent children and young people from seeking help may include:

- poor mental health literacy (limited knowledge or misguided beliefs about mental disorders which aid their recognition, management or prevention)
- a preference for self-reliance - some young people view seeking help as a weakness and of not being capable of dealing with life's problems
- confidentiality and trust - some young people fear that confidentiality will be breached and they report a distrust of service providers, some young people also see providers as judgemental and they have difficulty trusting people they don't know
- sense of hopelessness - a strong perception of hopelessness has a strong correlation with a reluctance to seek help
- the stigma attached to discussing their suicidal thoughts or behaviour.

For some young people from a culturally and linguistically diverse background, the research shows:

- they may have a lower rate of health service utilisation
- they may be more likely than those from an English speaking background to report having no support structures available
- in regional areas, they may have difficulty finding and accessing services that are culturally appropriate, including access to translating and interpreting services
- they may decide to not seek help in the future due to negative experiences such as cultural insensitivity or a failure to find an appropriate service for their needs.

Despite having the lowest rate of Aboriginal suicide of any state in Australia, Aboriginal people in NSW are still significantly over-represented in statistics relating to suicide and self-harm. Notwithstanding this, there is a strong view that self-harm is likely to go unreported by many Aboriginal people, who are less willing to seek help, or to be encouraged and supported by others to seek help, than is the case for non-Aboriginal people. In addition, statistics on suicide and self-harm need to be treated with caution as there has been, and continues to be, significant under-identification of Aboriginal people in hospitalisation data in NSW. As such, the true extent of self-harm and suicide in Aboriginal communities is likely to be understated.

Some of the barriers that may impact on Aboriginal children and young people seeking help are:

- mistrust of institutions and government service providers
- service and service provision is not responsive to the local cultural context and/or there is a lack of Aboriginal cultural awareness by staff
- limited number of Aboriginal staff in government funded, non-government organisations, especially in rural and remote areas
- access impacted by systems such as forms, protocols that do not recognise or value Aboriginal English speakers and limited understanding of the narrative style of communication

- the 'shame' factor – young people not wanting to be seen to access services, especially when living in rural and remote areas
- services with a gender imbalance of staff - young Aboriginal males are unlikely to discuss men's business with women and vice versa
- often the young person will not seek help from services due to a fear of family members being removed by authorities
- lack of transport and financial independence to seek out support services, including medical and/or those to support the mental health and wellbeing of the young person.

For young people with disability and in particular those with co-morbid intellectual disability and mental health problems, barriers may result from an inability of the individual to recognise or describe symptoms or access support including through their families and other professionals, including mental health services.

The Personal Development, Health and Physical Education curriculum plays an important role in educating students about identifying barriers and developing strategies to seek help, information and support to address the health needs of young people.

In NSW public schools, the Personal Development, Health and Physical Education (PDHPE) key learning area is mandatory for all students from Kindergarten to Year 10. To enhance their ability to manage the opportunities and challenges they may experience in their lives, students:

- explore the notion of connectedness
- identify and apply interpersonal communication skills
- develop and practice help-seeking skills
- recognise and manage the barriers to accessing support.

In secondary school, students learn about responding to, coping with and predicting future challenges that may face young people. Students learn to devise help seeking strategies to minimise harm and describe ways they could give support to others; develop the skills to establish support networks of adults and peers; identify health information, products and services designed to address the health needs of young people.

The Commission for Children and Young People is currently undertaking research in partnership with the NSW Mental Health Commission looking into the factors that promote and hinder young people seeking adult help on behalf of their friends with mental health problems. This work is likely to provide insights that would be of use to the National Commissioner's Inquiry. The results are expected to be published in July or August 2014.

Department of Family and Community Services (FACS)

In the available timeframe, FACS has not been able to provide a comprehensive response. However, as this issue is of key interest to FACS, the Department would like the opportunity to provide further and ongoing input to the project team preparing the National Children's Commissioner's 2014 Statutory Report to Parliament.

A select list of FACS programs and services that assist in overcoming barriers to seeking help is contained in the Addendum to this response.

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.

NSW Health – Mental Health and Drug and Alcohol Office

Although the suicide of any young person is a devastating and tragic event, low (from a statistical point of view) suicide base-rates create methodological difficulties in conducting scientifically valid studies. Unfortunately, large numbers are needed to draw conclusions and make recommendations. To this end, the work of the NSW Child Death Review Team is helpful in examining in some detail the deaths of young people over several years.

The involvement of a child and adolescent psychiatrist on the Child Death Review Team has previously provided a valuable contribution to the review process and is recommended by NSW Health.

Department of Family and Community Services (FACS)

The previously mentioned NSW Government Annual Child Death Report 2012 explored the interaction between domestic violence homicides and child custody issues. The Report found that in the 16 case studies reviewed, child custody was a key and recurring theme. Whilst the Report did not explore suicide of children and young people, it did commit that the next Report would look into developing case review and data collection protocols to examine the relationship between suicide and experiences of domestic violence.

FACS recommends that the project team preparing the National Children's Commissioner's 2014 Statutory Report to Parliament work with the NSW Domestic Violence Death Review Team to explore the connection between child suicide and domestic violence, and identify strategies for improving the documentation of accurate rates of suicide where domestic violence and/or sexual assault form part of the case history.

Furthermore, the NSW Child Development Study could provide useful data to inform policy, programs and practice. Commencing in 2009, the NSW Child Development Study has been designed as a 15-20 year longitudinal project following the development of more than 80,000 children across NSW into adulthood. The study aims to identify potential parental and environmental factors that contribute to vulnerability and resilience in childhood that may be useful predictors of mental health and wellbeing in adolescence and young adulthood. Whilst this study does not involve the systematic collection of data, the findings will help to inform the development of preventive intervention policies and programs for children, young people and young adults.

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

NSW Health - NSW Kids and Families

Data recording is complex and as noted previously differing definitions and study methodologies can complicate comparisons. For example a young person presenting to an Emergency Department for an injured hand, or an alcohol related condition will not necessarily be recorded as someone who has engaged in intentional self-harming behaviour.

It may be possible to support greater reliability of this data through clearer guidelines on what needs to be captured through the data collection systems. Training and education of staff on how to identify the young people who are at risk or who are self -harming (eg through

undertaking a "Home, Education, Employment, Activity, Drugs, Sexuality, Safety, Spirituality" risk assessment, known as a HEEADSSS assessment) may also assist this.

In addition investigation could take place on indicators associated with self-harming (such as substance use) to establish whether there are any proxy measures associated with young people's health and wellbeing that could be used to assess progress with reducing the likelihood of intentional self-harming behaviour.

Department Of Education and Communities (DEC)

The Australian Institute of Health and Welfare (AIHW) report *Serious childhood injury in New South Wales 2009-10* (the Report), commissioned by the Commission for Children and Young People (CCYP), is an important source of data on young people aged 0-17 who were hospitalised as a result of injury. The Report discusses some of the limitations and impediments to useful and accurate data collection.

The Report notes that there were 851 cases of children and young people aged 0-17 hospitalised due to intentional self-harm in 2009-10. Of these 77% were due to poisoning (commonly available pharmaceuticals were the main poisoning agent), 16% were due to intentional self-harm by sharp object and 3% were due to hanging, strangulation and suffocation. The Report also provides information on trends, mechanism, place, activity at time of injury and season.

The Report notes that determining whether an injury was due to intentional self-harm is not always straightforward. Cases may appear to be intentional self-harm, but inconclusiveness of the available information may preclude them from being coded as such. In such cases they may be coded as an 'undetermined intent' category.

The Report also notes that some patients may be unwilling or unable to disclose that injuries resulted from self-harm or feel ambiguous about their motivation. In very young children, intent may be difficult to ascertain and involve a parent or caregiver's perception of the intent. The Report notes that the ability to form an intention to inflict self-harm and to understand the implications of doing so requires a degree of maturation that is absent in infancy on early childhood. The age at which self-inflicted acts can be interpreted as intentional self-harm is the subject of debate. Such sources of uncertainty about the assignment of intent limit the certainty of estimates of intentional self-harm based on routine hospital data.

The issues discussed in the Report highlight the difficulties involved in collecting comprehensive information to accurately identify and gather information about intentional self-harm and suicidal behaviour in children and young people, and in turn for developing evidence-based recommendations for reform. Much of the self-harming behaviour among children and young people will not result in contact with hospitals or medical services and this poses further challenges for accurate identification and recording of prevalence, incidence, motivating factors, prevention and treatment.

The Report is available from the AIHW (http://www.aihw.gov.au/publication-detail/?id=60129542513) and CCYP (http://www.kids.nsw.gov.au/Publications---resources/Research-publications/Index-of-publications) websites.

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

NSW Health – Mental Health and Drug and Alcohol Office

In principle this is supported as larger data sets provide greater opportunities for examining trends, identifying patterns and for more rigorously evaluating the impact of interventions.

Department of Family and Community Services (FACS)

This is a complex and important issue. In the available timeframe, FACS has not been able to provide a comprehensive response. However, as this issue is of key interest to FACS, the Department would like the opportunity to provide further and ongoing input to the project team preparing the National Children's Commissioner's 2014 Statutory Report to Parliament.

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 sexuality diverse, those from culturally diverse backgrounds, those living with disabilities, and refugee children and young people seeking asylum. De-identified case studies are welcome.

NSW Health - NSW Kids and Families

As well as community based responses to the needs of these children and young people it is important to consider the tertiary response. Professionals working in paediatric health settings report that they are seeing a growing number of children and young people with this behaviour. Although self-harm is mostly under the auspice of Mental Health teams many children and young people require services from Paediatric Emergency and Paediatric inpatients. This impacts bed availability, staffing as well as the patient/ family needs and access to CAMHS services.

Care of young people with self-harm issues is complex because it requires a different skill set to other age groups in paediatrics, and not all staff have these skills. There is less opportunity for staff to develop the skills as young people are a smaller population within the larger paediatric group. MH-Children and Young People and NSW Kids and Families are planning to develop some resources on mental health for paediatric staff to assist with this issue.

Issues for older adolescents and young adults who require hospitalisation can also be complex. Placement of some young people in adult wards may not provide the level and type of care they require as there are often multiple complex problems that may need involvement of multiple disciplines of staff.

In terms of young people who are gender variant and sexuality diverse, a stronger response is needed to ensure that schools and other youth and health services are inclusive and safe. Initiatives such as the Safe Schools program as well as targeted professional and peer support programs can assist with reducing isolation and distress for these young people.

Support and education programs for parents of children and teenagers are also an important strategy for responding to these issues. NSW Kids and Families has recently worked with the Raising Children's Network to develop web based resources to help parents and practitioners communicate with teens, in particular those with emotional and social health concerns (see http://raisingchildren.net.au/)

NSW Health – Mental Health and Drug and Alcohol Office

The *NSW Suicide Prevention Strategy 2010-2015* (NSW Department of Health, 2010) focuses on all age groups and promotes a whole of community response. The Strategy supports (p.23):

- better informed Government policy and evidence based decision making including across portfolios not directly involved in suicide prevention;
- more dynamic sharing of information and best practice across the community and service providers to stimulate increased innovation and expertise;
- increased and more effective partnerships and networks across government and across the community with a shared approach to suicide prevention;
- greater community discussion on and participation in suicide prevention action and building resilience;
- better responses to at risk individuals and communities, including culturally relevant responses;
- better understanding of, and approaches to suicide bereavement;
- more responsive workplaces and better targeting of support for at risk workers.

The NSW Mental Health Commission oversees implementation of the Strategy.

NSW Health is currently reviewing and updating the policy directive on assessment and management of suicidal behaviour for people of all ages. The aim of the policy review is to ensure the provision of best practice clinical management for consumers presenting with possible suicidal behaviour to or within NSW public health services.

Follow-up within seven days of acute inpatient care is now a National Mental Health Key Performance Indicator for mental health consumers across the lifespan.

A recent systematic review (Robinson et al, 2010) found that the evidence for effective interventions for young people who present to clinical services with self-harm or suicidal behaviours was limited. They concluded that individual Cognitive Behaviour Therapy-based interventions appear to show promise and attachment-based family therapy is "certainly worth subjecting to further investigation in a high quality randomized controlled trial (p.25).

The UK National Institute for Health and Clinical Excellence (NICE) has a rigorous methodology for developing clinical guidelines. Although there is not strong evidence for specific interventions for self-harm in adolescents, the NICE guidelines on self-harm recommend the provision of evidence-informed interventions for associated conditions, including alcohol and other drug problems (NICE, 2011 and 2013).

The adolescent extension to Project AIR and the Assertive Community CAMHS teams have already been noted above. Other relevant mental health initiatives include School-Link, Getting on Track in Time (*Got It!)* and Whole Family Teams.

School-Link is a long-established formal partnership between the NSW Ministry of Health (MoH) and the Department of Education and Communities. School-Link is a statewide initiative and supports schools in the early identification of mental health problems in their students and facilitates early access to specialist mental health services. The NSW MoH provides funding of $1.9 million per annum to Local Health Districts and Specialty Networks for School-Link Coordinator positions across the state. These Coordinators work closely with school and TAFE counsellors as well as mental health services to facilitate the mental health and wellbeing of these young people and families.

Two innovative components have recently been added to strengthen the long-standing School-Link partnership. These are the statewide delivery of FRIENDS training and the development of an animated film to support teachers.

The FRIENDS programs are evidence-informed prevention and early intervention programs for mental health problems such as depression and anxiety. The FRIENDS programs include Fun FRIENDS, which is designed for children 4-7 years; FRIENDS For Life, for children 8-11 years; My FRIENDS for adolescents 12-15 years; and Adult Resilience for young people 16-18 years.

Fun FRIENDS has already been successfully implemented by Child and Adolescent Mental Health Service (CAMHS) clinicians and Department of Education and Communities (DEC) staff in NSW schools as part of the *Got it!* pilot program.

Through School-Link, more metropolitan and rural CAMHS clinicians and DEC School Counsellors have been equipped with the skills and training to deliver the FRIENDS programs in schools across NSW.

To complement the earlier School-Link focus on school counsellors, NSW Health is commissioning development of a short animated film for teachers to strengthen workforce competency for teachers in identifying mental health problems and assisting children, young people and their families to access appropriate professional help. The film will highlight to teachers the benefits of identifying mental health issues early and facilitating access to appropriate help.

As previously noted, abuse, neglect, parental mental health problems and disruptive behaviours are associated with increased risk for self-harm and suicidal behaviour, especially when young people have multiple risk exposures.

The NSW Keep Them Safe child protection response included $28 million over 5 years, beginning in 2009/10, to pilot 4 joint mental health and drug and alcohol Whole Family Teams. Whole Family Teams have been established in Lismore, Newcastle, Gosford and Nowra. These teams respond to the needs of families where there are child protection concerns and carers have mental health and/or drug and alcohol problems, as well as parenting difficulties and evaluation to date has been positive.

Getting on Track in Time – *Got It!* is the other mental health initiative funded through Keep Them Safe. $10 million was provided over 4 years from 2010/11. Got It! is a school-based clinical early intervention service targeting children in Kindergarten to Year 2 with disruptive behaviour problems and their families. The service model for this initiative was informed by the successful CAMHS and Schools Early Action (CASEA) program in Victoria. Got It! is delivered by CAMHS clinicians in partnership with the Department of Education and Communities. Pilots are located in Mt Druitt, Dubbo and Newcastle. Early observations and reports have been extremely positive with good uptake and high acceptability amongst both schools and parents. There is evidence of improved functioning and resiliency in children, improved parental functioning, increased help seeking by parents and greater connectedness between parents and schools.

NSW Health has recently provided intensive state-wide training for NSW CAMHS clinicians in Trauma Focused Cognitive Behavioural Therapy (TF-CBT) from Dr Laura Murray, an international trainer affiliated with the developers of TF-CBT. The training was an extension of earlier training in 2012 in response to the need to improve evidence-based mental health service delivery to children and adolescents who have mental health problems related to abuse, neglect and other trauma.

Department Of Education and Communities (DEC)

Every student who attends a public school in NSW has access to a school counsellor.

School counsellors are key members of the learning and support team and are able to provide psychological services, expert advice and professional learning in the area of mental health.

School counsellors are trained in the process of assessing, supporting and intervening with students with mental health problems who may be at risk of suicide and self-harm.

The learning and support team plans in conjunction with class teachers how to best help students with additional learning and supports needs in the school. Any student in the school can be referred to the team, who considers all available information relating to the specific learning and support needs of the student.

The role of the teacher, supported by the school's learning and support team, is to identify through assessment and the collection of data, each individual student's learning needs and to determine the right assistance for each student, in consultation with the student and/or their parents and carers and other professionals as needed.

The Department of Education and Communities provides an extensive range of services and programs in regular and special schools that support students with disability including those with a mental health disorder and/or who may be at risk of self-harm or suicide.

The Department has a range of policies that support schools and their communities to provide inclusive, safe and secure learning environments that are free from bullying, harassment, intimidation and victimisation. Both the *Bullying: Preventing and Responding to Student Bullying in Schools Policy* and the *Student Discipline in Government Schools Policy* support schools to work with their school communities to maintain a positive school climate of respectful relationships and to develop early intervention strategies to support students who are identified as being at risk of harm.

The NSW School-Link Initiative

As noted above a Memorandum of Understanding between the NSW Department of Education and Communities and the NSW Ministry of Health provides a framework for a collaborative approach to improving the mental health of children and young people in NSW through *School-Link*. The framework facilitates the interaction between the Department of Education and Communities and the NSW Ministry of Health on a number of issues, including:

- roles and responsibilities of the two departments in meeting the mental health needs of children
- issues relevant to the management of children and young people with mental health problems and the provision of shared care and collaborative support to students with mental health problems
- the development and delivery of mental health prevention, promotion and early intervention programs for children and young people.

School-Link aims to ensure:

- the early identification of mental health issues for children and young people
- the provision of evidence based early intervention programs in schools
- early access to specialist mental health services and support for recovery.

Through the School-Link Initiative, school counsellors receive training in recognising and responding to a range of significant mental health issues affecting students, including self-harm and suicide. A series of modules have been developed and are a resource for mental health workers and school and TAFE counsellors to enhance skills in the recognition, intervention, planning, treatment, support and prevention of mental health problems in children and young people by improving clinician's knowledge and skills and enhancing interagency collaboration.

The modules are:

1. Assessment and formulation of mental disorders in young people
2. Depression in adolescents
3. Anxiety in children and young people
4. Self-harm in adolescents
5. Co-existing mental disorders and substance use problems in young people
6. Mental health and wellbeing in Aboriginal young people
7. Mental health and wellbeing in same sex attracted young people
8. Mental health and wellbeing in culturally and linguistically diverse young people
9. Introduction to exposure-based cognitive behaviour therapy
10. Introduction to Interpersonal Psychotherapy for Adolescents

In addition, two modules have training packages designed to be delivered to staff. These are Module 3: Anxiety in children and young people and Module 4: Self-harm in adolescents.

Wellbeing Framework for Education

In 2014, the Department is developing a Wellbeing Framework for Education (for possible implementation in 2015). Wellbeing contributes significantly to how we function and experience life. It impacts the quality of learning experiences and also the learning opportunity of children and young people in our schools.

Schools play a very important role supporting, enhancing and building wellbeing. The Framework will underpin students engaging effectively in their schooling journey.

The Framework will focus on:

- mental health wellbeing which is critical for everyone
- hearing and responding to student voice
- building and maximising individual and community resilience
- maximising our community assets
- promoting belonging, responsible participation and inclusion in local and broader communities.

The Wellbeing Framework for Education will better guide schools as they respond to a complex range of issues impacting on individuals and the collective wellbeing of their community. These include health, education, achievement, school attendance, behaviour, social inclusion, resilience and participation.

The Framework will strongly enhance and build on the Government's broad reforms in education specifically; Local Schools, Local Decisions; Every Student, Every School; Great Teaching, Inspired Learning and the Rural and Remote: Blueprint for Education.

Child Protection

The Department of Education and Communities Child Wellbeing Unit provides advice and support to NSW public schools about responding to child protection concerns. Self-harm and suicidal behaviours in children can at times raise such concerns. For example, suicidal or self-harming behaviour can sometimes be a response to child abuse or neglect. Child protection concerns might also arise where parents or carers are neglectful in responding to the mental health needs of their children or when the behaviour of the child is significantly dangerous to him or herself, or to others.

The Child Wellbeing Unit assists schools by assessing the level of child protection risk, and advising on actions in response. These actions can include statutory child protection reporting and/or other responses to address the concerns identified for the child or family. Where there

are concerns that a child is engaging in self-harming or suicidal behaviour collaborative responses with health and counselling services (or other therapeutic practitioners) are critical. Involving families to support students is also important.

New South Wales has developed a Mandatory Reporter Guide to help mandatory reporters to make decisions where they have identified a child protection concern. The Mandatory Reporter Guide can help a mandatory reporter to decide if a statutory child protection report should be made or some other action taken. The Mandatory Reporter Guide includes a 'decision tree' about children and young people who are a danger to themselves or others. This 'tree' can be used in circumstances where a child or young person is demonstrating suicidal or self-injurious behaviours. The Mandatory Reporter Guide also includes a 'decision tree' for children or young people whose mental health needs may be being neglected. The Guide includes a range of other decision trees covering other abuse and neglect types.

Emergency Management Procedures

The overall response to suicidal behaviour is provided within the context of the Department's Work, Health and Safety Emergency Management Guidelines. The comprehensive and informed management of a school response following a death by suicide is essential to minimise the likelihood of other members of the community becoming at risk of self-harm. Specific information is available to schools to support the development of their emergency management plans as part of their preparation for any emergency.

In relation to suicide, risk factors, prevention strategies, response plans and recovery actions form part of the overall response.

Curriculum approach

Student mental health is addressed within the curriculum and in particular through the Personal Development, Health, Physical Education curriculum area. Students are provided with opportunities to learn about seeking help including benefits of support, identifying people and services that provide support, accessing support, strategies for seeking support, supporting others to seek help and barriers to access support.

Students also learn to enhance their ability to seek help by establishing individual support networks of adults and peers, practicing ways of accessing help, identifying barriers to seeking support and proposing strategies to overcome barriers.

Universal and targeted programs and frameworks

Universal and targeted evidence based programs specifically address student mental health and wellbeing to promote, develop and support mental health in children and young people. These incorporate proactive programs and interventions to support those with mental health issues.

Many school counsellors participate in or initiate the implementation of a range of proactive, pro-social and intervention programs in their schools. These include:

RAPS, ACE, FRIENDS, Get Lost Mr Scary, Bounce Back, PALS, Seasons for Growth and Kool Kids, amongst others. These are mainly targeted small group intervention programs aimed at students of a specific age range that address aspects of mental health and wellbeing such as anxiety, dealing with bereavement, school attendance, anxiety, resilience and social skills development.

Youth Mental Health First Aid

Many school counsellors in New South Wales are accredited to deliver the certificated Youth Mental Health First Aid course. This training gives participants (e.g. school teaching staff) skills and knowledge to recognise the early signs of the five most common mental illnesses affecting young people and to assist in supporting and directing them to appropriate care. These are: depression (which includes suicide and self-harm), anxiety, eating disorders, psychosis and substance misuse.

MindMatters

MindMatters is a resource and professional development initiative supporting Australian secondary schools in promoting and protecting the mental health and social and emotional wellbeing of all the members of school communities.

KidsMatter

KidsMatter Primary is a flexible, whole-school approach to improving children's mental health and wellbeing for primary schools. It can be tailored to schools' local needs.

Getting on Track in Time (Got It!)

A school-based mental health early intervention service is being implemented by NSW Health Child and Adolescent Mental Health Services in partnership with the Department of Education and Communities.

The *Got it!* program aims to prevent the development of severe behavioural disturbance and conduct related disorders in young children and a range of mental health and behavioural disorders later in life. It will establish school based mental health early intervention services for children and families in selected schools in the Blacktown, Newcastle and Dubbo Local Government Areas.

Brospeak and Sistaspeak

The *Brospeak* and *Sistaspeak* programs services metropolitan, regional and remote communities specifically targeting young Aboriginal people, 11 to 16 years who are identified as vulnerable and/or at risk. The program is a series of Aboriginal mentor supported workshops aimed at building student leadership and goal setting skills, developing a sense of belonging, building resilience, self-respect and respect for others and respect for Aboriginal culture.

Each workshop examines career options, working towards financial independence, improved health, nutrition and wellbeing. The program includes partnerships with local allied health services. Depending on the identified needs of participants, topics may address: mental health

and wellbeing, including self-harm and suicide; depression and anxiety; bullying; substance abuse; and family and community violence. The program builds resilience by providing young people with strategies that link students with appropriate service providers and community mentors.

NSW Aboriginal Suicide Prevention Strategy 2012-2015

The NSW Government has responded to Aboriginal self-harm and suicide through the NSW Aboriginal Suicide Prevention Strategy 2012-2015. This is a whole of government approach to providing the supports and services to those at risk of suicide. The work of Aboriginal Affairs is focussed on OCHRE- Opportunity, Choice, Healing, Responsibility and Empowerment.

While this plan is not specifically related to suicide and self-harm, there are plan elements that are of relevance to this issue. During the course of public consultations undertaken by the Ministerial Taskforce on Aboriginal Affairs leading up to the development of the OCHRE plan, the need for healing in many communities to respond to intergenerational trauma, loss and grief was a recurring theme. OCHRE recognises that such a process would enable many Aboriginal people and families to move forward and begin to tackle disadvantage. The plan commits the NSW Government to working with Aboriginal people, families and communities to develop workable and effective processes for community healing.

OCHRE is focused on reducing the socio-economic disadvantage experienced by many Aboriginal communities, and in addressing the gradual loss of culture and language that has been of concern to Aboriginal people for many years. An important contributor to wellbeing is for Aboriginal children to be engaged at school. To do this it is essential that Aboriginal culture and language is built into the school process and that there are clear pathways to further study and employment. The plan establishes Language and Culture Nests at 15 Connected Communities schools to ensure that languages, as the basis of culture, are not lost.

OCHRE also seeks to ensure viable and effective pathways for young people through education and training and into employment. Providing a solid basis for ongoing employment and economic development in communities is essential for reducing disadvantage and will have benefits in terms of the social issues confronted by many communities.

OCHRE is typified by local level decision making, which ultimately provides communities with a sense of empowerment and control over their destiny. It is important to recognise that a sense of grief and trauma and powerlessness, is a pervasive undercurrent to the social and economic disadvantage experienced by many Aboriginal people. Addressing this is critical in addressing a range of issues, including self-harm and suicide.

Connected Communities

The Connected Communities strategy seeks to address the educational and social aspirations of Aboriginal children and young people living in a number of complex and diverse communities in NSW. The strategy positions schools as community hubs that will deliver a range of services from birth, through school, to further training and employment.

The Connected Communities strategy has a focus on early intervention, providing opportunities for health service providers to build relationships with children and families, identify issues and provide any follow up required. By bringing these health services into the school, it is making those services more accessible to children and their families.

Organisation policies and procedures are in place, and training provided to staff to manage young people at risk of self-harm or suicide.

Family and Community Services (FACS)

FACS acknowledges that many Aboriginal families are faced with not just one but many challenges associated with low socio economic disadvantage. To improve better outcomes for Aboriginal people and their families, FACS is developing an Aboriginal Cultural Inclusion Framework to embed cultural inclusion into policies, service design and practices and increase accountability on how FACS will service their needs. This is supported by an Aboriginal consultation and engagement guide which is being developed to support FACS staff to work together and alongside Aboriginal people and their communities for better outcomes.

FACS funds a range of youth focused early intervention programs and statutory responses including the Child Youth and Family Support Services program (CYFS), Getting it Together services (GIT), Youth Hope pilot services and the Child Protection Adolescent Response (CPAR). These programs provide appropriate targeted child, youth and family support services to reduce the likelihood of children and young people entering or remaining in the child protection and out-of-home care (OOHC) systems. These services are provided along a continuum of family and community needs – from lower level parenting and youth support to intensive family preservation and statutory care.

A diverse range of clients receive these services and interventions and there will be occasions across all programs where referrals and support is provided for children and young people and families where there may be issues or instances of risk including self-harm and suicidal behaviour, however specific data on such incidences is not available.

Detailed information on these programs is outlined in the Addendum.

Department of Police and Justice (DPJ)

DPJ has a number of different strategies to reduce the risk of self-harm and suicide. These include the following;

- All young people entering custody are screened at the time of admission to help assess the risk of suicide and self-harm. Where a risk is identified a psychological assessment is carried out to assess the need for counselling, hospitalisation or other support.

- Justice Health and a forensic mental health registered nursed conduct a health assessment within 48 hours of admission to a centre. The Juvenile Justice Centre psychologist conducts an initial assessment of all young people with 72 hours of admission.

- Employees are provided with directions for responding and intervening if they note changes in behaviour and moods of clients, including how to approach the young person; and internal communication and record keeping that must be completed.

- The majority of Juvenile Justice NSW clients are supervised in the community. Referral systems are in place for clients in the community to access their local health services.

- The policy and procedures provide advice for employees on case management practices to actively involve young people at risk to develop a safety plan to protect their own safety and prevent suicide or self-harm.

- Safety plans are monitored by employees, for clients in the community this is also done in partnership with health services and the young person's carers and/or family.

- A process for the review of safety plans is in place for all Juvenile Justice clients.

- Within the custodial environment, security measures are in place to keep young people safe, such as removing hanging points, removing or replacing broken items, removing items of potential risk, and careful control and storage of dangerous substances.

- Young people at risk are closely supervised to restrict access to potential dangerous substances or equipment.

- Training is available for employees in first aid, and Mental Health First Aid and Suicide Prevention Strategies.

Kariong Juvenile Correctional Centre (KJCC) has a senior psychologist, a psychologist and nursing and psychiatric staff access. Staff at KJCC are also trained to deliver a CBT based program called RUSH. RUSH is an Australian forensic adaptation of Dialectical Behaviour Therapy (DBT) that has been found to be effective in reducing stress, depression and anxiety for offenders displaying suicidal, self-harming and borderline personality characteristics. This program is available to be run in all correctional centres managed by CSNSW. RUSH can be tailored to responsivity issues including age, gender, cultural background, cognitive function etc., and to remand as well as sentenced inmates.

Offenders at KJCC including those with self-harm and suicidal behaviours are also provided with intensive individualised behaviour and case management which allows tailored progression planning to ensure safe and secure management. Observation and camera cells are available to assist in graded reintegration for offenders who engage or have engaged in intentional self-harm and suicidal behaviours.

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.

NSW Health – Mental Health and Drug and Alcohol Office

WHO (2010) has recommended that policies to reduce harmful use of alcohol should be developed as a component of comprehensive suicide prevention strategies, especially for groups with high alcohol use.

While not solely focussed on young people, as part of the *NSW Suicide Prevention Strategy 2010-2015* the Hunter Institute for Mental Health has developed *Conversations Matter* online resources that provide practical information to support community discussions. http://www.conversationsmatter.com.au/

Department Of Education and Communities (DEC)

Any public campaign that is considered should be evidence based with a focus on prevention, building wellbeing and resilience and increasing help-seeking behaviours.

Family and Community Services (FACS)

The issue of a public campaign and the role of digital technologies (question 9 below) are highly contentious issues and a considered response can only be provided after canvassing the views of practitioners in the field and reviewing the evidence available on this. These issues are of key interest to FACS and the Department would like the opportunity to provide further and ongoing input to the project team preparing the National Children's Commissioner's 2014 Statutory Report to Parliament.

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.

NSW Health - NSW Kids and Families

Online interventions for a range of mental disorders and problematic health behaviours (for example, depression, anxiety, smoking, weight) have demonstrated efficacy, and the number of programs available is growing rapidly.

In September 2013, NSW Kids and Families released an *eHealth Vision and Strategy*. NSW Kids and Families has a vision for a future where the intelligent use of information, applications and technology helps drive improved health outcomes for children, young people and families of NSW.

The *NSW Youth Health Policy 2011-2016: healthy bodies, healthy minds, vibrant futures* has a strong focus on improving the youth friendliness of services by using creative approaches, including multi media and technology to engage young people and their parents, carers and families. NSW Kids and Families is working to support the implementation of the Policy including the take up of technology by services who work with young people. A series of workshops for service providers in NSW and consultation with young people will be held in 2014.

As part of the Young and Well Cooperative Research Centre, *Using technologies safely and effectively to promote young people's wellbeing: a better practice guide for services* (Campbell & Robards 2013) was developed in partnership with the University of Sydney. The guide examines the role of technology in facilitating direct communication, health promotion, health interventions, research and evaluation when working with young people.

NSW Health – Mental Health and Drug and Alcohol Office

Digital technologies are rapidly expanding into this field and many universities, non-Government organisations and consortia are developing material for young people at risk. It is important for interventions to be rigorously and independently evaluated with study replications.

Department of Police and Justice (DPJ)

Note that young people in Juvenile Justice centres cannot access social media, have extremely limited access to the internet (limited to monitored supervision in the education unit), telephones and digital communications.

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ADDENDUM
FACS PROGRAMS AND SERVICES RELEVANT TO REDUCING SELF-HARM AND SUICIDAL BEHAVIOUR

Child, Youth and Family Support (CYFS) - streams of service Child and Family Support (0-12 years) and Youth and Family Support (12-18 years)

The Child, Youth and Family Support (CYFS) early intervention service model aims to deliver a broader range of less intensive early intervention services to meet the needs of vulnerable children, young people and families who fall below the threshold for statutory child protection intervention.

Services provided to clients include advice and referral, assessment, case planning and management, parenting programs and parent support groups, skills focussed groups for young people, counselling and home visiting.

The CYFS program provides focussed short-term interventions designed to help improve their relationship with their child, and to support their development of skills in responding to children's need and appropriately addressing challenging behaviours and emotional problems. Importantly, services under this model include parenting and parent support groups.

Getting It Together (GIT) – Alcohol and Other Drugs Program (12 to 24 years)

GIT is an early intervention program designed to assist vulnerable young people aged between 12 and 25 years of age (priority is given to those under 18 years of age) with alcohol and/or drug problems. The goal for this program is to provide services and support to enable vulnerable young people to transition to, or to resume self-sufficient living, free of dependence on alcohol and/or drugs.

GIT delivers case management services, including assessment and case planning, (including referral), case work and brokerage to address income, health, social support, educational, employment training and accommodation needs of young people.

This model's strength is based on its ability to respond flexibly to its local service environment and meeting challenging client needs, and is viewed by the youth sector as one of the best ways of working with vulnerable young people who are unable or unwilling to access other services.

Clients are referred to CYFS and GIT through the NSW Family Referral Services or they access these services via soft entry points such as referrals from exiting clients or as a 'walk-in'.

Due to the types of services children, families and youth clients are receiving under this program if there was intentional self-harm and suicidal behaviour in children there is the professional capacity via case workers or other therapeutic professionals to refer these clients to clinicians or relevant health programs. Under the Child, Youth and Family Support program one of the funded services includes Twenty10 which is a long standing community organisation working across NSW with young people, communities and families of diverse genders and sexualities. Services include accommodation support for those experiencing homelessness; drug and alcohol assistance; counselling; social support groups; drop-in; art projects; research; community education and training. Given the violence, abuse and exclusion encountered by these youth in their families and communities, often leading them to access services for

accommodation, counselling and general support, therefore a service such as Twenty10 has an important role to play in addressing their needs and improving safety, welfare and well-being.

Youth Hope

Youth Hope is a trial in six FACS Districts (with referrals from 29 Community Services Centres) of innovative early intervention services for children and young people aged 9-15 years. The program aims to develop a range of innovative approaches that provide an effective response for 9-15 year old children/young people, their siblings and parents/carers. At least 480 families per year will receive Youth Hope services. 90% of referrals come from Community Services and the children/young people reported have met the Risk of Significant Harm (RoSH) threshold. The intended result is that children and young people completing the service have good family and community supports; are engaged in education and live in safe and protective home environments.

The Child Protection Adolescent Response Team (CPART)

The Child Protection Adolescent Response Teams (CPART) are designed to deliver a broad range of services to better meet the needs of vulnerable children/young people between the ages of 12 – 17 years who meet the threshold for statutory child protection intervention.

CPART aims to address risk concerns, maximise the likelihood of the adolescent remaining with their parents, to minimise the likelihood of them entering into OOHC and proactively engage with partner agencies to improve services for this age group.

CPART involves caseworkers (from either Community Services or an NGO) providing specialised advice, support and child protection case management services including planning, referrals, assessment to children/young people and their families who:

- are not in OOHC
- do not have an allocated case plan at the local Community Services Centre
- are the subject in a Risk of Significant Harm (ROSH) report or a Request for Assistance (RFA) with specific risk concerns such as:
    - homelessness or imminent homelessness
    - frequent running away from home
    - persistent and ongoing parent/adolescent conflict
    - persistent and ongoing involvement in criminal activity (including those young people subject to bail conditions declaring homelessness and/or reside as directed by CS).
    - physical, sexual abuse and neglect (no sibling at risk)
    - substance abuse
    - mental health issues
    - suicide attempts or other self-harm
    - involved in sex work or known sex offenders
    - sexual offending behaviours.

Brighter Futures

Brighter Futures is a targeted early intervention program designed to divert vulnerable children from the statutory child protection system. Eligible families receive a range of tailored services including case management, casework targeted at key vulnerabilities, home visiting, parenting

programs and quality children's services including child care. The program is aimed at families with children under nine years of age or expecting a child and which aims to ensure that children at high risk of entering the statutory child protection system can continue to live safely at home. The parent/carer will have at least one of five key vulnerabilities which impacts adversely on capacity to parent and/or the child's safety and wellbeing, including parental mental health issues.

The service model currently does not deliver specific mental health services for parents or children displaying intentional self harm and suicidal behaviour, however aims to support and build the capacity of parents to meet the needs of their children by providing education and support through case management, structured home visiting and parenting programs to ensure the wellbeing and healthy development of vulnerable children and young people. Some Brighter Futures lead agencies deliver counselling and psychological interventions as part of a multi-disciplinary approach. Alternatively they will engage and work with community mental health and other services as part of their case management of children and families.

Future directions for the program include a greater focus on addressing parental vulnerabilities, including mental health, as key drivers in child protection and will be pivotal in continuing to provide support, education and therapeutic intervention for children and parents to meet the needs of those displaying intentional self-harm and suicidal behaviour.

Project Air Strategy for Young People with Complex Needs and High-Risk Challenging Behaviours

Over the past 18 months, FACS, together with other agencies (NSW Health, Juvenile Justice, DEC, Aboriginal Affairs), has been working with the University of Wollongong to provide: a service model development and guidelines for young people with complex needs and high risk challenging behaviours; capacity building through training; and, case consultation and supervision.

An outcome from the program has been the development of a manual designed to help services intervene early and better support these young people and adults by providing practical therapeutic techniques in the prevention and treatment of personality disorders and management of complex and high-risk challenging behaviours in young people and adults.

This collaboration was based on the recognition that a service system that works as a whole in an integrated fashion, rather than any particular sector working in isolation, better supports young people and adults including those who are at risk of significant harm. In keeping with government policy, there needs to be a shared approach to keep vulnerable young people and adults safe. The risks of not intervening and meeting the needs of young people and adults (especially those aged 9 -15 years) can include the later development of high and complex needs such as personality disorder and associated mental health problems, criminal offending and criminal justice system involvement, drug and alcohol abuse, employment instability, high-use of mental health services, social isolation, and homelessness.

Young people and adults with complex needs and high-risk challenging behaviours often present with:

- Emotion dysregulation
- Physical and verbal aggression
- Self-harming behaviours
- Difficulties making and keeping friends
- Family dysfunction
- Learning problems

- Low self-esteem
- Trauma symptoms

Reflection, Resilience and Relationships (RRR) Program

The RRR Program was the result of a joint initiative between FACS and Marist Youth Care (MYC). This partnership was formed in response to the challenging and complex shared experiences in working with young people who have experienced serious abuse, neglect and other forms of trauma and in particular, the ramifications associated with the experience of young people attempting to suicide or who have died as the result of a suicide.

The RRR Program is designed for staff working in the complex context of a youth residential setting. This setting is often characterised by high ambiguity, emotionally laden situations, and by strong public and political pressure.[1] In the midst of this context, staff ability to make sound decisions and think reflectively are critical to supporting young people keep safe and achieve their own personal goals.

The *RRR Program* is designed to achieve the following goals:

- Introduce staff to the concept and language of reflective practice
- Increase staff confidence in their ability to undertake the functions of their role
- Increase staff confidence in decision making
- Increase staff sense of team cohesion
- Decrease staff feelings of stress in relation to their work
- Improve staff skills in managing work related stress

A Facilitator Guide is available and was written as it was delivered as a joint program with FACS and MYC however future MYC or other non-government facilitators can amend the structure of the program according to their situation and setting.

[1] Victorian Department of Human Services 2009, *Leading Practice: A resource guide for child protection frontline and middle managers,* Department of Human Services, Melbourne.