Thank you for the opportunity to make a submission.

1. Why children and young people engage in intentional self-harm and suicidal behaviour.
    a. Anecdote: I used to show a video clip from the film "Ground Hog Day" to a group of adult male offenders as part of a Drug and Alcohol program. In the clip Tom Hank's character is miserable and attempts suicide in multitude of ways to end his agony - only to begin the next day unharmed and back in his hotel bed when his alarm goes off! Eventually he becomes so desperate he confides in the most trustworthy person he knows about his troubles! I ask every group, "What does Tom Hank's character do that may show his desperation even more than his suicide attempts do?" or "What does Tom Hank's character progress to after suicide attempts?" Answer – "seeks counselling" or "tells a friend". The guys generally seemed to agree that disclosing one's sense of failure as a person can be harder than suicide.

       Tom Hank's character calls himself a "jerk". He seems dissatisfied with, but trapped in, the mould of *who he is*. He suffers an inability to disclose and articulate this because of the shame he feels. In my view, people's typical response to shame – that of denying their shame (to others if not also to themselves) - makes them both a) *rigid, inflexible, unadaptable and unable to change* their view of self and others, *and* b) isolates them emotionally from others and from outside input. In my view, love is the key ingredient to empower someone who is feeling completely worthless and hopeless to admit and share these most horrible thoughts and feelings. Love and empathy support deeper understanding of the sufferer – but understanding can be more insightful where there is an understanding of shame. Yet current psychological research seems preoccupied merely with the down side of *intransigent* shame.

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

    a. following on from the shame issue, I suspect that a factor in contagion and clustering is that those relatives and friends bereaved through suicide, and who themselves are struggling with feelings of inadequate and hopeless, may have their own distress intensified because of the testimony of the deceased implicit in the suicide – that there is no hope of personal transformation or a purposeful and joyful life.

    b. I think people need to come to a place of understanding and forgiveness toward relatives and friends who suicide, but this does not mean endorsing their suicide. Though it may be the best option for the deceased personally (if people believe in life after death), yet it is always a terrible option for the bereaved. It might likely to be the case, and helpful to think, that the deceased committed suicide because they were

a) too preoccupied with their own despair to think of others and b) too overwhelmed by shame to verbalise their distress to others. This naturally leads on to being explicit to the bereaved at risk about the need to be mindful of both of these aspects. I suspect that the messages should be along the lines of: a) "Don't suicide because of the effect on loved ones!" and b) "Do be brave to verbalise your own distress and shame until you find someone who can help!"

c. I suspect that where the shame components in the deceased and in the bereaved are not recognised, accepted, explored and dealt with in some way or other, there can be little amelioration of any shame-component present and which is contributing to contagion and clustering. According to Affect Theory all feelings are meant to be both shared and allowed to direct our problem-solving skills towards problematic issues. In Affect Theory, it is helpful to recognise feelings explicitly - and as gradually as necessary (so as not to be overwhelmed by them) – until the person is able to sit with the feelings long enough to be able to work through the reasons/source/cause of them. Without such explicit recognition, emotions operate on behaviour very powerfully at a sub-conscious level, beyond the reach of conscious decision-making. Denial of any feeling, including denial of shame, is therefore counterproductive.

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

   a. Shame

   b. Parental denial including Religious anxiety. Anecdotes: I know of two Aboriginal families, whose Christian beliefs around suicide dramatically increase their stress levels and derail their effective response to suicide risk. Both families believe a suiciding person will roast in hell for eternity. One family therefore denied their son could ever be suicidal. In the other family, family members threaten suicide to each other "if you don't get off my case" – thereby adding to everyone's stress levels, in a vicious circle. The former family's other strategy is to threaten to flog, or to flog, any child talking "silly talk" about suicide.

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.

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.

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

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.

a. I would like to recommend that Mental Health professionals explore the shame management techniques of Donald Nathanson e.g. his Compass of Shame model

b. I think Affect Theory (by Tomkins & Nathanson) should be taught in schools and by mental health programs. Affect Theory holds that our feelings are our natural allies leading us to psychological and social health – emotions are not things we need to escape from in diversions, drugs, or suicide. Sadness teaches us about what is most important to human beings (cf 'intuitive intelligence' by Aboriginal 'griefologist', Rosemary Wanganeen), anxiety to be focused on doing our best, anger in being highly effortful to resolve a problem, etc.

c. Resolve modern Psychology's current general negativity about shame. I think this should involve the mental health community to do the following:

i. Stop seeing shame as an artificial, outmoded and negative construct

ii. Accept that *intransigent* shame is a problem akin to *intransigent* fear – and the problem is the *intransigence* of the emotion, not the capacity for fear or shame.

iii. Stop seeking to make guilt an alternative to shame; see them as complementary.

iv. See normal shame as part of a healthy process in which *shame is converted to guilt*; intransigent shame occurs when shame is *not* converted to guilt and that is when shame results in extreme anger, hostility and rigidity.

v. See the strength of shame as:

1. Enabling human beings to develop a conscience (internalise values) in childhood and through the life journey

2. Having the capacity, when activated, to arrest anti-social behaviour despite enormous momentum toward anti-social behaviour being generated by drives for survival and sex. (Hence, shame is a bedrock of civil behaviour.)

vi. See the conversion of shame to guilt as dependant on the individual successfully identifying the *anti-social core beliefs* underlying, and driving, the anti-social behaviour (Cognitive-Behavioural Theory). The exquisite discomfort of shame is a powerful motivator in this difficult task. During this process, the *nature* of the problem transforms from being a problem of the self with the self, to being a problem of the *actions* of the self (i.e. about which beliefs the individual previously chose ,and which they now choose instead,

to give personal truth status to.)

vii. The payoff for identifying anti-social core beliefs is that one can decide to 'jettison' unhelpful beliefs for pro-social ones. This results in character improvement and can lead to restitution, reconciliation, changes in life direction, such that the person feels proud of their actions in these areas. So the progression is: from crime, shame, self-awareness, guilt, restoration, to (healthy) pride.

viii. (cf. Brene Brown's TED talks, etc)

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.
    a. Yes I think this message is quite communicable in a public education campaign, in a low key, inoffensive way but which can strongly speak to this issue in individuals caught up in it. Why not try this approach and see how it works??? !!!

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 Worker

Nb. All views are expressed are my own and should not be construed to necessary represent those of my employer.