Submission on intentional self-harm and suicidal behaviour in children

Prepared for the National Children's Commissioner

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NHMRC Centre of Research Excellence in Suicide Prevention,

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INTRODUCTION

The Black Dog Institute is a research institute dedicated to reducing the impact of depression in the community. The Centre for Research Excellence in Suicide Prevention (CRESP) is located within the Institute and funded by the Australian National Health and Medical Research Council (NHMRC). CRESP brings together, for the first time, leading Australian and international experts in suicide prevention to share expertise and resources and undertake the necessary research to affect rapid advances in suicide prevention and lower suicide rates in Australia. In addition, advice and input are provided from those at the coalface of suicide prevention, including crisis support services, helplines, online services, general practice, schools and health promotion and advocacy organisations.

The Institute maintains that suicide is both a medical and a public health issue, and that solutions to lowering suicide rates in Australia require an approach that targets both individual mental health risk factors and broader societal factors. A new idea is emerging globally that suicide can be reduced through a "systems" approach operating across all systems. "Systems" include schools, community groups, hospitals, emergency departments, workplaces, and emergency services. These services must act in unison, simultaneously and in localised areas.

Below we outline responses to your questions. We also make suggestions from Black Dog's perspective as to how the issues might be resolved or changed. These are labelled "recommendations", although they simply reflect our view as to how to improve understanding around suicide prevention.

ISSUES & BLACK DOG RECOMMENDATIONS

ISSUE 1

WHY CHILDREN AND YOUNG PEOPLE ENGAGE IN INTENTIONAL SELF-HARM AND SUICIDAL BEHAVIOUR.

It is known that biological, neurological, and genetic mechanisms interact with environmental events, such as trauma and adversity, to increase the risk for suicide. For indigenous young people, intergenerational issues also have significant effects. However, further research is needed to understand the causes of suicide in children and young people. Relative to other mental health conditions, and in comparison with other physical health conditions, very little funding (less than 3% of NHMRC funding in mental health) is spent on suicide research (Christensen et al., 2011), despite the fact that suicide accounts for 7-10% of mental health disease burden in Australia (Christensen et al., 2013). More generally, less funding is spent on mental health research in comparison to the other health priority areas. .For young people and adults, suicide is the major killer, outstripping deaths from fatal road accidents. The UK spent nearly ten times more in road safety awareness in one year than they did on suicide research over three years (Aleman & Denys, 2014), a finding that is likely to reflect the situation in Australia. Clearly investment in suicide prevention research is needed.

BLACK DOG RECOMMENDATIONS

Greater suicide prevention knowledge in young people and children is required. A NHMRC Targeted Call in youth and child suicide, which examines basic biological mechanisms in conjunction with psychological factors, trauma and violence, and social determinants, may be a start to building capacity in suicide research particularly as it affects children and very young teenagers. A NHMRC Targeted Call for Suicide Prevention in

Indigenous Communities is in the process of being awarded. This does not preclude an additional call for young people and children.

ISSUE 2

THE INCIDENCE AND FACTORS CONTRIBUTING TO CONTAGION AND CLUSTERING INVOLVING CHILDREN AND YOUNG PEOPLE.

Some studies suggest that adolescents who have been exposed to family or friends engaging in suicidal behaviour may be more likely to engage in suicidal thoughts and behaviours (De Leo & Heller, 2008; Swanson & Colman, 2013; Abrutyn & Mueller, 2014). Suicide clusters often attract considerable media attention and levels of concern within communities. In fact, suicide clusters remain a rare event, although it is widely recognised that there is a need to better understand their causes and risk factors. A systematic review (Niedzwiedz, Haw, Hawton, & Platt, 2014) while calling for more research, identifies key factors to consider. The authors emphasise the need to maintain a focus on general suicide prevention activities, given the rare occurrence of suicide clusters and the potential for such activities to eliminate or reduce their occurrence, but they also highlighted a range of specific cluster factors. These include:

- Further development and dissemination of media reporting of suicide guidelines and engagement of journalists in their use.
- Increasing mental health literacy among both journalists and the public.
- Research and understanding of the role of social media in suicide clusters.
- Guideline updates and review for the prevention and containment of suicide clusters as further evidence emerges.

CRESP in association with Black Dog is planning work in this area in conjunction with the University of Canterbury, Christchurch, NZ using geospatial mapping to further inform the evidence base around suicide clusters and suicide prevention more generally. In addition to this, Black Dog and CRESP are currently undertaking a range of research projects examining the role of social media networks and their potential for use in both assessing suicide risk and delivering appropriate help-seeking options and interventions. Evidence suggests that social network analysis using online and offline sources can identify 'isolated' people, who may be at risk, but that the same networks can be a way of connecting with individuals to deliver 'connectedness'. Certainly our research in young adult populations suggests that connectedness/ belongingness are key factors in suicide risk.

BLACK DOG RECOMMENDATIONS

Education to the public and the community is required about suicide. Urgent research is needed, using new technologies and approaches to understand 'contagion' and to investigate how connectiveness can be used to lower risk and to promote safe communities.

ISSUE 3

THE BARRIERS WHICH PREVENT CHILDREN AND YOUNG PEOPLE FROM SEEKING HELP.

Extensive literature indicates that young people do not seek help for mental health problems for a variety of reasons including stigma, poor mental health literacy, lack of appropriate services, and not understanding that help is available or how to obtain it. Although there is little literature on facilitating help-seeking, it is known that by far the biggest facilitator for help-seeking is the individuals' friends and family (Gulliver, Griffiths, & Christensen, 2010).

There is also not much known about the relationship between stigma, literacy and help-seeking specifically for suicide risk. Prior research though has found that those with depression (which is a major risk factor for suicide) are less likely to seek help if they had either more self-stigma or perceived depression stigma (Barney, Griffiths, Jorm, & Christensen, 2006). However, stigma around suicide is not the same as stigma around depression and anxiety. (Batterham, Calear, & Christensen, 2013b) have identified three types of attitudes towards those with suicidal ideation in adults (these three themes are attribution to depression, glorification/ normalisation, and stigma- e.g. 38% of the public believes those who take their lives are selfish (Batterham et al., 2013b) with higher suicide stigma associated with being male, younger, and from a linguistically diverse background (Batterham, Calear, & Christensen, 2013a)).

Further research has demonstrated that the community also has a low to moderate level of suicide literacy, with the greatest deficits in the identification of the signs and symptoms of suicide and the risk factors associated with in (Calear, Batterham, & Christensen, In submission-a). Lower suicide literacy has been found to be associated with being male, older and from a linguistically diverse background (Batterham et al., 2013a).

There are limited data available in young people, with data from (Chan, Batterham, Christensen, & Galletly, 2014)suggesting that medical staff are likely to hold stigmatising views and that medical students have been shown to have high levels of stigma and suboptimal levels of knowledge, and their attitudes worsen through their medical training.

In addition to this, recent research evidence suggests that individuals with low levels of suicide literacy and high levels of suicide stigma have lower levels of help-seeking attitudes and intentions (Calear, Batterham, & Christensen, In submission-b). This same relationship has been established in medical students (Chan et al., 2014).

BLACK DOG RECOMMENDATIONS

- To measure suicide stigma and suicide literacy annually across the community, as this will provide a benchmark as to whether stigma activities and campaigns are likely to be successful.
- Increase mental health literacy around suicide risk factors in young people, medical professionals and friends and family through training and education, and through health promotion activities.
- Develop materials to assist teachers and parents to get their young people to help early, and distribute these through schools and sporting clubs.
- Recognise that good information around suicide is unlikely to incite suicide contagion. Evidence from our research activities shows that a small percentage of people report becoming upset when answering questions around suicide in surveys. However, they also report that, despite this, they are eager to complete the research because they want to help improve suicide rates.

ISSUE 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.

Our research program has identified the following challenges in collecting and using suicide data:

a. Requirement to obtain clearance from multiple Ethics Committees for the same research project,

especially for indigenous research and for school based studies. For example, each state requires separate ethics proposals for collection of data from school students in National studies.

b. Permission to recruit young people to suicide research projects is taken seriously by Ethics Committees resulting in numerous revisions and significant duty of care requirements (as they should!). However, as a result, it can sometimes be hard to engage schools, and other organisations to help support the 'duty of care' requirements for the research. Lifeline and school counsellors etc. have limited resources, making research costly and slow (for example, we employ clinical psychologists to support our trials, and cannot rely on other mental health organisations).
c. Research in the suicide prevention field now often turns to data mining of social media to better understand aspects such as networks/contagion. As the technology is so new, Ethics Committees are often unfamiliar with this type of research and there often needs to be a process of knowledge dissemination through ethics committees to assist them to understand what is feasible/reasonable – e.g. whether the usual consents apply/what are the duty of care requirements etc.
d. Determining suitable eligibility/exclusion criteria for studies can be difficult (e.g., it is often important to monitor distress of participants, but determining cut off for exclusion can be tricky as some participants in these types of studies might have quite high levels of distress yet still be well enough to participate so long as an appropriate risk management system is in place).
e. Limited availability of data e.g., hospital admission data on suicide/self-harm, and of what is available; there is little consistency across states/jurisdictions. In addition, not all states have registers, and suicide data is not reported in uniform ways.
f. Lack of availability of geographical data on suicide/self-harm which could assist in developing/evaluating policy and programs to target areas of high need.
g. Use of a multitude of different suicide risk assessment measures across different studies that lead to an inability to combine datasets. CRESP has produced a guide summarising key characteristics of a range of commonly used suicide outcome measures (available on request). CRESP researchers are currently undertaking further work to highlight the most appropriate outcome measures for research and surveillance, with a paper currently in submission (see Batterham et al., in submission). We invite the Commissioner to contact us should further details be required regarding this paper.
h. No agreed upon standardized evaluation exists to allow comparison across supported government programs. Community based programs often do not incorporate the evaluation or research components into their programs that would allow an effective assessment of impact.
i. Lack of a national suicide prevention research agenda to ensure funding goes to areas of gaps/priorities.
j. The belief that completing surveys/talking about suicide will make things worse. Evidence we have collected suggests that the majority of people are not upset by talking about suicide, and those that do become upset are willing to complete them for the common good.

BLACK DOG RECOMMENDATIONS

- Develop a new national suicide prevention research agenda for children and young people.
- Streamline data collection, including linked data sets and coroner data sets.
- Investigate the use of social media and other technology platforms as a means to identify trends in mental health/suicide, and also as means to deliver health literacy.
- Provide guidelines around suicide prevention duty of care when collecting data around suicide.
- Simplify Ethics Committee processes.
- Establish standardised guidelines and key outcome reporting.
- Consider collecting data routinely through schools via online or offline surveys. We recently undertook data collection in Year 9 students in NSW, using six items around suicidality. This proved to be feasible and did not cause undue concern. This could be extended to younger participants.
- Encourage suicide data collection in all data collections around children and their parents.
- Measure mental health suicide risk at the times of the The National Assessment Program – Literacy and Numeracy (NAPLAN) for students in Years 3, 5, 7 and 9.

- Collect measures of suicidality/stigma/parental concern in the Census, and in the next National Survey of Mental Health and Wellbeing (Children). Continue data collection on suicidality by YAWCRC (Burns et al., 2013).
- Request self-report of suicide data be included in major data set collections, such as Mission Australia's Annual Youth Survey (currently collects data on K6 distress only) https://www.missionaustralia.com.au.

ISSUE 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.

Black Dog Institute and CRESP have identified the following three major impediments to accurate identification of self-harm and suicidality;

a. *The failure to detect risk by others.*
   It is difficult to detect suicide risk. Generally speaking, workforce training of health professionals does not focus on suicide, so there is opportunity to improve assessment through curriculum development. Moreover, because suicide is a relatively rare event, it is nearly impossible to predict at the individual level whether someone with severe depression is more or less likely to take their own life in comparison to someone else who doesn't report the same level of severity. Moreover, commonly used suicide risk measures do not have great predictive validity for identifying suicidal behaviours. Many primary and high school teachers can detect risk of mental illness, but rarely are there easy conduits to mental health care. Health professionals have low suicide literacy and low mental health literacy. They also need to be trained or empowered to act if they feel someone is at risk. Mental health professionals often report to us that they are ill at ease around suicide. We find they will not refer their patients to online resources or to research projects around suicide prevention, possibly because they want to control their own risk.

   Health professionals recognise their need for greater training in suicide assessment. A recent survey of almost 2000 Australian psychologists undertaken by Black Dog found that suicide training was among the top 5 topics identified as a high priority, with almost 60% of respondents identifying the issue.

   Family and friends also have poor knowledge of the signs of suicide and lack of knowledge about how and in what circumstances they should act.

b. *The lack of willingness to reveal suicidal thoughts in those with the condition.*
   Many of those at risk of suicide prefer to remain anonymous, do not like to seek help from health professionals and prefer not to reveal their concerns. This factor has been a prime driver to the development of Black Dog's online suicide prevention programs, which are offered anonymously to those who wish to complete them.

c. *The failure to take advantage of big data in assessment of risk.*
   Recent data suggests that hospital records are better at identifying (adult) suicides than clinicians by utilising administrative data, demographics, knowledge of prior self-harm, and mental and physical health diagnoses (Tran et al., 2014).

BLACK DOG RECOMMENDATIONS

- Training and empowerment for clinicians and those in contact with young people (e.g. parents, teachers).
- Need more research on the predictive validity of the most promising measures for assessing suicide risk and the development of new measures based on latest evidence of risk factors for suicide (e.g., based on the Interpersonal Psychological Theory of Suicidal Behaviour (Joiner, 2005), using adaptive screening methods or using Stroop-like methods as employed by Prof. Matthew Nock).
- Opportunities for those at risk to seek help anonymously via evidence based websites and other anonymous services.
- Collection and use of 'big data" to predict those at risk of suicide. This may include data collection within schools.

ISSUE 6

THE BENEFIT OF A NATIONAL CHILD DEATH AND INJURY DATABASE, AND A NATIONAL REPORTING FUNCTION.

We believe that a national injury base and national reporting function is essential. As noted above**,** we also believe regular data collection on 'softer' measures of suicide such as suicide ideation and major risk factors as part of school data collection will be very useful.

BLACK DOG RECOMMENDATIONS

- Record of rates of suicide, attempt and self-harm, and rates of suicide stigma and literacy are critical to measure performance and understand cause.
- Must have geographic location/postcode, be linked to risk factors and health services factors, and be available in a timely fashion for use by researchers, clinicians and policy makers. The use of such data can assist in identifying useful interventions (While et al., 2012).

ISSUE 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.

The following are examples of effective programs with which we have had direct contact, either because we provide them or offer them directly through our research programs

Depression specialist clinics

Appropriate and early intervention is critical for young people at risk through specialist depression clinics such as those at the Black Dog Institute: The BDI Clinic has only recently commenced a specialist clinic for

children of secondary school age (i.e. young people aged around 12-17 years). All of the referrals so far have been of adolescents in a good deal of strife, nearly all with suicidal thoughts and a history of suicidal behaviour and self-harm, most commonly, self-cutting. The nature of our clinic means that these young people are generally suffering from "difficult to treat depression", which in turn means that there are often other factors which have been overlooked or which have been identified but have not been properly treated.

There are three factors which stand out: untreated or poorly treated mental illness in a parent or carer, untreated or poorly treated co-morbid substance use disorder in the young person, and other undiagnosed or untreated co-morbid disorders in the young person, especially anxiety disorders, learning difficulties and ADHD (Attention Deficit Hyperactivity Disorder). The vast majority of these patients have not seen a Child and Adolescent Psychiatrist although their presentation certainly warrants this.

Youth information sites – BITE BACK

Youth information websites which promote positive psychology and resilience are helpful. These provide the opportunity for young people to raise concerns which can then be handled offline and published online to provide increased literacy to benefit other young people that may be experiencing similar issues.

BITE BACK www.biteback.org.au is a positive psychology website created by the Black Dog Institute which aims to improve wellbeing and mental fitness of young people by encouraging them to share and read real life personal stories, as well as interactive activities built upon mindfulness, gratitude and other positive psychology principles. A community RCT of the effectiveness of BITEBACK was undertaken and has been accepted for publication (Manicavasagar et al., In submission (accepted)). Should the Commissioner require further info prior to the publication of this paper, please contact us for details. The site targets all young Australians between the ages of 12 and 18 years, not only those with mental health difficulties. Evidence suggests that addressing emerging issues in young people can help prevent the onset of mental health problems at a later stage.

BITE BACK has a section entitled 'Real Stories' which allows young people to submit anonymous stories about themselves - including stories of chronic hardship and stressful episodes in their lives. The purpose of those stories is to stimulate community engagement and discussion about resilience between young people. These stories are pre-moderated by the Institute to ensure that published stories contain some indication of resilient behaviours and hopefulness. An escalation process is in place for submissions that indicate that the young person is undergoing significant difficulties. This process is overseen by a senior clinician. Some examples of these stories are:

- This is Me - http://www.biteback.org.au/things-to-do/real-stories/stories/this-is-me/
- My Life - http://www.biteback.org.au/things-to-do/real-stories/stories/my-life1/ (See Appendix 1)

Mobile APPS for indigenous suicide

An app which delivers Acceptance Commitment Therapy to young indigenous Australians is proving to be very successful. Suicide rates in Aboriginal and Torres Strait Islander communities are amongst the highest in the world and despite increased funding and implementation of new prevention programs, very few Indigenous people seek help before acting on suicidal thoughts. In rural and remote areas, the mental health workforce is small in number and many are untrained to deliver evidence based services. Often people don't ask for help because they feel disconnected, ashamed or are worried about anonymity. **iBobbly** is an app aimed at suicide prevention and designed especially for use by Indigenous Australian youths. It is anonymous and available on tablet devices (once it is downloaded no internet access is required). It has been developed and piloted in the Kimberley by BDI in partnership with WA-based *Alive & Kicking Goals!*, a community controlled suicide prevention organisation. The app seeks to reduce suicidal thinking and psychological distress. Treatment is based on Acceptance and Commitment Therapy, which uses mindfulness and values-

based action and also draws on Indigenous metaphors, images and stories drawn from local Aboriginal artists and performers (Shand, Ridani, Tighe, & Christensen, 2013). Data from the pilot RCT is promising, and a large RCT has been funded by the NHMRC (APP 1060477), due to commence in 2015.

In addition to the programs above, with which we have direct experience, we have also reviewed the scientific literature over the last year for both adolescent and adult programs which are effective. The following is a brief summary of the findings to date. We have neither reviewed literature on bullying as a risk factor for suicide, nor examined the literature on drug and alcohol as a contributor. With this caveat, our conclusions are:

a. *There is some evidence that screening of young people can be effective in identifying young people at risk, but further research is required.* Screening involves case-finding by assessing students for suicidality, either universally (screening all school kids) or screening among those identified as being at-risk (because of high scores on depression scales). Students who screen positive are referred for further assessment or treatment. The success of these programs is dependent on the accuracy of the screening tool and subsequent referral and availability of services. It is important to investigate the effectiveness of screening via randomised controlled trials.

b. *There is some evidence to support the use of gatekeeper programs for teachers in schools.* Gatekeeper training programs are designed to improve the identification of suicidal youth by training school staff or parents to recognise the warning signs of suicide and to refer students onto further care. Gatekeeper training can be delivered universally or selectively (e.g., for parents of at-risk students) and has been found to be effective at improving suicide knowledge, attitudes and confidence (Isaac et al., 2009).

c. *There is good evidence for peer support/social connectedness programs if these are well implemented.* One of the promising suicide prevention programs identified in the reviews of school-based programs (Katz et al., 2013) is the universal <u>Sources of Strength</u> peer leadership program (Wyman et al., 2010), which takes a social connectedness approach to improving help-seeking for suicide and general psychological distress. This program is designed to build socioecological protective influences across an entire school student population and focuses on enhancing help-seeking norms, youth-adult communication, and coping skills to promote help-seeking (LoMurray, 2005). With the support of adult mentors, peer leaders from diverse social cliques, including at-risk adolescents, are trained to conduct whole school messaging activities that are intended to change peer group norms, attitudes and behaviours. The program harnesses the social networks of the peer leaders to diffuse the program's messages. More specifically, the peer leaders are taught to model and encourage friends to: (a) reinforce and create an expectancy that friends ask adults for help for suicidal friends, thereby increasing the acceptability of seeking help and reducing implicit suicide acceptability, (b) name and engage "trusted adults" to improve communication and connections between youth and adults, and (c) identify and use interpersonal (e.g., family, positive friends) and formal coping resources (e.g., mental health services, positive activities) to promote healthy coping attitudes. An integral part of the program is the identification and utilisation of eight key protective factors, referred to as Sources of Strength. These sources encompass family support, positive friends, caring adults, positive activities, generosity, spirituality, mental health access and medical access. Overall, the program acts to reduce suicidal behaviours by connecting suicidal youth with capable adults, and to prevent the development of suicidal behaviour by promoting positive coping for psychological distress (e.g., depression, anxiety) (Wyman et al., 2010). Members of CRESP (Calear and Batterham) are currently seeking funding for this program within Australia.

d. To date there is little evidence for postvention programs in schools in lowering suicide risk. This may be because data has not been collected well, or studies are poorly designed, but at this stage evidence is weak, and universal delivery of these programs in schools should not be prioritised.

BLACK DOG RECOMMENDATIONS

We recommend that the following programs be continued and expanded for young people and their families:

- Early specialist psychiatric **diagnosis clinics be expanded.**
- Youth information sites such as BITEBACK for young **teenagers (11-14) be supported.**
- **Online apps which are co-produced with children and teenagers.**
- Teacher and parent gatekeeper training.
- Screening for suicide risk with appropriate referral.
- Sources of Strength programs in high schools.

ISSUE 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.

In our view, a public education program aimed at reducing the number of children who engage in intentional self-harm is likely to be both feasible and effective. However, it would need to take into account the following characteristics:

a. Recognition that effective public education interventions will require that stigma around self-harm and mental illness is considered. There is a need to recognise that we do not know as much about stigma when it is associated with suicide in comparison to what we know about stigma in comparison to depression and other mental health conditions. More knowledge is needed about suicide stigma and the messages that might be used to reduce it.

b. To consider all parties – the community, the child, the child's friends and the family and parents- the same program may not be effective for all.

c. Initially measure the levels of stigma and literacy to determine whether the campaigns/activities were effective (or indeed made matters worse).

d. To determine the best methods to transmit the information – via classrooms or via contained social media. Evidence suggests that stigma for depression lowers when the message is transmitted by a person who has recovered, and is "known" to the recipient of the message (Corrigan, 2005).

ISSUE 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.

Our own research has indicated the potential for effective interventions for suicide ideation using websites and apps in adults. We have also found interventions using apps with indigenous groups to be effective (see ibobbly data above). Two studies from other researchers have similarly reported success with websites for suicide ideation for adolescence (below).

Adolescent studies*:* A pre-post study (n=83) of general practice adolescent patients with suicidal ideation (but not frequent ideation or actual intent) found reductions in self-harm thoughts and depressive symptoms at 6 weeks and 12 weeks using the "PROJECT CATCH-IT" web program (CBT, IPT and parent workbook) (Van Voorhees et al., 2009). A non-inferiority RCT (n=94) of psychiatric outpatients with depression compared a computerised self-help program "SPARX" (CBT) with TAU (face to face therapy) and found that SPARX was non-inferior on levels of hopelessness (a proxy measure of suicide ideation) (Merry et al., 2012). Together, these studies indicate the potential of e health applications for suicide ideation in adolescence and young people.

More recently, we have embarked on a program of research which has aims to understand and use social media in measuring suicidality, to potentially detect and then intervene in suicidal behaviour. The aim is both for "population surveillance" but also for individual detection. If successful, this type of research will help us to harness social networks and connectiveness to facilitate suicide prevention strategies via these conduits.

BLACK DOG RECOMMENDATIONS

We see the following potential innovations that are likely to have a huge impact on suicide prevention in young people and in adults:

- The use of Facebook and Twitter and other platforms to detect and intervene in suicidal behaviour.
- The use of Twitter and other techniques to "detect" population-based changes in distress.
- The use of technology to build a systems approach to suicide prevention.
- Screening and self-screening using online tools linked to clinicians (if requested).
- Screening for suicide ideation in schools.
- Online webinars for parent and teacher gatekeeping.

CONCLUSIONS

Black Dog and CRESP welcome the opportunity to comment on these issues for the Commissioner.
We are committed to lowering suicide rates in Australia. If the resources of the institute or of CRESP are useful, they will be made available. We would also like to invite the Commissioner/ and or representatives of the office of the National Children's Commissioner to be members of the Centre for Research Excellence in Suicide Prevention to facilitate future collaboration.

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