APS Submission to the National Children's Commissioner

Intentional self-harm and suicidal behaviour in children

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Introduction

The Australian Psychological Society (APS) welcomes the opportunity to make a submission in response to the National Children's Commissioner's (the Commission) examination of intentional self-harm and suicidal behaviour in children. As the peak body for psychology, representing over 21,000 members, the APS has a proud history of working with all levels of government, consumer groups and other health profession peak bodies to improve the health and wellbeing of Australians. Psychologists have expertise in a range of applied settings including the application of psychological theory and skills to the understanding of the human rights of special groups.

This submission by the APS will address the issues raised in the consultation paper from a psychological point of view to assist the Commission to develop their recommendations in the 2014 Statutory Report to Parliament. The submission will address each of the nine questions posed in the consultation paper, and will provide a viewpoint on the matters based on psychological research findings. There is an extensive literature on the development of young people and suicidal and self-harm behaviour and a comprehensive critical review of this literature is beyond the scope of the current submission. This paper therefore provides an overview of this literature only. If the Commission requires a more substantial literature review, please contact the APS.

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

What is intentional self-harm and suicidal behaviour?
Before one can consider the reasons why young people under the age of 18 engage in intentional self-harm and suicidal behaviour, it is critical to define the two terms. Specifically, one must understand whether a young person engages in these types of behaviours with the intent to die (suicidal intent) or whether the behaviour serves a different purpose. Determining the degree of intent can be challenging, particularly when individuals may be reluctant to acknowledge intent, and in situations where this may cause distress to loved ones or result in involuntary hospitalisation. Drawing from the most recent evidence-based literature, a brief outline is provided of the core features of the two behaviours.

Nonsuicidal Self-Injury
The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) has designated nonsuicidal self-injury (also known as nonsuicidal self-harm) as a condition that requires further study. The DSM-V outlines that "*the essential feature of nonsuicidal self-injury is that the individual repeatedly inflicts shallow, yet painful injuries to the surface of his or her body*" (AMA, 2013, p.804). Nonsuicidal self-injury most often starts in the early teen years and can continue into adulthood. Methods of nonsuicidal self-injury include scratching, burning, cutting, banging, hitting and interfering with wound healing (Klonsky, 2011). Seventy to ninety percent of individuals who engage in nonsuicidal self-injury use skin cutting (Klonsky, 2007). Most commonly the purpose is to reduce difficult emotions such as

anxiety and tension and/or to cope with an interpersonal difficulty (AMA, 2013). The act of self-injury is thought to bring immediate relief and to achieve a positive mood state. Despite growing interest in this condition, much remains unknown about why non-suicidal self-injury occurs, including fundamental features of its etiology and causal mechanisms.

Suicidal Behaviour Disorder
An area that is also designated as requiring further study in the DSM-V is Suicidal Behaviour Disorder. The main features of this disorder include a suicide attempt which is a *"self-initiated sequence of behaviours by an individual, which at the time of the initiation, expected that the set of actions would lead to his or her own death"* (AMA, 2013, p. 801). Suicidal behaviour can occur at any time in the lifespan but is rarely seen in children under the age of 5 (AMA, 2013). Suicidal behaviour is often classified in terms of violence of the method. Nonviolent methods include overdoses with illegal or legal substances, whereas gunshot wounds and falling to someone's death would be considered violent methods. Regardless of whether an individual has engaged in violent or nonviolent methods, the behaviour may or may not lead to death, injury or serious medical consequences. In the case that the individual does not bring serious harm to themselves, the suicide attempt must still be treated with the same degree of caution as a prior attempt places an individual at a higher risk of a completed suicide in the future.

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

In 2006, Bridge, Goldstein and Brent reviewed the precipitants of adolescent suicide and suicide behaviour internationally, with a focus on the spectrum of suicidality, from suicidal ideation to suicidal behaviour, with passive thoughts of death and completed suicide representing extreme ends of the risk spectrum. Nonsuicidal self-harm was not included as it fell outside of the scope of the review due to the definition of the purpose of the behaviour. Bridge, Goldstein and Brent (2006) articulated a model whereby suicidal behaviour ensues as a result of an interaction of socio-cultural, developmental, psychiatric, psychological, and family environmental factors. A summary of the risk factors for completed and attempted suicide as outlined in the review are presented below:

- *Suicidal ideation:* The more severe and pervasive the suicidal ideation, the more likely such ideation will lead to an attempt.

- *Previous suicidal behaviour:* A prior attempt is the most potent risk factor, elevating the risk of subsequent completion 10 to 60 fold.

- *Lethality of the suicide attempt:* Attempts of high medical lethality are at extremely high risk for completed suicide.

- *Intent and motivation:* Suicidal intent consists of four factors:
    - Belief about intent
    - Preparation before attempt

- Prevention of discovery, and
- Communication.

Factors that discriminate attempters from completers include evidence of timing the attempt to avoid detection, expressing a wish to die, confiding suicidal plans ahead of time, and planning.

- *Precipitants:* The most common precipitants are interpersonal conflict or loss particularly for substance abusers.

- *Mental Disorder:* Psychiatric disorder is found in approximately 90 percent of adolescent suicide victims and poses 9 times the increased risk for suicide. In approximately 80% of community and referred cases of attempts there are associated psychopathological conditions. Chronicity and severity of disorder have been associated with increased suicidal risk. Mental disorders associated with an increased risk of suicidal attempts and completions include:
  - Mood Disorders
  - Substance use disorders
  - Conduct Disorder/Antisocial behaviour
  - Anxiety Disorders
  - Post-traumatic stress disorder
  - Psychosis
  - Eating Disorders
  - Psychiatric comorbidity.

  An Australian study conducted at the University of Western Australia has investigated the different profiles of risk of self-harm among clinically referred primary school aged children (Angelkovska, Houghton, & Hopkins, 2012). The authors found that individuals with both internalizing (anxiety/ withdrawn, anxiety/depressed and somatic complaints) and externalizing (rulebreaking behavior and aggressive behavior) characteristics were more at risk of self-harm.

- *Physical health:* Poor physical health, health risk behaviours (e.g. binge eating, tobacco use etc.), chronic illness and physical disability are associated with suicidal ideation or attempts, even after controlling for other risk factors.

- *Personality and psychological factors:* Personality disorders are found in approximately one-third of suicide victims. Personality disorder is associated with 2.9 times increase in risk, with an 8.5 times increased risk of suicidal behaviour for individuals diagnosed with a DSM-V cluster B personality disorder (antisocial, borderline, histrionic, and narcissistic personality disorders), after controlling for mood, substance and conduct disorders. Psychological traits associated with an increased risk of suicidal attempts and completions include:
  - Impulsivity
  - Neuroticism
  - Self-esteem
  - Hopelessness
  - Perfectionism

- Sexual orientation.

- *Familial factors:* Parental psychopathology including depression, substance abuse and antisocial behaviours is a risk factor for suicidal behaviour. Family history of suicidal behaviour also increases risk for suicidal behaviour.

- *Family-environmental factors:* Family-environmental factors associated with an increased risk of suicidal attempts and completions include: family constellation, loss, family relationships, maltreatment and disconnection.

- *Biological factors:* A small number of studies on young people have found a link between altered levels of serotonin, and systems involved in cell signalling and signal modulation.

- *Exposure to suicide:*
  - *Clusters and contagion:* A small statistically significant number of adolescent suicides occur in time-space clusters, consistent with the mechanisms of contagion and imitation.
  - *Media influences:* Publicity about suicide, regardless of the media modality, is followed by an increased rate of suicide completion and attempts.

- *Availability of lethal agents:* Case-controlled studies have shown a clear link between firearms in the home and completed suicides. Keeping a gun locked and unloaded, storing ammunition locked, and in a separate location are each associated with a reduction in firearm risk. Cross country comparative studies have found a relationship between stricter gun control legislation and firearms availability and lower suicide rates. Quasi-experimental studies have found that the availability of legal drugs that pose potential lethality increases the risk of suicide attempts and behaviour. Restricting the amount of legal drugs available per purchase and the use of blister packs (rather than sold as loose tablets in a pill container) may reduce these risks.

- *Indigenous Australians:* In Australia national data shows that indigenous suicide mortality is three to five times the age-specific rates of non-indigenous youth aged 0 to 24 years old (ABS, 2008), in addition to higher suicide behaviour for indigenous Australians (Westerman, 2007). Luke and colleagues (2013) have identified five components that are positively and independently associated with suicidal ideation and attempt (with the exception of cultural connection which showed a negative association) in a Koorie cohort of youth:
  - *Emotional distress:* Depression, anger, boredom, poor self-esteem, and sexual abuse.
  - *Social distress (type A):* Koorie values are perceived as not important, parents not living together, no adults to talk to, homeless, injecting drug use, and previously in youth detention.

- *Social distress (type B):* No friends to talk to, few friends, parents with substance problems, physical abuse, and previously in youth detention.
- *Cultural connection:* The ability to talk to elders about Koorie issues, understand Koorie history, use of Victorian Aboriginal Health Service as a main service provider, and parents have high expectations.
- *Behavioural:* No participation in sport, smoker, heavy drinker, and marijuana use.

- *Children in detention*: Asylum-seeking children are one of the most vulnerable groups of displaced persons. There are approximately 1000 children currently in immigration detention (with as many as up to 200 in offshore locations). The experience of being a detainee, with limited ways of communicating one's difficulties, can often result in the expression of distress which may manifest as suicidal and/or self-harming behaviour. The Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention (2004) found alarming levels of suicidal ideation and acts of self-harm amongst young detainees. For example, in 2001 the Catholic Commissioner for Justice, Development and Peace identified 20 self-harming incidents by children under the age of 17. Unaccompanied minors have been identified as a particularly at risk group with unaccompanied female minors being particularly vulnerable. While it is recommended that unaccompanied minors are accommodated separately from adult asylum seekers, accommodation of unaccompanied minors, particularly female minors in compounds with families poses additional risks of sexual predation.

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

As with any psychological difficulties, promotion, prevention and early intervention are the key to higher rates of identification, clinical management and recovery. Suicidal and nonsuicidal behaviour, although complex, are no different and should be considered high priority due to the morbidity and disability rates, in addition to the burden on healthcare resources. Rather than outlining the barriers, it might be helpful to discuss the determinants or facilitators that allow young people to seek help. Some of the key facilitators include:

Promotion: Knowledge and awareness
This is not confined just to children and youth, but includes their carers, friends, educators and other stakeholders such as the police. Education and promotion can help to minimise stigmatisation, fear of repercussion by authority figures (school, parent, police etc.), helplessness and peer pressure, among many other barriers. Improving public health strategies to promote mental health will also maximise health and wellbeing. Settings such as schools, youth drop in centres, local libraries and online services are all avenues by which knowledge and information can be obtained and shared in a safe and anonymous manner.

Prevention: Availability of resources and early detection
Once information on intentional self-harm and suicide is made available, it is vital that there are enough appropriate resources to direct queries for assistance and help. As outlined above, such resources can be made online and in publicly accessible places. However, it is equally important that there are sufficient numbers of qualified staff available to offer front-line services. This measure will directly affect the ability of vulnerable children and youth to access prevention and early intervention services as well as enhancing the protective factors that promote mental health and wellbeing. Offering interventions that occur before the initial onset of a disorder and reducing the risk factors for the disorder will lead to long-term reduction in the number of children and youth displaying intentional self-harm and suicidal behaviours.

Early Intervention: Services and specialist support
Early intervention is comprised of interventions that are appropriate for and specifically targeting the early signs and symptoms of intentional self-harm and suicidal behaviour. It is important that these interventions occur shortly after a need has arisen, aiming to reduce distress, shorten the episode of care and minimise the level of intervention required, reduce dependency, as well as enhance hope for future wellbeing. It is vital that such services are provided by specialist clinicians with the appropriate training and qualifications due to inherent safety issues. Many children with intentional self-harm and suicidal behaviour will not access the appropriate early intervention or specialist support service due to barriers such as under-reporting, relationship with their carers/authorities and fear of repercussion or upsetting loved ones. Therefore such early intervention services and specialist support must be locally based and be accessible, in order to make it as easy as possible for a young person to seek help. In addition, clinicians in these services must be supported so they can provide evidence-based interventions (e.g. access to professional supervision and professional development) and access the services to maintain service quality and prevent burn-out and staff turnover.

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.***

There currently are three central conditions required in order to collect meaningful information to inform policy, programs and practice:

1. In the community there needs to be a distinction between nonsuicidal self-harm and suicidal behaviour. Once a distinction is made a standardised data definition is required for each construct. This is by far the most important issue and will involve not only research and clinical communities, but also stakeholders from welfare agencies, education, emergency response and law enforcement.

2. The role of various authorities must be clearly documented and agreed to (schools, police, family/carers, health professionals, at both State and Commonwealth levels). In particular, the reporting requirements for each authority need to be reliably implemented in order to minimise children and youth falling through the gaps.

3. Finally, there must also be a structure to enable the aggregation of data from various sources into a centralised repository. This national database should be available to government agencies and research entities.

Once such as database is established, it would provide valuable information on injuries, patterns, locations and other variables to allow specific measures and policy responses to be developed and enable emerging issues to be addressed. It is vital that such database only contains de-identified data and have the most strict protocols in terms of accessing, transferring and destruction of the data.

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.

Please see response to question 4

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

Please see response to question 4

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.

In brief, there are no programs that have the direct goal of preventing suicide, and as such and there is limited high quality evidence regarding the most effective approaches for suicide prevention. Suicide prevention strategies generally aim to either reduce risk factors for suicide, or identify people at risk for suicide for referral and eventual treatment. At this stage the best results have been found for reducing the availability of lethal means and providing services to reduce depression and improve general wellbeing. Interventions focus on treating mental health problems such as anxiety and depression, reducing stress and increasing individual protective factors through activities that help to build self-esteem, psychological strength and personal competence. For example, teaching young people social and emotional

skills, fostering positive peer relationships and relationships with teachers and other adults, and encouraging help-seeking behaviours.

School-wide or classroom programs which foster a culture of mental health literacy, and caring supportive responses may reduce some of the barriers for people obtaining help for mental health issues. However, unless individual services are easily accessible, such as the availability of a psychologist in the school, other barriers (e.g., stigma, cost) are likely to prevent individuals from obtaining help. School-based programs whose effectiveness is supported by evidence include:

The availability of a school psychologist
Psychologists are the most appropriate professionals to work with students with mental health problems. Psychologists have knowledge and skills in the assessment and management of mental health disorders as well as the general developmental and emotional issues affecting children and adolescents, which is applied to work in the school setting. Psychological therapy for depression and anxiety has a strong evidence base for positive outcomes. Risk assessment is a fundamental part of a psychologists' training and they are guided by the APS Code of Ethics to act in situations where risk is identified. The psychologist's role in the school setting includes:

- Providing direct assessment and/or treatment to children
- Working with family members and other carers
- Providing training and working with teachers to ensure identification of children at risk
- Providing emergency response services for critical incidents.

All school counsellors whether they be psychologists or social workers, should be trained in suicide risk assessment and treatment and the absence of such programs increases the risk of failing to identify and provide appropriate intervention to those at risk. Whilst teachers do not have the time or the training to deal with issues such as suicide risk or self-harm, they must receive training to identify the situations in which they need to provide for the immediate safety and support of a student and refer on to the appropriate professional.

There is also a need for intensive tracking and follow-up of the peer cohort and others linked to the person who has died through suicide. Suicides, particularly in youth, can and do occur in clusters. It is crucial therefore that service providers and others understand the fundamental differences in grief processes for young people who have experienced the suicide of one of their peers, as well as the very different thinking of young people who were already at risk. Having psychologists based in schools allows for the monitoring of at risk students following a suicide. The ration of school psychologists to students is inadequate with accessibility to a school psychologist becoming increasingly difficult. For example, in Victoria the current school psychologist to student ratio is one psychologist per 2500 students. In order to meet the demand for psychology services in the school setting this ratio needs to be one psychologist per 500 students.

The APS is concerned about the use of external providers (such as Access to Allied Psychological Services and Better Access) storing student notes outside of the school. The "outsourcing" of such services raises a plethora of legal and ethical issues for the professionals involved, as well as for schools, particularly around increased barriers to access, continuity of care, confidentiality, transmission of information, ownership of information, etc. All of these compromise the young person's well-being, and the school's legal duty of care. The APS receives a disproportionate number of queries from schools and psychologists in Victoria around these particular matters. Adequate psychological support should be provided to students in the school setting rather than a reliance on external resources.

MindMatters and KidsMatter
KidsMatter (*in primary school)* and MindMatters (*in secondary schools)* adopt a whole-school program approach which aims to improve the mental health and wellbeing of children and adolescents, reduce mental health problems amongst, promote resilience and achieve greater support for young people experiencing mental health difficulties, and their families. These programs provide education and resources with the focus on:

- A positive school community
- Social and emotional learning for students
- Working with parents and carers
- Helping children experiencing mental health difficulties.

Evaluations of these programs have been positive and indicate an uptake by schools of the resources provided and increased student wellbeing (Slee et. al.,2009; Slee et. al., 2012). Unfortunately, these programs are not running in all schools with around 40% of schools nationwide having been involved in KidsMatter Primary. Involvement of schools in programs that have been shown to promote good social and emotional functioning for children and adolescents is crucial in suicide prevention.

Other programs
A number of other programs are available in some secondary schools including:

headspace School Support which provides support to schools affected by suicide including online training modules on Psychological First Aid and Skills for Psychological Recovery. The uptake by schools of this resource varies across the state.

In the past, programs and training in Psychological First Aid and Skills for Psychological Recovery have been provided by senior psychologists from the Department of Education and Early Childhood Development. It the understanding of the APS that this training is no longer provided.

The Gate Keeper program teaches specific groups of people such as counsellors, teachers, and police, to identify people at high risk of suicide and refer them for

treatment. There is a strong evidence base for this program however, it is unclear if the is widely used.

It is important to note that schools must take caution when inviting groups and organisations into schools as there has in the past been groups that have offered to provide "suicide prevention" work in schools where there is no evidence to support their methods. There have also been incidences of unfettered media discussions of youth suicide. The literature is clear that such well-meaning programs and media discussions can cause harm and may result in an increased suicide rate. It is important therefore that only evidence-based programs are provided by qualified professionals.

Mindframe is a national media initiative that provides access to up-to-date, evidence-based online resources to support the reporting, portrayal and communication about suicide and mental illness. The online resources were developed to guide media professionals to help ensure that the reporting and portrayal of suicide is sensitive and responsible. The recommendations for reporting a suicide death (Hunter Institute of Mental Health, 2014) include the following principles:

- Decide whether to report on a suicide death
- Reduce the prominence of the story
- Modify or remove information that may increase risk
- Take care when interviewing family and friends
- What about online?
- Apply specific cultural considerations
- Reporting celebrity suicide

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.

Please see response to question 7

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.

The advancement and use of technologies such as the internet, the media and smartphones has undoubtedly increased by young people over the last decade which provides new opportunities for self-harm and suicidal behaviour outreach. However, there is currently limited literature demonstrating the efficacy of digital technologies and media in preventing and responding to intentional self-harm and suicidal behaviour among children and young people. Luxton, June and Kinn (2011) conducted a review on current and emerging technologies for suicide prevention which included interactive educational and social networking websites, e-mail outreach and programs that use mobile devices and texting. In the review the

authors also described applications such as virtual worlds, gaming and text analysis, which are currently being developed and applied to suicide prevention.
Luxton and colleagues (2011) found that some of the main advantages of technology assisted services are that individuals in crisis can access support 24 hours a day and are not limited to seeking help during business hours. Furthermore the confidentiality and anonymity offered may assist an individual to initially turn to the internet rather than seeking help in-person. Other advantages include technology's ability to overcome barriers to care by removing the geographical limitations of suicide prevention programs by servicing individuals in rural and remote areas.

The use of digital technologies and the media also has its disadvantages. Limited access to the internet, media modalities and smartphones is a barrier to care. Social networking sites can foster negative effects on user's psychological health, including increased susceptibility to cyber-bullying, victimisation and social exclusion. Equally, use of online forums can be associated with feelings of hopelessness and increases in suicidal ideation (Daine et. al., 2013). These forums can also foster shared instructions for suicide methods and suicide pacts. Another important issue to consider is clinical safety associated with response times when using these types of services. Luxton and colleagues (2011) argue that service users may expect immediate responses if they disclose intent of harm to self. The development of usage guidelines may assist in streamlining some of these issues.

These articles highlight how technology and media will play an important role in preventing and responding to intentional self-harm and suicidal behaviour among children and young people. It is tool that can be used to overcome barriers such as geographical location, limited accessibility to healthcare professionals and can be used to seek help outside conventional business hours. Despite these benefits, it is a tool that cannot replace the services of a clinician, clinical case management or the use of evidence-based assessment, diagnosis and treatment. In the case of risk of suicide or self-harm, trained health professionals are guided to strive to gain permission from the young person to contact a parent or other significant persons where possible in order to facilitate the prevention of self-harm and suicidal behaviour.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Angelkovska, A., Houghton, S., & Hopkins, S. (2012). Differential profiles of risk of self-harm among clinically referred primary school aged children. *School Psychology International, 33,* 646–660.

Australian Human Rights Commission (2004). A last resort? National Inquiry into Children in Immigration Detention. Retrieved 2 June 2014 from: www.humanrights.gov.au/human_rights/children_detention_report/index.html

Australian Bureau of Statistics. (2008). *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (Catalogue No. 4704.0). Canberra, Australia: Author.

Bridge, J.A., Goldstein, T.R., & Brent, D.A. (2006). Adolescent suicide and suicidal behaviour. *Journal of Child Psychology and Psychiatry 47*, 372–394

Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S., & Montgomery, P. (2013). The power of the web: A systematic review of studies of the influence of the internet on self-harm and suicide in young people. *PLOS ONE, 8,* 1-6.

Hunter Institute of Mental Health (2014). *Reporting suicide and mental Illness: A Mindframe resource for media professionals.* Newcastle.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, *27*, 226–239.

Klonsky, E. D. (2011). Non-suicidal self-injury in United States adults: Prevalence, sociodemographics, topography and functions. *Psychological Medicine*, *41*, 1981–1986.

Luke, J.N., Anderson, I.P, Gee, G.J., Thorpe, R., Rowley, K.G., Reilly, R.E., Thorpe, A., & Stewart, P.J. (2013). Suicide ideation and attempt in a community cohort of urban aborigional youth" A cross-sectional study. *The Journal of Crisis Intervention and Suicide Prevention, 34,* 251-261.

Luxton, D.D., June, J.D., & Kinn, J.T. (2011). Technology-based suicide prevention: Current applications and future directions. *Telemedicine and E-Health, 17,* 50-54.

Slee, P.T., Lawson, M.J., Russell, A., Askell-Williams, H., Dix, K.L., Owens, L., Skrzypiec, G., & Spears, B. (2009). *KidsMatter Primary Evaluation Final Report*. Centre for Analysis of Educational Futures, Flinders University of South Australia.

Slee, P.T., Murray-Harvey, R., Dix, K.L., Skrzypiec, G., Askell-Williams, H., Lawson, M., & Krieg, S., (2012). *KidsMatter Early Childhood Evaluation Report*. Shannon Research Press, Adelaide.

Westerman, T. G. (2007). *The Westerman Aboriginal Symptom Checklist – Youth Development.* Perth, Australia: Indigenous Psychological Services.