Northern Territory Government

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To the National Children's Commissioner;

Submission regarding intention self-harm and suicidal behaviour in children

The Child and Youth Mental Health Team Central Australia

The main purpose of this submission is to elucidate, in our clinical opinion and experience, the unique challenges faced in a remote region and the cultural complexities of dealing with self-harm and suicidal behaviours with Aboriginal children, young people and families in Central Australia.

Background

The Child and Youth Mental Health Service (CYMHS) is a multidisciplinary team that provides therapeutic intervention to children, young people up to the age of 18 years (or until they finish school) and their families with moderate to severe mental health concerns. This can include behavioural and emotional issues, depression and/or anxiety, self-harming or suicidal behaviours, psychiatric conditions, social/communication issues, as well as grief, loss, bullying or transient stressors. The team provides psycho-education and targeted behavioural management strategies for parents, carers, teachers and other involved parties, individual therapy for young people and psychiatric assessment and consultation.

The Child and Youth Mental Health Team is referred all young people who present to the Alice Springs Hospital with a suicide attempt or suicidal ideation. This includes those young people who are from remote communities and may have been evacuated into Alice Springs. The team is seen as the most well equipped team to deal with children and young people who are self-harming, presenting with suicidal ideation or previous suicidal risk. Referrals for 'self-harm behaviour or intent' have remained relatively steady over the past three years. Aboriginal young people are overrepresented in referrals related to self-harm (as can be seen from the table below). Just over 40% of CYMHS total clients in 2013 identified as Aboriginal.

Financial Year	% of total referrals for 'self-harm behaviour or intent'	% of referrals for 'self-harm behaviour or intent' that identified as Aboriginal
2011-2012	25	75
2012-2013	15	69
2013-2014	16	71

Given the obvious trends in clients that are seen by CYMHS in this category, this submission will focus on self-harm and suicidal behaviour in Aboriginal young people, the reasons for this and the difficulties in treatment.

1. Why children and young people engage in intentional self-harm and suicidal behaviour and The incidence and factors contributing to contagion and clustering involving children and young people.

It is important to distinguish between several categories of self-harm and suicidal behaviour that we see in Central Australia some of which are likely common in other areas.

1. Self-harm by young people as an expression of their level of distress without suicidal ideation. Can include cutting, scratching, small burns etc, usually in the context of ongoing low mood, anxiety or lack of distress tolerance coping mechanisms. This is not as common in Aboriginal young people as non-Aboriginal young people.
2. Suicidal ideation or behaviour, including self-harm behaviour in the context of ongoing depressed mood or chronic levels of disruption or distress. Young people who present with suicidal ideation, may have a plan, may have attempted (overdose common).
3. Suicidal behaviour and 'threats' of suicide in the context of drug and alcohol use, relational conflict and usually as an impulsive act to express distress or gain the attention of those around. This is the most common referral presentation to our service.

The Child and Youth Team see all three presentations above. There are significant differences in relation to the presentation and lethality of the means across these presentations and the preferred intervention. All three presentations present a level of risk and concern for the young person. In scenario one, the young person would likely be engaged in a therapeutic intervention with the inclusion of family and other systems as appropriate in the assessment and intervention phase. Some would consider this the lowest risk of all three scenario's with intervention focusing on treating underlying issues triggering self-harm behaviours and attempting to teach the young person how to engage in more appropriate coping strategies.

In scenario two, the level of risk is increased with suicidal ideation and possible planning and attempts. In this case the intervention would involve safety planning with the individual, family and other involved services and supports as a priority (school, extended family, friends, GP etc). Intervention that would lead on from safety planning could include individual therapy with the young person focused on addressing underlying concerns leading to suicidal behaviour and development of

more adaptive coping strategies. The involvement of the family in this process is a critical feature, as well as developing a shared understanding with those individuals and service surrounding the young person about the plan and their specific role. In scenarios one and two where young people may be coming from a stable environment with stable family or other supports in place, and initial therapeutic interventions have trouble shifting the self-harm or suicidal behaviour, medication for treatment of underlying depression and/or anxiety may be included as a component of the treatment plan.

Scenario 3: Common Central Australian presentations of self-harm and suicidal behaviour that present unique challenges for intervention in our region.

In the case of scenario three, CYMHS most common presentation, the young person usually identifies as Aboriginal, is living in the context of several socioeconomic pressures which could include, overcrowding, substandard living conditions, poverty, non-attendance at school, drug and alcohol abuse, domestic and family violence, and chronic health concerns (overweight/obese, diabetes, chronic lung and ear issues, skin conditions). The presentation is complicated by a 'trend' that has been observed and documented previously regarding the use of 'suicidal threats' in Aboriginal communities. That is when a person threatens suicide of self-harm as a mechanism for drawing attention, when they are not equipped with any other available means or strategies to successfully to do this (e.g. asking for help) and have likely witnessed this behaviour within the community.

This 'threat' of suicide is usually impulsive, when the young person is intoxicated (alcohol, drugs, volatile substance/sniffing) and usually triggered by relational conflict or external pressures requiring something from a young person that they do not wish to do (e.g. fights with family, friends, partners; requests to engage in activities at school or at home). This 'threat' can be accompanied by suicidal behaviour that most commonly involves hanging as a means. Hanging is one of the more lethal means of suicidal behaviour. This 'threat' behaviour and the threat or use of often lethal means creates dilemmas for those responding. Specifically, the use of 'I am going to hang myself' as a threat is not an uncommon phrase for young people who have history of trauma, exposure to similar behaviours, limited support or safety structures and have minimal if any other available coping strategies. The frequency of the suicidal threat and behaviour can result in those around the young person (family, friends, teachers, child protection staff, carers, other involved persons) becoming more immune to the threat and decrease the intensity of the response. In some cases the young person's threats can be ignored, resulting in further escalation. The concern in these cases is around misadventure. Although the young person generally has no 'suicidal intent' or understanding of the finality of their behaviour, the means they use to threaten (hanging) is lethal and easily accomplished. It is the threat of misadventure; a young person accidentally hanging themselves when no-one is responding or paying attention that is of most concern and the most difficult to treat or intervene.

There are two possible cohorts that present in scenario three. Young people who have an underlying diagnosis such as depressive disorder or post-traumatic stress disorder and are reacting to underlying mood components; and young people who do not meet the criteria for these or similar disorders, although have likely experienced trauma in their history, but do not present as having underlying mood concerns. These cases combined provide the majority of our referrals in the area of self-harm and suicidal behaviours, but have different trajectories in terms of intervention and likely outcome.

Young people who present in both of these categories usually deny any ongoing suicidality post incident. The difficulty arises with regard to engagement and treatment. A large proportion of the young people who present are living in town camps or residential housing in the care of the Department of Children and Families and both often lack strong support networks. Young people living in town camps are often living in overcrowded, substandard housing. If they are not living with and being cared for by their biological parents they can be living with aunts, and grandmothers who may be looking after several other children and young people also. There can be 3-4 families residing in one house on any occasion, with other transient members of the family coming and going on a regular basis. Living conditions are often unclean, personal hygiene poor, access to food can be intermittent and access to nutritious food almost non-existent. Young people are often exposed to and become involved in excessive alcohol consumption. Sniffing is currently also on the rise in Central Australia in recent months. In combination with drug and alcohol exposure and use, young people are often witness to and/or victims of domestic and family violence. Young people are often not engaged with school or any ongoing activities; this can be due to fatigue, lack of resources (clothes, shoes, lunch food, books), lack of support from family and resulting lack of interest and as a result are transient during the day and difficult to locate. Families and young people are also still wary of government services, feel that these are often imposed on them and can link anything related to their children to ‘welfare’. In addition to scepticism around services mental health remains a stigmatised topic and families can feel ‘shame’ about engaging with mental health teams.

In light of these compounding issues we must consider intervention options. Ideally, a young person and family would engage with the mental health team develop a safety plan, engage in individual and family therapeutic work around underlying concerns and work towards developing more appropriate coping strategies. The plan would include involvement with other relevant service providers, school teachers, GP or Paediatrician, drug and alcohol services and any other involved service providers as relevant (child protection, disability, juvenile justice). In the scenarios presented above however, there appear to be in some cases insurmountable challenges to these interventions.

Transport is often an issue, so outreach is necessary. In this case even via outreach it is difficult to locate the family and the young person. In some cases other service providers may be involved to assist with transportation and joint consults, however, locating the young person and family is still a significant barrier. If you are able to locate the young person and/or family, often family will under report symptoms report that everything is fine or good and be generally avoidant of any meaningful contact or follow up. In the event that a young person presents as having a significant depression or depressive symptoms and is refusing to engage, even medication options became difficult due to lack of consistency in a young person’s life and adequate familial support to encourage compliance.

This is the point when many services become uninvolved. The young person and the family no-longer report any concerns and continue to resist engagement. It is important to note that it is common for these young people to present on more than one, if not regular occasions with self-harm of suicidal behaviours.

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

There are a number of barriers in Central Australia, in addition to those already discussed above that prevent children and young people from seeking help.

- Lack of appropriate services to provide support for children and young people in remote communities. The Child and Youth Mental Health Team does not have the resources to provide consistent consultation liaison services to remote communities in Central Australia. Additionally, Remote Health Clinics are already overwhelmed with visiting services and required follow up. It is important that services in remote communities provide a consistent and effective service, which sounds easier than it seems.
- Stigma surrounding Mental Health and ongoing service scepticism from some areas of the Aboriginal community that is a remanent of the stolen generation.
- General lack of hope that engaging will result in any differences in their life.

3. The role of data collection in relation to self-harm and suicidal behaviours

Accurate data collection and understanding of the unique challenges faced in some areas is critical to effectively moving forward in this area. The issue of data collection in the area of self-harm and suicidal behaviour in Central Australia has been raised in the region previously. It is complicated by a number of factors:

- Presentations of self-harm and/or suicidal behaviour can be to any number of services with Central Australia (Health Clinic, Emergency Department, Support services, Mental Health, Child protection etc). Accurate data would need to be able to capture presentations through all relevant services.
- In line with above, responses to self-harm and suicidal behaviour are different from different services. Not all young people who present with self-harm, suicidal ideation or even suicidal attempts are seen by Mental Health or presented to the Emergency Department. This is linked to the 'threat' phenomenon and the tendency toward over and under responsiveness to these behaviours.
- Additionally, the definition of self-harm or suicidal behaviour isn't clear for all of those involved with these young people.
- The biggest issue with regard to data collection is that there is no system or service dedicated to recording this information, so that, even if some services in Central Australia are attempting to collect this data, they are siloed attempts and would not reflect the true scope of the issue.

4. The role of management and utilisation of digital technologies and media in preventing and responding to intentional self-harm and suicidal behaviour among children and adolescents.

Digital technologies moving forward are seen as critical components of intervention in this area. Specifically in rural and remote regions, where connecting young people with self-harm or suicidal behaviours with a Mental Health Team, may only be available through digital means. Young people who present with self-harm and suicidal behaviours in remote communities almost exclusively fall within category three presented above. In line with this their behaviours are generally impulsive and in response to specific stressors within the community. As discussed above, the impulsivity of these acts is critical and by the time a young person has presented to the Remote Health Clinic or is

evacuated into Alice Springs the young person is usually denying any ongoing self-harm or suicidal impulses, cannot be kept under the Mental Health Act and returns to community within 24-48 hours of evacuation. Digital technologies are critical in assisting remote health clinics to respond to these presentations and where possible engage in follow-up and review.

What we think might be useful in responding to the unique challenges in Central Australia.

Beyond the larger issues of resources, accurate data and digital technology, there are a couple of suggestions for enhancing services to this population group in Central Australia.

- Improved capacity to “follow" kids better between Alice Springs, town camps and remote communities, by enhanced intensive case management capacity which could operate over the six weeks or so after presentation, thus not putting so much pressure on the existing services but enhancing links to already established services. This may look like a team that is embedded within Mental Health Services that is established for the primary function of intensive follow up during the critical period and connecting young people and families with established services (which may be lower-level support services depending on resources available e.g. youth workers in remote communities, Health Clinics, counsellors, GP’s) that can continue to support them post the critical period. This is a model used in cities and some large towns.
- Enhanced capacity to identify kids across services, which could be done through establishment of an ‘at risk register’ between local services including, health, education, welfare and NGO’s, with regular meetings, reviews, understanding of expectations and joint case planning as well as other relevant functions as required.

We thank you for considering our Submission and are happy to make ourselves available if the Commission requires any further information or wishes to discuss our submission in more detail.