Chapter 3:
Intentional self-harm, with or without suicidal intent, in children and young people under 18 years of age

A selection of photos from roundtables throughout Australia about intentional self-harm, with or without suicidal intent

Section 46MB(1)(c) of the *Australian Human Rights Commission Act 1986* (Cth) (the AHRC Act) provides that the National Children's Commissioner may:

> ...undertake research, or educational or other programs, for the purpose of promoting respect for the human rights of children in Australia, and promoting the enjoyment and exercise of human rights by children in Australia.

Utilising this function, I have examined intentional self-harm and suicidal behaviour in children and young people aged 0-17 years.

Intentional self-harm and suicidal behaviour in children and young people is a serious issue in Australia and overseas.[1] [2]

Too many precious young lives are lost or damaged by intentional self-harm and suicide. It has profound impacts on families and communities, both at the time and for many years on.

When one member of a family is distressed, the whole family feels pain.

Family members can react in different ways to a child or young person in this situation, including feelings of despair, anger, guilt, shame, sadness and grief.

Families have told me they want to be able to do more to help their children in distress, and children and young people want to be able to reach out to people they trust, including family members. I hope that by conducting this examination I have gone some way to highlighting what is happening for our children and young people, and to shine a light on the kinds of supports children, young people and families need to better prevent and respond to intentional self-harm with or without suicidal intent.

3.1 What do we know about intentional self-harm, with or without suicidal intent, in children and young people?

The Australian Bureau of Statistics (ABS) has reported that intentional self-harm is the leading cause of death among Australian children and young people aged 15-24 years,[3] with 214 deaths by males and 110 by females in 2012.[4]

For those aged 15-19 years, intentional self-harm accounted for 21.9% of deaths in males[5] and 32.6% in females.[6] Six males[7] and eight females[8] under 15 years of age died due to intentional self-harm.

Prior to 2013, ABS had not separately published data about deaths due to intentional self-harm in children and young people under 15 years of age.

Work conducted in the United Kingdom in 2004,[9] and cited by headspace, the National Youth Mental Health Foundation,[10] estimates that the number of children and young people who have engaged in intentional self-harm is between 40-100 times greater than the number of children and young people who die due to intentional self-harm.

Given the estimated level of non-suicidal self-harm in children and young people, it is concerning that our surveillance systems may not be detecting the actual number of children and young people engaging in this behaviour.

The Australian Institute of Health and Welfare (AIHW) has reported that, in 2011-12, intentional self-harm was the cause of 2,855 hospital separations for males aged 15-24 years.[11] In the same time period, there were 7,154 hospital separations involving females aged 15-24 years.[12] There were 690 hospital separations due to intentional self-harm for females aged 5-14 years.[13] No data was provided for males.[14]

A separation is defined as an episode of care for an admitted patient.[15] An admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care.[16] In the remainder of this report, separations are referred to as hospitalisations.

In 2013, Kids Helpline, Australia's national telephone crisis and counselling service for those aged 5-25 years, facilitated 9,649 counselling sessions with children and young people who were assessed by the counsellor as having current thoughts of suicide.[17] Kids Helpline also responded to 15,948 contacts from children and young people aged 5-25 years who were assessed to have self-injury and self-harming behaviour.[18]

Research suggests that a growing number of children and young people are engaging in intentional self-harm and are not seeking help.[19] [20] However, the extent and cause of this poor help-seeking behaviour is unknown.

It is clear that some children and young people are disproportionately affected by intentional self-harm and suicidal behaviour.

These groups include Aboriginal and Torres Strait Islander children and young people, children and young people who are sexuality diverse, transgender, gender diverse and intersex, children and young people in out-of-home care, children and young people with disability, children and young people from culturally and linguistically diverse backgrounds, and children and young people living in rural and remote areas of Australia.

The ABS reports that **Aboriginal and Torres Strait Islander** males and females aged 15-24 years were 5.2 times more likely to die due to intentional self-harm than other children and young people in the same age range.[21] [22] The AIHW reports that 60 Aboriginal and Torres Strait Islander children and young people under 18 years of age died due to intentional self-harm during the period 2007-2011, compared to 143 non-Indigenous children and young people.[23]

The AIHW notes that this data only includes New South Wales, Queensland, Western Australia, South Australia and the Northern Territory as only these five jurisdictions are considered to have adequate identification of Indigenous deaths in their registration systems for the reporting period.[24] Since 2010, the Close the Gap Campaign Steering Committee has reported there is lack of reliable data in some areas to show whether the gap in Indigenous health and life expectancy is closing.[25]

During 2013, I attended the launch of the report, *Growing Up Queer*, released by the Young and Well Cooperative Research Centre.[26] This report identified intentional self-harm and suicide as a significant issue for children and young people who are sexuality diverse, transgender, gender diverse and intersex.[27]

1,032 children and young people aged 16-23 years participated in an online national survey as part of this report. 41% of participants had thought about self-harm and/or suicide, 33% had harmed themselves, and 16% had attempted suicide.[28]

At 30 June 2013, there were 40,549 **children and young people in out-of-home care** in Australia.[29] Of these, 13,952 were Aboriginal and Torres Strait Islander children and young people.[30] Research suggests there are higher rates of intentional self-harm and suicidal behaviour for children and young people in out-of-home care compared to the general population.

One Australian study involving 326 children and young people aged 6-17 years living in home-based foster care, found that 6.7% of the 13-17 year old children and young people reported a suicide attempt that required medical treatment within the last 12 months.[31]

Children and young people with disability can also be at an increased risk of intentional self-harm and suicidal behaviour. A US study found that 30-64% of children and young people with an intellectual disability develop comorbid mental health disorders, a rate of around 3-4 times that of their peers, including higher rates of depression, anxiety and psychosis.[32] Children and young people with co-occurring chronic physical and mental health conditions are also said to have higher probabilities of self-harm, suicidal ideation, and suicide attempts when compared with healthy peers.[33] Research also suggests an association between chronic pain and suicidality in children and young people.[34]

Children and young people from culturally and linguistically diverse backgrounds are described as being particularly vulnerable. While there is limited data about the prevalence of intentional self-harm and suicidal behaviour within multicultural communities, the stresses of migration, settlement in a new country and low language proficiency can increase mood and anxiety disorders.[35]

Children and young people in rural and remote areas of Australia experience unique challenges. Ratios for death due to intentional self-harm among young men are particularly high, with some estimates finding that it occurs at almost twice the rate as in metropolitan areas.[36] [37]

According to Suicide Prevention Australia, underemployment, lack of infrastructure, including health and education services, restricted social and career opportunities, drought, and cultural stoicism may contribute to the distress of young people in rural Australia.[38] Children and young people with mental health needs often experience a lack of services and access to information in rural Australia.[39]

3.2 An identified need for further investigation

Reflecting on what was known about intentional self-harm and suicidal behaviour in children and young people in Australia, I became acutely aware of the gaps in our knowledge base.

Disaggregated data, at a national level, is generally not available for children and young people, under the age of 18 years, who are engaging in intentional self-harm and suicidal behaviour. The ABS, AIHW and Kids Helpline publish national data using broad age ranges: 5-14 years; 5-24 years; and 15-25 years.

These age ranges combine data about children and young people who are functioning at different developmental stages. The two later age ranges also mix those who are legally defined as minors with those who are legally defined as adults. The circumstances facing those under 18 years of age and those over 18 years of age vary considerably.

Additionally, the age ranges do not align with the 0-17 year age range used in reporting by the child death review bodies across the different jurisdictions.

In my 2013 report to Parliament, I outlined the paucity of data in Australia about the wellbeing of children and young people in a range of critical domains. The dearth of information in the area of intentional self-harm and suicidal behaviour has implications for policy development, the design of interventions and for the evaluation of the effectiveness of these interventions.

As far back as February 2010, the National Committee for Standardised Reporting on Suicide recognised that suicide statistics in Australia were characterised by underreporting and inconsistency across the regions.[40] In 2010 they stated that inadequate data about suicide:

> has implications for policy development, monitoring and evaluation and can lead to misinformed and misdirected prevention, intervention and postvention activities. Critically for suicide prevention initiatives, this may result in inadequate resource allocation and neglect of at-risk groups and regions.[41]

Four years later, little appears to have changed with respect to the availability of disaggregated data relating to Australian children and young people engaging in intentional self-harm and suicidal behaviour.

The United Nations Committee on the Rights of the Child specifically asks for disaggregated data on the death of children and young people under 18 years of age who die due to intentional self-harm.[42] As a party to the *Convention on the Rights of the Child* (CRC), Australia provides periodic reports to the Committee on the Rights of the Child every five years. These periodic reports examine how Australia is meeting its obligations under the CRC. Australia is due to provide its next periodic report to the Committee on the Rights of the Child in 2018.

Since 2010, two inquiries into suicide have been conducted at the national level:

- Senate Inquiry: The Hidden Toll: Suicide in Australia (2010)[43]
- House of Representatives Inquiry into Early Intervention Programs aimed at Reducing Youth Suicide (2011).[44]

Other reports have been published at state and territory levels,[45] [46] including those prepared by the various child death review bodies that regularly review the deaths of all children and young people in their jurisdictions.

While acknowledging the value of these inquiries and reports, I was conscious that children and young people, and their advocates, had specifically raised issues relating to intentional self-harm and suicidal behaviour with me during my national listening tour in 2013. They asked me to examine, at a national level, how the human rights of children and young people engaging in intentional self-harm and suicidal behaviour could be better protected.

Intentional self-harm and suicidal behaviour in children and young people was also brought to my attention through the Australian Human Rights Commission (the Commission) BackMeUp competitions, which were run in 2012 and 2013. The BackMeUp competitions asked children and young people to create videos that promoted bystander action to combat cyberbullying. Some entries alluded to intentional self-harm and suicidal behaviour. The Commission's guidelines for the competition clearly stated that videos including depictions of methods of self-harm would not be uploaded for public viewing, consistent with advice provided by headspace. Where this occurred, children and young people were referred to mental health support hotlines.

The Commission reported in its 2013 Snapshot Report, *Asylum seekers, refugees and human rights*, that between 1 January 2013 and 14 August 2013, there were 50 incidents of actual self-harm and 49 incidents of threatened self-harm at Pontville Alternative Place of Detention involving unaccompanied minors.[47] I visited those children and young people held in Pontvillle Alternative Place of Detention in April 2013. I am pleased that Pontville Alternative Place of Detention has since been closed. However, I am aware of reports of intentional self-harm by children and young people in other Australian immigration detention facilities.

For the reasons that I have outlined, and consistent with my statutory function under section 46MB1(c) of the AHRC Act, I decided to undertake a national examination.

3.3 Why is intentional self-harm, with or without suicidal intent, a child rights issue?

Intentional self-harm and suicidal behaviour relates to Australia's obligations under the CRC:

Article 6(1)	States Parties recognise that every child has the inherent right to life.
Article 6(2)	States Parties shall ensure to the maximum extent possible the survival and development of the child.
Article 19	States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 23(1) States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions, which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

Article 24(1) States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Article 25 States Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Associated with intentional self-harm and suicidal behaviour are experiences of homelessness; imprisonment; substance misuse; physical and mental health problems; out-of-home care; child abuse and neglect; domestic violence; peer victimisation; increased rates of family breakdown; and sexual abuse.[48] These experiences are connected with breaches of other children's rights, including:

Article 27(1) State Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 33 States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 37 States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner, which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39 States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment, which fosters the health, self-respect and dignity of the child.

The United Nations Committee on the Rights of the Child issues General Comments on specific articles of the CRC, which provide an interpretation of children's rights.

General Comment No. 13 on the Right of the Child to Freedom from all Forms of Violence makes specific reference to suicide and self-harm as health consequences resulting from exposure to violence and maltreatment.[49]

General Comment No. 13 includes self-inflicted injuries, suicidal thoughts, suicide attempts and actual suicide in its definition of self-harm.[50]

In *General Comment No. 13* the Committee on the Rights of the Child indicates that suicide among adolescents is of particular concern to it.[51] It argues that counselling support should be available to children and young people who are engaging in self-harm, including 24-hour toll-free child helplines with trained personnel.[52] It specifies that all interventions must be supportive and not punitive in any way.[53] The United Nations guidelines for periodic reports to the Committee on the Rights of the Child specifically asks for information on measures taken to prevent suicide and other relevant issues affecting the right to life, survival and development of children and young people.[54]

3.4 How I conducted my examination

Over a six month period, I ran national consultations, with a public submission process, roundtables, analysis of key data, and engagement with children and young people at risk through supported processes.

Overview

140 written submissions were received from individuals, government, private and non-government organisations (see Appendix 5).

12 roundtables were held and 154 people participated (see Appendix 6).

There were nine individual consultations (see Appendix 7).

3.4.1 Data requests

Death and hospitalisation data are a significant and important input to health and social policy formulation, planning, research and analysis.[55] [56]

National data about death and hospitalisations due to intentional self-harm are collected by ABS and AIHW respectively. The National Coronial Information System (NCIS) is an electronic database of coronial information that contains case details from coronial files of most states and territories since 1 July 2000. Queensland coronial files were made available from 1 January 2001. The function of NCIS is to develop and maintain a high quality information service for coroners, policy makers and researchers to benefit the community by contributing to a reduction in preventable death and injury.[57]

As part of my investigation into intentional self-harm and suicidal behaviour, I sourced data from NCIS, ABS and AIHW. I was charged on a cost recovery basis for all data.

The NCIS agreed to provide data by six age ranges: 0-3 years; 4-9 years; 10-11 years; 12-13 years; 14-15 years; and 16-17 years. This data was disaggregated by Indigenous status, state or territory of residence, mechanism of intentional self-harm and incident location of intentional self-harm. The NCIS also provided data about the time when the incident of intentional self-harm was recorded to have occurred.

The ABS agreed to provide data by two age ranges: 5-14 years and 15-17 years. This data was disaggregated by sex, state and territory of residence and mechanism of intentional self-harm. The ABS also provided data about all children and young people aged 5-17 years disaggregated by Indigenous status and area of usual residence by capital city and the remainder of the state or territory.

The AIHW agreed to provide data by three age ranges: 3-9 years; 10-14 years; and 15-17 years. This data was disaggregated by sex, area of usual residence by major cities, regional Australia and remote Australia, mechanism of intentional self-harm and incident location of intentional self-harm. The AIHW also provided data about all children and young people aged 3-17 years disaggregated by Indigenous status and socioeconomic status by area of residence.

3.4.2 Accessing the experiences of children and young people

Hearing directly from children and young people about their experiences is critical to my work. In the case of this examination, I wanted to hear from children and young people in a way that was safe and did not traumatise them in any way. I accessed the voices and stories of children and young people affected by intentional self-harm and suicidal behaviour through partnerships with organisations working directly with them as this was the safest, most confidential and sensitive way of hearing from children and young people.

Through these partnerships, a number of children and young people provided me with their stories directly. I have included some of their stories throughout this chapter. Some were over 18 years of age and were no longer engaging in intentional self-harm or suicidal behaviour. Parents and carers of children and young people also told me their stories through their submissions.

I wish to thank the courageous children and young people, and their families, who shared their stories with me.

The Kids Helpline supplied me with a detailed report of 6,703 contacts from children and young people aged 5-17 years, who directly stated that suicide was their main concern. The Kids Helpline also reported 4,380 contacts from children and young people who directly stated that self-injury and self-harm was their main concern. These contacts were made during 2012 and 2013.

In addition to this, Kids Helpline gave me a qualitative analysis of 50 contact notes for counselling provided to children and young people in relation to suicide issues, and 84 contact notes for counselling provided in relation to self-injury and self-harm issues.

The Kids Helpline submission stated that:

> Given the importance of these issues to Australian children, this organisation has prepared a detailed analysis of its experiences in supporting children to both inform the National Children's Commissioner's deliberations and to ensure that the voice of young people is heard.[58]

Data provided in the Kids Helpline submission is based on the experiences and views of children and young people who are actively seeking help. This contrasts with most other data sources that report on children and young people who are either in recovery, hospitalised or who have died due to intentional self-harm.

I sincerely thank Ms Tracy Adams, Chief Executive Officer, and Mr John Dalgleish, Manager of Strategy and Research, at Kids Helpline for generously providing this data about children and young people aged 0-17 years. It is my hope that this previously unpublished data may be used by researchers and policy makers to better support the rights of children and young people engaging in intentional self-harm and suicidal behaviour.

With respect to engaging with the views of children and young people, I am pleased to report that *Growing Up in Australia:* The Longitudinal Study of Australian Children (LSAC) has recently included items of suicidal behaviour and non-suicidal self-harm in its survey completed by children and young people. The LSAC has followed the development of 10,000 children, young people and families from all parts of Australia since 2004. The questions that it asks are provided in Table 1. The LSAC told me that it views these questions as critically important and intends to continue to include them in future waves of LSAC.[59]

Table 1: Questions asked by Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC)

Sometimes people feel like hurting themselves.

1. During the past 12 months have you…
    a. thought about hurting yourself on purpose in any way? (e.g. by taking an overdose of pills, or by cutting or burning yourself)?
    b. hurt yourself on purpose in any way (e.g. by taking an overdose of pills, or by cutting or burning yourself)?
2. During the past 12 months did you…
    a. ever seriously consider attempting suicide?
    b. make a plan about how you would attempt suicide?
3. During the past 12 months, how many times did you actually attempt suicide?
    0. 0 times
    1. 1 time
    2. 2 or 3 times
    3. 4 or 5 times
    4. 6 or more times

Did any attempt result in an injury, poisoning or overdose that had to be treated by a doctor or nurse?

1. Yes
2. No

Footprints in Time: The Longitudinal Study of Indigenous Children (LSIC) which includes two groups of Aboriginal and/or Torres Strait Islander children who were aged 6 to 18 months (B cohort) and 3½–5 years (K cohort) when the study began in 2008, informed me that its Steering committee is currently considering questions on self-harm and suicide ideation to be included in its future work.

The LSIC explained that the questions are planned for its K cohort when the children are 11 years old. It informed me that some parents and carers who have been interviewed in previous years have mentioned suicide when asked about life events. The LSIC indicated that it was especially interested in protective factors and in exploring prevention strategies and the development of coping skills. Additionally, LSIC told me that it was concerned about contagion and it would be trying to ensure that it had some questions about happenings at a community level.[60]

The work being conducted by LSAC and LSIC is commendable and their recent efforts in the area of suicidal behaviour and non-suicidal self-harm have the potential to contribute much to an area where too much remains unknown.

3.4.3 Call for written submissions

On 22 April 2014, I called for written submissions from individuals, government, private and non-government organisations about some key areas of interest. These included:

- Why children and young people engage in intentional self-harm and suicidal behaviour.
- The incidence and factors contributing to contagion and clustering involving children and young people.
- The barriers which prevent children and young people from seeking help.
- 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.
- 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.
- The benefit of a national child death and injury database, and a national reporting function.
- 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 feasibility and effectiveness of conducting public education campaigns aimed at reducing the number of children who engage in intentional self-harm and suicidal behaviour.
- 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.

I received 140 written submissions, which are listed in Appendix 5. The submissions can be viewed online at https://www.humanrights.gov.au/publications/childrens-rights-report-2014.

I thank everyone who took the time to make a written submission.

3.4.4 Roundtables and individual consultations

From 13 May 2014 to 11 September 2014, I held roundtables with experts in intentional self-harm and suicidal behaviour in all capital cities across Australia. I also held a roundtable in Alice Springs. In addition, I conducted two targeted roundtables; one focused on data and research issues and the other on Aboriginal and Torres Strait Islander children and young people.

The Aboriginal and Torres Strait Islander Social Justice Commissioner, Mr Mick Gooda, co-chaired the roundtable that focused on Aboriginal and Torres Strait Islander children and young people. Commissioner Gooda also co-chaired the roundtables that were held in Western Australia and the Northern Territory. The contribution made by Commissioner Gooda enabled Aboriginal and Torres Strait Islander people to have a strong presence in my roundtables. I sincerely thank Commissioner Gooda for his invaluable support.

I also held a roundtable with the Royal Children's Hospital Mental Health Community Reference Group. I thank Mr Harry Gelber OAM for facilitating this opportunity.

In order to stimulate discussion, up to two experts presented at each roundtable. I would like to thank all those who presented. Appendix 6 includes a list of participants and expert presenters who attended the national roundtables.

I had 9 consultations with individuals. These are included in Appendix 7.

I would like to thank all those who participated in roundtables and individual consultations.

I would also like to acknowledge the significant contribution made by DLA Piper in hosting a number of my roundtables and transcribing the discussions that took place. Appendix 8 includes a list of DLA Piper staff who participated in this investigation.

Additionally, I would like to thank those State and Territory Children's Commissioners/Guardians who hosted some of my roundtables and who participated in my examination.

Staff at the Commission worked tirelessly throughout, and in particular I wish to thank Dr Susan Nicolson, Mr Loki Ball and Ms Jennifer Ross.

My examination of intentional self-harm and suicidal behaviour in children and young people aged between 0-17 years was welcomed by a cross-section of government and non-government bodies as well as academics and individuals.

Jesuit Social Services: What has been missing is sustained political will and community understanding and commitment to tackling this important issue. We welcome this Commissioner's inquiry and hope that it leads to meaningful and sustained action to prevent further unthinkable tragedies from occurring.

National LGBTI Health Alliance is pleased to make a submission on intentional self-harm and suicidal behaviour in children and young people. We appreciate the explicit inclusion of young people of all sexual orientations and genders in this investigation. We also encourage the future inclusion of intersex children and young people in such investigations.

Youth Affairs Council of WA (YACWA) is thankful for the opportunity to submit to this critically important examination. Self-harm and suicide is at epidemic levels in Australia, with mental health illness impacting greatly throughout our communities. However, these are not at all new phenomena, with many inquiries and reports conducted both at a state, national and international level. Without immediate action, we will continue to see the lives of many young people in Australia lost as stigma, lack of services and a lack of funding prevent them from accessing help. The true impact of this examination will not be in the revealing of new information, but in the changes we see to the lives of young people at risk of self-harm and suicidal behaviour, through change to the way we support their needs.

Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback into the National Children's Commissioner's examination into intentional self-harm and suicidal behaviour among children under 18 years. The RANZCP welcomes this inquiry particularly in view of the release of recent statistics that suicide continues to be a leading cause of death among children and young people.

Northern Territory Council of Social Services welcomes the opportunity to contribute to the National Children's Commissioner's examination of intentional self-harm and suicidal behaviour in children. We welcome the opportunity to comment on this distressing subject, and are heartened that the National Children's Commissioner considers this as a matter of great importance.

Hunter Institute of Mental Health believes this review is an important step towards preventing self-harm and suicidal behaviour in children and young people.

Australian Bureau of Statistics continues to seek opportunities to enhance the availability and content of relevant data which supports suicide prevention work, and values the opportunity to make a submission to the National Children's Commissioner's examination of how children and young people under the age of 18 years can be better protected from intentional self-harm and suicidal behaviour.

3.5 Key findings

My primary finding is that too much continues to be unknown and this is impeding us from predicting and preventing injury and death in children and young people due to intentional self-harm.

Despite previous inquiries, efforts relating to children and young people in this area are fragmented and lack a sound evidence base. In relation to suicidal behaviour, the Australian National Coalition for Suicide Prevention stated:

> We do not have a clear picture of suicide in this country and until we have access to that information we are limited in how we can affect change.[61]

The picture about intentional self-harm is even less clear.

Establishing a national research agenda for children and young people in the area of intentional self-harm and suicidal behaviour could serve as a focus and a means to coordinate some of the excellent work already being undertaken by those in this field.

3.5.1 Definitional challenges and research considerations

Many different terms are used to define intentional self-harm and suicidal behaviour. It is evident that:

> there is no uniform set of terms, definitions, and classifications for the range of thoughts, communications, and behaviours that are related to self-injurious behaviours, with or without the intent to die.[62]

The distinctions between the terms used are not well understood, are not agreed upon, and are not clear.

For example, some use the term self-harm broadly and do not differentiate between self-harm with suicidal intent, non-suicidal self-injury and self-harm episodes with unclear intent.[63] They argue that:

> suicidal intent is fluid and its assessment remains unreliable and that a professional judgement about suicidal intent may be different from that stated by the young person.[64]

Some of those who hold this view maintain:

> self-harm in adolescents is likely to be associated with a spectrum of suicidal and purely non-suicidal groups at each end of the spectrum and the majority of adolescents reporting mixed or unstable intent.[65]

While others distinguish intentional self-harm with suicidal intent from intentional self-harm without suicidal intent, the definitions used vary and so the reliability and validity of findings are compromised.[66] Research from the UK and Europe tends to use the broader definition while research from the US is inclined to differentiate between them.[67]

At this point, I would like to highlight the fact that some submissions and participants in the roundtables used the term 'self-harm' when referring to 'non-suicidal self-harm' and used the term 'suicidal behaviour' when referring to 'self-harm with suicidal intent'. Others used the term 'self-harm' to include 'self-harm with suicidal intent' as well as 'self-harm without suicidal intent'. Some substituted the term 'self-harm' with the term 'self-injury'.

These definitional issues present significant challenges for those working in the field. For example, researchers cannot easily compare their study populations and research findings and clinicians have difficulty in translating research findings into practical applications.[68]

Professor Nock, an eminent researcher in this area, points out that:

> over the past several years, there has been a great deal of discussion, and some debate, in the scientific and clinical community regarding what terms we should use to describe self-harm behaviours and how we should define them…future efforts are needed to operationalise these constructs even more clearly and specifically.[69]

In Australia and internationally, many professionals use the American Diagnostic and Statistical Manual of Mental Disorders (DSM)[70] as the authoritative guide[71] for diagnosing mental disorders, including for children and young people. In 2013, the fifth revision of the DSM included, 'Suicidal Behaviour Disorder' and 'Non-suicidal Self-Injury' as conditions for further study.

The proposed criteria are provided in Table 2. It is argued that using these common definitions and criteria could:

> increase the reliability and validity of findings from the studies in the area… increase consistency across studies and…further facilitate research progress.[72]

Table 2: Criteria proposed by American Diagnostic and Statistical Manual of Mental Disorders-5

Proposed Criteria for **Suicidal Behavior Disorder**[73]

A. Within the last 23 months, the individual has made a suicide attempt.
   Note: A suicide attempt is a self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would lead to his or her own death. The "time of initiation" is the time when a behavior took place that involved applying the method.
B. The act does not meet criteria for non-suicidal self-injury – that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.
C. The diagnosis is not applied to suicidal ideation or to preparatory acts.
D. The act was not initiated during a state of delirium or confusion.
E. The act was not undertaken solely for a political or religious objective.

Specify if:

Current: Not more than 12 months since the last attempt.
In early remission: 12-24 months since the last attempt.

Proposed Criteria for **Non-suicidal Self-Injury**[74]

D. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).
   Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.

E. The individual engages in the self-injurious behavior with one or more of the following expectations:

1. To obtain relief from a negative feeling or cognitive state.
2. To resolve an interpersonal difficulty.
3. To induce a positive feeling state.

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.

C. The intentional self-injury is associated with at least one of the following:

1. Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
2. Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.
3. Thinking about self-injury that occurs frequently, even when it is not acted upon.

D. The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.

E. The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.

F. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking] disorder).

When the DSM-5 was raised in the context of my roundtables, some misgivings were expressed. This related to the categorical approach taken in the DSM-5 and the narrowness of the proposed criteria and its cut-off points, with the end result being that 'you either have it or you don't'.

In the roundtables, there was clearly a preference for a more dimensional approach to diagnostic classification where clinicians are not restricted by such concrete thresholds.

This view has been gradually gaining international momentum in the area of psychiatry where:

> after decades of categorical approaches to psychiatric disorder through the DSM, science is considering a shift toward integrating new dimensional applications with the current categorical approaches.[75]

To some extent, the DSM-5 has recognised this shift and while all disorders remain in categories, it has, for some disorders on a spectrum, added measures related to degrees of severity.[76] The degree to which the DSM-5 has done this for its proposed criteria for Suicidal Behavior Disorder and Non-suicidal Self-Injury appears questionable.

While apprehensive about the proposed criteria provided in the DSM-5, the participants at roundtables and many who made submissions were clearly of the view that it was important to examine non-suicidal self-harm as a condition outside of a suicide perspective.

Conceptually this separation has been difficult in the past given that the risk of suicide in adolescents has been shown to increase by approximately 10-fold where there is a history of intentional self-harm, with or without suicidal intent.[77]

However, as pointed out in the submission made by the Royal Australasian College of Physicians, 'not all self-harm is related to suicide risk'.[78]

The Hunter Institute of Mental Health makes the important point that:

> self-harm and suicide are distinct and separate acts. However the relationship between the two is complex… Self-harm is different from suicidal behaviour, but some people who self-harm are also suicidal or can become suicidal.[79]

The Rosemount Good Shepherd Youth and Family Services submission emphasises the need to clearly differentiate between non-suicidal self-harm and suicidal behaviour.[80] The Phoenix Centre reinforces this in its submission when it states:

> it is essential that stakeholders have a shared understanding of terminology. Self-harm and suicidal behaviour are phenomena with differing characteristics. Confusion arises when "self-harm" and "suicide" are used synonymously.[81]

The NSW Department of Education and Communities notes that:

> a range of behaviours and motivations (including ambiguous motivations) are captured by the terms "intentional self-harm" and "suicidal behaviour" and this confounds agreement on the reasons why children and young people may engage in this type of behaviour.[82]

The Youth Affairs Council of Western Australia told me:

> the reasons why young people engage in self-harm and suicidal behaviour are complex. It is important that we recognise differences between the two behaviours.[83]

The Australian Psychological Society argued:

> 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.[84]

headspace pointed out:

> the terms "intentional self-harm" and "suicidal behaviour" are not consistently defined within the literature, and are therefore not necessarily understood in the same way across different contexts or service settings. headspace views the difference between self-harm and suicidal behaviour as the intent behind the behaviours. In the vast majority of cases, self-harm is a strategy used to cope with underlying distress and not a suicide attempt.[85]

The Child and Youth Mental Health Service, Children's Health Queensland Hospital argued:

> there can be confusion regarding the overlap between the concepts of self-harm and suicide, let alone what they each constitute. If there is to be more accurate identification and recording of these behaviours, it would be helpful to promote a shared understanding of their scope across sectors supporting children and young people.[86]

International researchers in this area, Muehlenlamp, Claes, Havertape and Plener assert that:

> essential qualitative and phenomelogical differences do distinguish suicidal from non-suicidal self-injurious behaviour so continuing to differentiate self-injury with and without suicidal intent is essential to building precise understandings of these behaviours as well as how non-suicidal self-injurious behaviours relate to and influence suicidality.[87]

Clearly these definitional issues must be resolved. Addressing definitional issues should form an essential part of any national research agenda that is focused on children and young people who are engaging in non-suicidal self-harm and suicidal behaviour.

It was pointed out to me that conducting research in the area of suicidal behaviour and non-suicidal self-harm has challenges that are not present when conducting research in other areas such as depression, anxiety or psychosis. It is possible in these other areas to directly observe the symptoms in real-time whereas it is not possible to do this for suicidal behaviour and non-suicidal self-harm.[88]

Information is usually collected retrospectively. Some argue 'future research is needed to capture such thoughts and behaviours and study the individuals as they actually occur in real-time'.[89] With advancing technology, this may be possible.

To some extent the information collected online and over the phone by Kids Helpline is already moving towards this. As pointed out by Child Helpline International:

> Child helplines provide children with unique opportunities to express their thoughts, feelings, and needs and to seek help in their own terms, without fear or inhibition. Trusted by children, child helplines help to keep children safe and to receive respect, nurturance and support. They do this through their own direct responses and by using the knowledge given to them by children to advocate on their behalf.[90]

Another issue raised with me was the dearth of research that actually involved the direct participation of children and young people.

There is a perception that it is unsafe to include children and young people engaging in non-suicidal self-harm and suicidal behaviour in research about them. This often leads to their exclusion from research studies.[91] This exclusion is based on the belief that it can lead to increased risk.

However, as Orygen Youth Health Research Centre emphasised to me, recent studies:

> have demonstrated that participation in research related to suicide prevention appears to have no iatrogenic effects among participants. Therefore continuing to build an evidence base specifically relating to the safety of engaging young people in research is an important step towards overcoming the current absence of evidence.[92]

Many submissions also raised the need for youth friendly services that have the resources, skills and capacity to respond to children and young people engaging in non-suicidal self-injury and suicidal behaviour.[93]

headspace pointed out the need for:

> a youth friendly approach that prioritises young people's participation in their own treatment as well as in service development and quality improvement.[94]

It is important that future research develops better knowledge about how to provide youth friendly services, and services are evaluated in terms of their accessibility to children and young people.

Summary – definitional challenges

There is inconsistent use of terms and definitions relating to intentional self-harm with or without suicidal intent. The distinctions between the terms used are not well understood, are not agreed upon, and are not clear. Researchers cannot easily compare their study populations and research findings, and clinicians have difficulty in translating research findings into practical applications.

It is necessary to distinguish between non-suicidal self-harm and suicidal behaviour. Non-suicidal self-harm is different to suicidal behaviour. Differentiating between them is essential to building precise understandings about them.

Directly involving children and young people in research about intentional self-harm, with or without suicidal intent, is essential.

3.5.2 Why do children and young people engage in non-suicidal self-harm and suicidal behaviour?

Death due intentional self-harm

In my examination there was a significant focus on suicidal behaviour. This is consistent with international research, which indicates, 'the vast majority of research on self-injurious behaviours has focused on suicidal, rather than non-suicidal, self-injury'.[95] As a result, we have some 'valuable data on the epidemiology of suicidal behaviours'.[96]

Many of the submissions outlined the distal risk factors for suicidal behaviour in children and young people. Distal factors are those that predispose a child or young person to risk. These included:

- mental health problems
- alcohol and drug abuse
- child abuse, including physical and sexual abuse
- adverse family experiences, including poverty, domestic violence, parent with alcohol or drug dependency, parent in gaol, parent with a mental illness, person known to the child who died due to intentional self-harm
- previous suicide attempt(s)
- communicated suicidal intent
- intentional self-harm, with or without suicidal intent.[97]

As we know, the different forms of child abuse, including sexual, physical, emotional, neglect, and family and domestic violence, can co-occur and be cumulative in nature.[98] Cumulative harm 'is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods'.[99]

The vulnerability and consequent need for assessment is increased for children and young people who are exposed to multiple risk factors and who experience a lack of key protective factors.[100]

Specific concerns about the relationship between domestic and family violence and suicidal behaviour were brought to my attention at roundtables and through the submissions.

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council told me that data collected over the past three years in the NPY region of Central Australia showed that, 'domestic and family violence is the most significant factor that is contributing to these incidents, along with prior exposure to suicide in close family members'.[101]

The National Children's and Youth Law Centre identified domestic violence in all reported suicide attempts to its service in the last 18 months.[102] The NSW Government submission specifically called for further exploration of this possible risk factor.[103]

The submission made by Orygen Youth Health Research Centre reasoned that proximal risk factors are often the 'tipping point' for those who are exposed to one or more distal risk factors. They suggested that:

> these can include negative or adverse life events including relationship difficulties, interpersonal losses or conflict with parents or peers, bullying (including cyberbullying), substance abuse, availability of means, excessive worrying or rumination and certain types of media reporting.[104]

The Young and Well Cooperative Research Centre reinforced this in its submission, stating that:

> the act of suicide and indeed suicidal behaviour is complex and is often the result of a culmination of individual-socio-environmental-genetic risk factors coupled with adversity across the lifespan.[105]

It was made clear to me that the understanding of these risk factors was predominantly based on research with older adolescents, with only limited research about suicidal behaviour in pre-pubertal children.[106]

This leaves the differences between children and adolescents who die due to intentional self-harm less well understood.

As understanding is central to prevention, it is necessary to know if children and adolescents who die due to intentional self-harm share common risk factors or whether their risk factors are different.[107] This also applies to non-suicidal self-harm.

Intentional self-harm, without suicidal intent

In terms of non-suicidal self-harm, Bentley, Nock and Barlow maintain:

> despite growing interest in this perplexing phenomenon, much remains unknown about why non-suicidal self injury occurs, including fundamental features of its etiology and underlying mechanisms. In addition, no evidence-based interventions that directly target this maladaptive behavior currently exist.[108]

Submissions provided to me and those participating in the roundtables held similar views and voiced the need for more research in this particular area.

The submission by the Young and Well Cooperative Research Centre explained how:

> [the] reasons for intentional self-harm are not well understood and clinical expertise often describes self-harming behaviour in the context of self-management, that is it can be used as a tool for escape, a way to transfer mental frustrations into physical manifestations, a coping mechanism for feelings of failure or guilt, or simply as a way for people to "feel again".[109]

Orygen Youth Health Research Centre made the point that 'longitudinal evidence is lacking and caution should be exercised when interpreting the risk factors associated with self-harm'.[110]

Others, while recognising this, offered their understandings of possible risk factors.

For example, the Rosemount Good Shepherd Youth and Family Services submission posited that non-suicidal self-harm provides temporary release from intense feelings such as anxiety, depression, stress, emotional numbness, sense of failure, self-loathing, low self-esteem and perfectionism.[111]

beyondblue stated that:

> many young people describe self-harm as a way of coping with feeling numb or intense pain, distress or unbearable negative feelings, thoughts or memories. They are trying to change how they feel by replacing their emotional pain or pressure with physical pain. Some people harm themselves because they feel alone, and hurting themselves is the only way they feel real or connected; while others self-harm to punish themselves due to feelings of guilt or shame or to "feel again". Some young people who self-harm are experiencing depression and/or anxiety.[112]

The NSW Department of Family and Community Services suggested:

> self-harm is often used to try and control difficult and overwhelming feelings or to gain some kind of relief from emotional pain. It may also be used to express anger, to feel "something" (if you're feeling numb) or to communicate a need for help. People who self-harm may have been experiencing a range of problems such as difficulty getting along with family members or friends, feeling isolated or bullied by someone, a relationship break-up, current or past physical, sexual or emotional abuse or neglect, loss of someone close such as a parent, sibling or friend and/or serious or ongoing illness or physical pain.[113]

The Kids Helpline analysed the case notes of 84 randomly selected online and phone contacts from children and young people under 18 years of age who contacted the service between May 2013 and May 2014. Of the 84 contacts, all were coded as engaging in current self-injury and self-harm or wanting assistance with their self-injuring and self-harming behaviour. The analysis of the case notes revealed a range of situational risk factors with emotional distress being the most common, followed by diagnosed mental and physical health concerns.[114] The results of the thematic analysis are outlined in Table 3.

Table 3: Thematic analysis of immediate concerns – current self-injury and self-harm in young people under 18 years of age May 2013 to May 2014[115]

Situational risk factors of young people who contact Kids Helpline with issues of current self-injury and self-harm	Online contacts	Phone contacts
Emotional distress (overwhelmed, confusion, existential concerns, feeling unloved, lonely, not coping with change, anger issues, current suicidal thoughts, past suicide attempts, or past suicidal ideation)	46.5%	35%
Diagnosed mental and physical health concerns	22%	28%
Grief and loss (such as death of family member, end of a friendship or other relationship)	8%	14%
Physical/emotional abuse (including sexual abuse, child abuse, bullying)	12%	7%
Family conflict (including breakdown in relationship with parents/ siblings, extended family, parents separating, father living away from home/country)	8%	10%
School pressures		3%
Body image issues (weight, weight gain)	2.5%	3%

As my examination of the issues progressed, I became increasingly aware that while there is a growing body of knowledge about the risk factors that increase the likelihood of suicidal behaviour and non-suicidal self-injury, 'much less is known about *how* or *why* they do so'.[116]

Jesuit Social Services pointed out in its submission to me 'there have been relatively few explanations for how these complex risk factors interact'.[117] For example, we do not know whether non-suicidal self-harm develops as a result of multiple interrelated risk factors or only one or two predominant vulnerabilities, or whether specific combinations of risk factors can accurately predict non-suicidal self-harming behaviour.[118]

Understanding the multiplicity of risk factors for intentional self-harming and suicidal behaviour in children and young people is central to effectively targeting and supporting them.[119]

Building knowledge about this must be a focus of future research. This 'will help us to start to make sense of the many risk factors that have been identified, and will yield the most clinically useful information'.[120]

It is important to point out that the nature of the research conducted will have to change to do this. Currently, 'most studies examine bivariate, linear associations between individual risk factors and self-harm'.[121] Research that simultaneously considers multiple risk factors is required.[122]

While many submissions and discussions at my roundtables focused on risk factors, there was also some dialogue about protective factors and how risk factors can be moderated by the presence of protective factors.[123]

There are a range of protective factors associated with reducing non-suicidal self-harm and suicidal behaviour, including:

- parent connectedness
- connections to other non-parental adults
- closeness to caring friends
- academic achievement
- school safety
- neighbourhood safety
- awareness of and access to local health services.[124] [125]

The Kids Helpline provided me with some of its data on protective factors for children and young people engaging in self-injury and self-harm. It analysed protective factors identified by children and young people between May 2013 and May 2014. These children and young people identified the importance of 'support received from health professionals, school staff, family and friends'.[126] The Kids Helpline emphasised that 'the involvement of others in assisting the young person to manage their self-injury and self-harm is a significant protective factor'.[127]

While the identification of protective factors is valuable, it is essential to better understand the impact of the different protective factors, how they are interrelated, whether some are more predominant than others, or whether specific combinations offer more protection.

Consistent with the issues relating to risk factors, there is little empirical evidence about this. Exploration of these issues should form part of a research agenda that pertains specifically to children and young people.

Summary – why do children and young people engage in non-suicidal self-harm and suicidal behaviour?

Research has predominantly focused on intentional self-harm with suicidal intent compared with non-suicidal self-harm. As a result, we know more about intentional self-harm with suicidal intent leading to death than we do about non-suicidal self-harm.

Risk and protective factors are identified for both. These are primarily based on research involving older adolescents. It is necessary to know if children and young people share common risk factors, or whether their risk factors are the same.

Research is required to improve understanding of the impact of different risk and protective factors, how they are interrelated, whether some are more predominant than others, or whether specific combinations offer more protection.

Domestic and family violence was raised as a risk factor requiring further research.

3.5.3 Clusters and contagion

Throughout my examination, I asked about the incidence and factors contributing to clustering and contagion involving children and young people.

Participants at the roundtables and those who made submissions commented on the inconsistent uses of, and definitions of, the terms 'contagion' and 'clustering' across the field.

The Child Death and Serious Injury Review Committee South Australia asserted in its submission that:

> If epidemiologically robust answers to questions about clustering and contagion are sought, then definitions of what is meant by clustering and contagion need to be provided.[128]

It seems the terms are often used loosely with little attention given to the different meanings that can be attached and associated with them.

It was also made clear to me that the issues of contagion and clustering for death due to intentional self-harm and non-suicidal self-harm should be treated separately.

(i) Contagion and clustering involving death due to intentional self-harm

headspace defines suicide contagion as:

> the process whereby one suicide or suicidal act within a school community, or geographic area increases the likelihood that others will attempt or die by suicide. Suicide contagion can lead to a suicide cluster where a number of connected suicides occur following an initial death.[129]
>
> Direct or indirect exposure to another suicide has been shown to be a prerequisite of cluster membership.[130]

The submission by the Black Dog Institute emphasised that 'suicide clusters remain a rare event'.[131] This was reinforced by headspace,[132] Menzies School of Health Research,[133] Child Death and Serious Injury Review Committee South Australia,[134] Queensland Commission for Children and Young People and Child Guardian,[135] and Orygen Youth Health Research Centre.[136]

Acknowledging the rarity of suicidal clusters is important because:

> communities may be vulnerable to concluding there is a suicide cluster if two suicides occur by chance in a population that has not experienced a suicide for some time, or has not been aware of occasional suicides occurring in previous years.[137]

Some coroners attending my roundtables pointed out that communities may perceive themselves to be experiencing a suicidal cluster even when the evidence does not support this. It is important to address this because 'the perception of suicide clustering in itself may increase the risk of imitation and contagion'.[138]

Having said this, it is important to recognise that death due to intentional self-harm for Aboriginal and Torres Strait Islander children and young people is more likely to occur in clusters.[139]

It is also probable that these children and young people were exposed to multiple sources of risk. The submission made by Menzies School of Health Research, which focused predominately on death due to intentional self-harm in Indigenous communities, pointed out that:

> While general exposure to suicide in communities creates the conditions for modelling and imitation of suicidal behaviour among young people, it is suggested that the rapid escalation of suicide rates among youth and preadolescent children already exposed to some degree of neglect or trauma may be most powerfully influenced by the frequency of suicide threats and attempts within families and households, and of suicide completions in families and within related social networks.[140]

The Menzies School of Health Research calls for more research in this area.

Participants at the roundtables, and those who made submissions, mainly focused on point clusters where 'an unusually high number of suicides occur in a small geographical area or institution and over a relatively brief period of time'.[141]

When determining the existence of clusters, some focused on identifying and exploring the relationships between those who had died through their case histories, while others used geo-statistical techniques to test statistically if cases were sufficiently close in space and time.[142]

Disparity was evident in terms of how many deaths, and their temporal proximity, constituted a cluster.[143] Some specified the number of cases should be two or more,[144] while others specified three or more.[145] Time intervals varied. These definitional issues make it difficult when comparing findings.

Despite this, both these approaches have contributed to increasing our understanding of the risk factors for death due to intentional self-harm in a cluster. Overall, the risk factors for cluster suicide are not dissimilar from those associated with individual adolescent suicide.[146]

This means they are not particularly helpful in assisting to identify those children and young people who may be most at risk of becoming part of a suicide cluster. Empirical evidence is lacking in terms of the 'psychological mechanisms underlying the spatio-temporal clustering of suicides (point clusters)'.[147] It is suggested that psychological mechanisms may include contagion, imitation, suggestion, social learning theory, and assortative relating, but it is argued that:

> there is no firm evidence that these mechanisms operate in cluster formation. It would seem reasonable to infer that multiple mechanisms operate together, and that the main mechanism is different for different settings and populations. Which mechanism, if any, is dominant in any particular cluster is unknown.[148]

Some very recent research,[149] published in August 2014, has started to identify some socio-demographic and contextual characteristics of suicide clusters from national and regional analyses of suicide clusters using NCIS data for all suicides in Australia between 2004 and 2008.

It used all available variables in the NCIS dataset that earlier research had indicated could be associated with the risk of suicide. These were sex, age, marital status, employment status, Indigenous status, method of suicide and state or territory of residence of each suicide case. The study noted that variables such as exposure to a peer's suicide, diagnosis of psychiatric illnesses and history of suicide attempt are contained in NCIS case files but not currently available in the NCIS dataset. The study used only the information in the dataset.

Conducting similar research on children and young people under 18 years of age using the NCIS dataset and case files is critical if we are going to increase our understanding of the mechanisms that may trigger suicide clustering in children and young people.

A focus on children and young people is essential because, as the Australian Institute for Suicide Research and Prevention reinforced to me, 'children and adolescents differ in terms of physical, sexual, cognitive, and social development and warrant separate consideration'.[150]

As the Royal Australian and New Zealand College of Psychiatrists pointed out:

> the nature of the stressors vary according to age; children and younger adolescents describe familial stress, whereas older adolescents typically describe peer-related stressors.[151]

Two other cluster types were acknowledged in the roundtables but were not addressed to the same extent as point clusters.

One was mass clusters, which are 'media-related phenomena where suicides occur during a restricted time period following, and linked to, the broadcasting or publishing of actual or fictional suicides'.[152] The Mindframe National Media Initiative provides a range of resources and guidelines for the media reporting of death by suicide in Australia. Additionally, guidance is provided by the Australian Press Council's Standards.

The Coronial Council of Victoria informed me in its submission that it favours the approach advocated by the Mindframe guidelines, stating 'the Council does not recommend any changes to current policy on media reporting'.[153] It indicated that this view is shared by ABS, the Brisbane Coroner, Chief Coroner of the ACT, Queensland Commission of Children and Young People and Child Guardian, Dr Michael Dudley from the University of New South Wales, Queensland Police Service, Dr Andrew Stocky, Associate Professor Susan Walker of Queensland University of Technology and Member of the WHO-FIC Mortality Reference Group, and Western Australian Ombudsman.[154]

The third cluster type mentioned involved 'geographical but not temporal clustering of suicides'.[155] For example, deaths due to intentional self-harm at railway stations with close proximity to mental health inpatient facilities. This cluster type was only raised at my Victorian roundtable.

In my call for submissions and at roundtables, I asked for comment about the impact of media and digital technologies.

I was consistently told that these were very important issues in the context of point clusters. Some coroners and police who attended my roundtables pointed out that, in some cases, deaths due to intentional self-harm were reported on social media before they had been able to complete their preparatory work and had informed family members of the death.

The submission by Hunter Institute of Mental Health emphasised:

> the effects of media, digital technologies, and contagion are important factors in the self-harm and suicide of young people alongside significant contributors such as genetic vulnerability and psychiatric, psychological, familial, social, and cultural factors.[156]

Professor Jane Pirkis pointed out:

> research into suicide among online communities is lacking, largely, I think, because it is very difficult to do… It certainly seems plausible that suicide clusters could exist in online communities.[157]

The Child Death and Serious Injury Review Committee in South Australia informed me that:

> Death scene investigations do not routinely collect information about the use of social media by young people. We have been told that it is expensive and time consuming to access and analyse this information, for example the messaging between young people prior to an event or their use of facebook and other social media. For these reasons we find it difficult to comment on the role, management and utilisation of social media in prevention as we are not yet certain of the extent of the use of social media or of the ways in which it influences a young person's decision to suicide.[158]

The Young and Well Cooperative Research Centre stated in its submission that:

> Increasingly with the advent of social media, and the concept of a networked 24/7 society, it is clear that we need to rethink the role of "media guidelines" and think more broadly about guidelines for social networks… A vital component to this conversation is an understanding that factors contributing to contagion and clustering are complex, as are the reasons behind the suicide and self-harm behaviours of young people.[159]

The Black Dog Institute reinforced that:

> 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.[160]

The complexity of the issues was reinforced to me through a submission provided to me by a parent:

> The completed suicide of a 14-year-old girl (who I shall refer to as Alice)…resulted in an enormous ripple effect throughout the community where it seemed that an enormous proportion of the youth aged between 12 and 18 had some connection to Alice.

> This connection was made, often, through social media, where young people were either "friends" with Alice or had friends or siblings who were in turn "friends" of Alice or her 2 teenaged siblings (who each attended different local schools). Most of these "friends" had never met Alice as such, but either before (and often after) her death, they were able to access a glimpse at her life through access to her Facebook/Myspace/ other social media profile. This created a sense of closeness and connection that was not real, in the way that we adults would see it.
>
> But for young people, these connections do feel real and indeed, in many ways they are real. The distress at Alice's death and the widespread sharing of her means of suicide may have triggered suicidal thoughts or sharpened suicidal plans in others.
>
> On the other hand Alice's death did generate enormous community discussion, at both formal and informal levels, about the causes of her death, the presentation of mental illness in youth, possible triggers and of course the catastrophic impact on her family and her friends. The ubiquitous use of social media platforms means that this will always be a challenge when a young person suicides.
>
> We need to work with young people to understand what opportunities might exist via these fora to help young people and to protect them from harm.[161]

The Australian Interactive Media Industry Association (AIMIA) Digital Policy Group – Cyber-Safety Sub Group made a submission to my examination. The AIMIA Digital Policy Group represents 460 organisations in the Australian digital industry, including Facebook, Google, Twitter, Microsoft, eBay and Yahoo!7. The submission outlines the various policies, tools and infrastructures that particular organisations are implementing to manage content about non-suicidal self-harm and suicidal behaviour. It also provides information about connecting users to support services that may be of assistance to them.

It was evident from the submission, and also from other submissions, that AIMIA Digital Policy Group is working with key organisations such as headspace, beyondblue, and the Young and Well Cooperative Research Centre to receive information about current issues facing children and young people and also to give information about the relevant safety policies and tools that are available.

I welcome this collaborative approach and encourage it to continue. However, I am concerned that not enough is being done to evaluate the awareness that children and young people have of these policies and procedures. It would be pertinent to undertake research that explores the extent to which children and young people are aware of the policies and procedures and how this type of information can be most effectively disseminated to them.

(ii) Postvention services following death due to intentional self-harm

Following a death due to intentional self-harm, postvention services are said to be essential for those children and young people who have been exposed to it.

Case study provided by Jesuit Social Services about postvention and intervention[162]

A 15 year old was referred to Support After Suicide following a phone call from her school counsellor. Her father had taken his own life a year earlier and she was depressed, was self-harming by cutting and was at risk of suicide.

She wanted to meet other young people who had lost a parent to suicide as she was feeling isolated and alienated from her peers in school. She attended the Adventures camp program on several occasions and was able to keep in contact with the other young people on a private group page of the Support After Suicide Facebook page.

She requires ongoing support due to issues with depression, family conflict and in response to bullying at school. Also, the relationship with her father was complex as before he died he was physically and emotionally abusive to her and her mother.

Supporting her has involved one-to-one counselling which has focussed on the grief and trauma of her father's death, family counselling to assist in the development of supportive relationships and communication, and a case manager arranging contact with other young people bereaved by suicide.

There have been times when there was an increased risk of self-harm and suicide. Providing understanding and support has been crucial in minimising the risk. She has needed to feel understood, connected as opposed to isolated, alone and misunderstood. It has required a high level of expertise to respond appropriately to her.

headspace is funded by the Australian Government Department of Health to provide schools with support in dealing with the aftermath of a death due to intentional self-harm.

headspace recommends a number of strategies to reduce the risk of suicide contagion in a school or community.[163] These include:

- identification and monitoring of young people at increased risk
- appropriate support and treatment for young people at risk including initial one-to-one support for distressed students as well as ongoing treatment by mental health clinicians
- appropriate reporting of suicide in the media
- well considered provision of information that is age and culturally appropriate, including:
    - » clear, concise and timely provision of information so that inaccurate information and distress are minimised
    - » factual information, without unnecessary detail, to be provided as soon as possible
    - » information should be provided to small groups, with close friends and family being told individually prior to this.

While these strategies would seem responsive to the immediate circumstances, there is no empirical evidence that they actually facilitate positive outcomes. As far back as 1993, Professor Hazell, who participated in one of my roundtables, noted that:

> while there has been considerable enthusiasm for the implementation of postvention programs, particularly in the school setting, such programs have yet to undergo systematic evaluation of their efficacy in preventing imitative suicide.[164]

The systematic evaluation of postvention programs has not progressed in over 20 years. There is still no solid evidence base documenting the effectiveness of postvention services.

A review of the literature on postvention strategies delivered to children and young people in response to suicide clusters concluded that, with so few evaluations of postvention responses, it was difficult to draw firm conclusions about the effectiveness of these strategies on the reduction of suicide risk or death due to intentional self-harm.[165]

The general lack of evaluation of programs, strategies and services was also raised in the *Evaluation Report of the National Suicide Prevention Program*, published in 2014.[166] The report noted that a lack of outcome data made it difficult for projects to demonstrate their effectiveness.

The headspace submission informed me that:

> a rigorous evaluation of School Support is currently being undertaken. This is exploring: awareness of and perceived need for the service; satisfaction with School Support written resources; satisfaction with postvention support provided by the service; impact on knowledge, awareness and skills; and the effectiveness of gatekeeper training provided by the service.[167]

I am told that the timeframe for providing this evaluation has been brought forward and is due to be completed by the end of 2014. I look forward to the publication of this evaluation by headspace and hope that it will contribute not only to our Australian context but also internationally.

I also want to draw attention to the fact that some children and young people are disengaged from school.

The Northern Territory Council of Social Service reinforced this in its submission, pointing out that:

> There is a need to adapt school based interventions to community settings, such as in Aboriginal communities, recreational centres, community centres, etc. to ensure that the information reaches young people who are not in school anymore.[168]

This was also raised by the Northern Territory Department of Health who told me that:

> 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.[169]

The review of the literature on postvention strategies delivered to children and young people in response to suicide clusters identified some 'promising' strategies, including:

- the development of a community response plan
- educational/psychological debriefings
- provision of both individual and group counselling to affected peers
- screening of high-risk individuals
- responsible media reporting of suicide clusters
- promotion of health recovery within the community to prevent further suicides.

In 2012, the Australian Government produced a set of guidelines that provide assistance to communities who wish to develop and implement community response plans to suicide clusters.[170] The extent to which community plans are being developed and evaluated is unknown.

Evaluation of postvention services must be on the national research agenda for children and young people. Without this evidence base, it will continue to be difficult to identify what works to reduce deaths due to intentional self-harm. It will also decrease the likelihood of ineffective interventions being funded and implemented.[171]

(iii) Contagion involving non-suicidal self-harm

It is widely assumed that non-suicidal self-harm is contagious,[172] and this may be true. However, as pointed out to me by the Royal Australian and New Zealand College of Psychiatrists, 'empirical evidence is lacking for the incidence and mechanisms leading to clustering of adolescent self-harm'.[173] This view was consistent across roundtables and submissions.

A recent review of studies, reporting an association of social contagion and non-suicidal self-harm among adolescents and young adults, outlined some of the limitations of existing research, including:

- small sample sizes
- limited to all male or all female participants
- failure to report racial and ethnic demographic information
- lack of standardised assessment or no assessment of non-suicidal self-harm
- staff/researcher determination of intent of self-harm behaviour
- lack of information regarding initial onset of non-suicidal self-harm outside of the study context
- limited generalisability due to occurrence of contagion in specific unit/facility of interest, and inability to infer causality from exposure to non-suicidal self-harm and initiation of non-suicidal self-harm behaviour
- non-suicidal self-harm definitional differences
- cross-sectional study designs that hinder determination of causality
- examination of social contagion factors as a secondary versus primary focus
- lack of studies focused on initial onset of non-suicidal self-harm (i.e., retrospective vs. prospective designs)
- lack of diversity (e.g., racial/ethnic, socioeconomic status, sexual orientation) among participants
- self-report measures used for assessment of non-suicidal self-harm and exposure to non-suicidal self-harm.[174]

Rosemount Good Shepherd Youth and Family Services told me that while it can be argued that there is a contagion effect with regard to exposure to non-suicidal self-harm, some of those who respond to peers, media, and popular culture could be identified as having risk factors prior to exposure.[175]

Available research reflects this view when it suggests that exposure to peer non-suicidal self-harm 'may put vulnerable adolescents (e.g., persons with comorbid conditions) at particular risk for perceiving the behavior as an effective coping strategy, especially because adolescents often identify with similar peers'.[176]

A submission I received from an adult with a history of non-suicidal self-harm commented on this issue:

> I'm dubious about the idea of self-harm as contagious, just because it is so personal. Since I was 14, I've covered up my scars with long sleeves and/or cosmetics. Even though I'm now open about the fact I have a mental illness amongst friends, only my husband and clinicians are aware of my history of self-harm. It's the most shameful part of my experience of mental illness. The shame arises from the fact that often when self-harm comes up in conversations it is referred to as "silly" or is trivialised as being a private school girls on tumblr thing. I don't want to subject myself to that level of judgment, even though I do feel able to tell others about my paranoid delusions.[177]

Discussions at some of my roundtables focused on children and young people who connect online and communicate about non-suicidal self-harm. The consensus reached about this was that further research is required about the online communicability of non-suicidal self-harm, including examination of the processes by which communications initiate, reinforce, and/or help to extinguish non-suicidal self-harm.[178]

One young person told me that:

> I found tremendous support on online forums. We would help each other commit to cutting less often and just share our stories and frustrations for the day. It was nice to know that there were people out there who understood, which put me in good stead when I did eventually get help at age 20.[179]

While the Hunter Institute of Mental Health informed me that there was limited research addressing media reporting of non-suicidal self-harm, it advocated reference to the codes of practice and guidelines used for reporting death due to intentional self-harm. It also provided some guidance that specifically used the term 'self-harm'. In essence, this guidance reflected the existing content in the codes of practice and guidelines used for reporting death due to intentional self-harm.

Professor Graham Martin, who attended my Brisbane roundtable and who also made a submission, told me that non-suicidal self-harm must be taken more seriously as an 'entity', with research funding specifically allocated to large scale examinations.[180] Given how little is actually known in this area, I agree with the views of Professor Martin.

Summary – clustering and contagion

There is inconsistent use of, and definitions of, the terms 'contagion' and 'clustering' across the field. The issues of contagion and clustering for death due to intentional self-harm and non-suicidal self-harm should be treated separately.

Despite perceptions about the frequency and existence of suicide clusters, suicide clusters are very rare. Empirical evidence is lacking in terms of the psychological mechanisms underlying suicide clusters.

There is still no solid evidence base documenting the effectiveness of postvention strategies. It is difficult to draw firm conclusions about how effective these strategies are in terms of reducing death due to intentional self-harm.

Empirical evidence is lacking for the incidence and mechanisms leading to clustering of intentional self-harm, with or without suicidal intent.

More research about children and young people who connect online and communicate about non-suicidal self-harm is required in relation to the online communicability of intentional self-harm, with or without suicidal intent, including examinations of the processes by which communications initiate, reinforce, and/or help to extinguish non-suicidal self-harm.

3.5.4 Barriers that prevent children and young people from seeking help

Those attending my roundtables and those who made submissions were generally in agreement about the types of barriers that prevent children and young people from seeking help.

Barriers were identified in terms of those experienced by the child or young person, those shaped by parents and carers, and those imposed by system constraints. Some participants and submissions cited help-negation as a barrier.[181] The ACT Health and Education and Training Directorate pointed out to me, 'there is considerable stigma attached to help-seeking behaviours'.[182]

Stated barriers experienced by children and young people included:

- feelings of embarrassment and guilt
- fear of the response from parents and/or the source of help
- concerns about the confidentiality of information shared and not wanting parents to know
- fear about stigma and being judged in an unfavourable light
- concern about cost of services/treatments
- previous negative experiences accessing services
- inexperience with independently seeking help and limited awareness of available support services
- not identifying intentional self-harm, with or without suicidal intent, as a serious problem.

Language barriers can also be problematic for children and young people seeking assistance. The Jesuit Social Services highlighted in its submission that English is a second language for many young people in remote communities.[183]

The Northern Territory Council for Social Services pointed out:

> while many Aboriginal children and young people in remote settings are able to converse in two or three different Aboriginal languages they might find it difficult to communicate in English. Explaining mental health concepts in English and not being able to converse in a familiar language can potentially be alienating and stressful and lead to misunderstandings, misidentification and wrong diagnosis of the symptoms and impact negatively on the subsequent intervention.[184]

This was highlighted at my roundtable in Alice Springs by the NPY Women's Council who shared with me an impressive guide developed to help Aboriginal children and young people talk about mental health. The guide, called the Words for Feelings Map, depicts characters experiencing a range of adverse feelings and links English and Aboriginal words to express them. The Words for Feelings Map has been created in two languages, Ngaanyatjarra and Pitjantjatjara. I have included a copy of the Pitantjatjara version. I hope this guide will encourage children and young people to talk about their feelings and seek help when they need to. A more comprehensive word list is available at www.npywc.org.au/ngangkari.

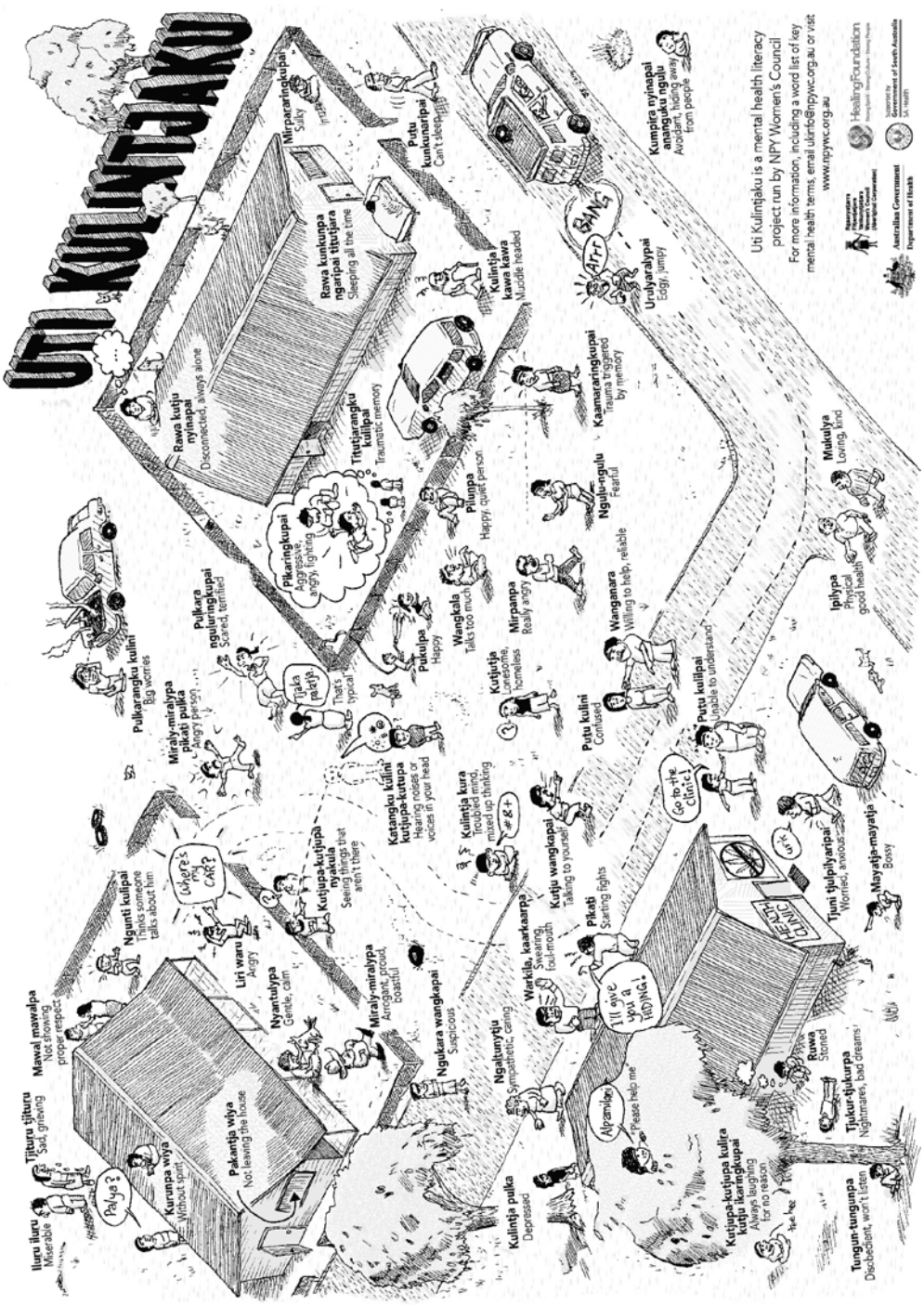
Language barriers were also raised in the context of children and young people from culturally and linguistically diverse backgrounds (CALD). A number of submissions reported that confidential phone counselling and the use of interpreters is crucial in the provision of services for children and young people from CALD backgrounds. Children and young people prefer telephone interpreters for confidentiality reasons.[185] This is especially important where communities are small and groups are connected. The Kids Helpline reported that phone counselling was the preferred method of contact for CALD children and young people under 18 years of age seeking help for non-suicidal self-harm or suicidal behaviour.[186]

CALD children and young people also face numerous other individual, cultural, and service-related barriers when seeking help for non-suicidal self-harm and suicidal behaviour. This includes cultural and community stigma, a shortage of culturally appropriate early intervention and mental health response services, as well as poor mental health literacy due to the lack of suitable information for children and young people and their families.[187]

The Phoenix Centre told me that their clients may not share their distress with their parents for a range of reasons. These reasons included, personal sharing between parent and child may not be culturally appropriate; family issues such as intergenerational conflict or unrealistic expectations may be contributing to the child's or young person's distress; and a reluctance to add to the psychological distress and burdens of the family.[188]

A number of submissions noted that intellectual disability in itself may be a barrier for some children and young people when seeking help and guidance. The submission by the ACT Community Services Directorate cited intellectual disability as a possible 'barrier for children and young people who have difficulty in identifying and communicating the nature and extent of their feelings and mental health needs'.[189]

Words for Feelings Map



The ACT Community Services Directorate also highlighted a lack of screening measures for suicidal behaviour for children and young people with intellectual disabilities, making 'assessments of needs and service accessibility more difficult where children and young people have limited comprehension and language skills'.[190]

Mention was made about the developmental stage of some young people where self-reliance and autonomy are foremost.[191] A survey of 1,032 Australian children and young people aged 14–25 years found that believing 'I should and/or could solve my problems alone' was a strong barrier to seeking mental health care.[192]

Help-negation was also recognised as a barrier to help-seeking. Research by Wilson and Deane describes help-negation as:

> help-avoidance or withdrawal that has been found in samples of adolescents who are currently experiencing clinical and subclinical levels of suicidal thoughts (e.g., Wilson et al. 2005a), depressive symptoms (e.g., Wilson et al. 2007), and symptoms of general psychological distress (e.g., Wilson 2010). In each study, adolescents with higher symptom levels are also those with lower intentions to seek help from health-care professionals, family, and friends, and higher intentions to seek help from no one.[193]

A submission by Dr Mareka Frost, on research conducted at Griffith University in 2011, suggested that:

> the more significant the extent of a young person's self-harm, the lower their intentions to seek help for self-harm. This effect occurred primarily for help-seeking from family and friends, who typically act as gatekeepers to care for young people under the age of 18. As such, this is a key barrier to help-seeking for young people in this age range.[194]

Support for these findings is becoming increasingly common in the literature.[195] Suggested ways to respond to help-negation include:

- education about the help-negation process, which may assist young people to seek help early by increasing their awareness that a desire to withdraw from others may signal a need to seek help
- assisting young people to increase their emotional competency and feel more confident in expressing their problems and concerns to others may also assist them to seek appropriate and timely help
- improving the ability of informal supports to respond to non-suicidal self-harm and suicidal behaviour may increase help-seeking
- increased education regarding help-negation for individuals who support young people may highlight the need to be more proactive in providing help.[196]

While these particular strategies have been proposed in the context of help-negation, it could be argued that they are also applicable when addressing other barriers.

In its submission, headspace highlighted some factors that have also been shown to facilitate help-seeking in children and young people. These include:

- good knowledge of mental health problems and awareness of the need for help
- past positive experiences of help-seeking by the child or young person
- social support and encouragement to access help
- good relationships with service staff and trust that information will be treated confidentially.[197]

Barriers associated with parents included:

- limited awareness of available support services
- worries about cost of services/treatments
- non-consent to treatment due to stigma attached with receiving services/treatments
- failure to understand the significance of the difficulties being experienced by their child
- lack of capacity to assist due to their own physical or mental health issues and parental lack of time.

The Menzies School of Health Research highlighted the lack of capacity among families and communities to identify and respond to escalating non-suicidal self-harm and suicidal behaviour, in the context of other pressing social and economic issues.[198]

Barriers as a result of system constraints included:

- lack of appropriate and culturally sensitive support services
- limited capacity of support services where there are waiting lists and motivation to seek support may have decreased by the time an appointment is available
- limited appointment times outside school or work hours
- restricted accessibility to support services due to location, transport and hours of operation
- inundated school counsellors who can only prioritise crisis cases.

Concerns were also raised about the types of responses children and young people received when presenting at accident and emergency departments of hospitals.

There was consensus that staff in these departments were generally not trained or equipped to deal with children and young people engaging in non-suicidal self-harm and suicidal behaviour.

Often children and young people were perceived as 'attention-seeking', 'wasting professionals' time', or 'nuisances'.[199]

In its submission to my examination, the Black Dog Institute, while recognising that there was limited research in this particular area, cited research completed in 2014 that suggests:

> 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.[200]

Limited access to mental health professionals within accident and emergency departments was also identified as a problem at the roundtables. A set of Guidelines for the Management of Deliberate Self Harm in Young People were developed by the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists in 2000.[201] The extent to which these guidelines have been adopted or how they impact on practice is unknown. This is an area that requires follow-up and evaluation. Where children and young people present to an accident and emergency department, there is a genuine opportunity to connect with them and facilitate follow-up intervention.

The Menzies School of Health Research submission informed me that:

> Even when children and young people do seek help, there is often very little or no follow up available and very little coordination between services resulting in a reduction in the effectiveness of the help that is available.[202]

A submission made to me by a young person under 18 years of age raised this issue:

> i am 16 (nearly 17), and i have self-harmed for nearly 3 years. from what i have learned in these three years, is there is no real "cure" for it. i have attempted suicide dozens of times to no avail, and have spent time in the mental ward a few times. doctors have not really had a chance to sit down and look at the problems, so it seems, because some will make asinine attempts to deter self harmers or suicidal adolescents, by saying how stupid they are acting and how much hurt they are causing to their families. we are treated as though we have no understanding of the "real" world, and that our mind just cant see how wrong it is to do what we do, or think how we think, when really, our minds just dont care anymore. most of us have lost hope in being "cured", because we know that it will always be there, whenever we come into a bad situation, calling our names (not to confuse us with having schizophrenia)(maybe we do), and a lot of self harmers think the coping strategies given are unhelpful, and kind of make us feel like we are being made to look under developed. we know that we should think happier thoughts (those with depression) but we can't just change ourselves because you bring up the idea![203]

A study by the Menzies School of Health Research on hospital admissions in the Northern Territory showed that Indigenous people accounted for over half of the hospital admissions due to intentional self-harm between the period 2000-2012, and that Indigenous children and young people aged 0-14 years were three times more likely to be admitted during that period than non-Indigenous children and young people.[204]

The Menzies School of Health Research concluded that further research is required 'to investigate the types of contact that people at risk of suicide do have with professional help and where the missed opportunities for prevention lie'.[205]

Conjoint Professor Greg Carter, who attended my research roundtable, described jurisdictions that direct non-suicidal self-harm cases to one hospital within a region where expert care and treatment can be provided. Professor Carter explained that his unit in Newcastle Mater Misericordiae Hospital works in this way, and as far back as 1997 an evaluation of this model showed some positive results.[206]

This type of model has the capacity to gather valuable epidemiological data that can be used to inform practice. It allows data to be collected on presentations of intentional self-harm with or without suicidal intent, as well as repeat presentations, and the linkage of these presentations to deaths due to intentional self-harm.

This model has the potential to contribute much to our understanding of intentional self-harm with or without suicidal intent. Some participants at my roundtables told me that children and young people treated for non-suicidal self-harm and suicidal behaviour were often discharged into the community without follow-up, despite evidence that during the hours and days immediately after discharge the child or young person can be at high risk.

I was also told about the need for teacher training to promote early detection and intervention. School is an important site for early universal interventions, as the opportunities for prevention can diminish in adolescence where school attendance often decreases.

The report by the House of Representatives Standing Committee on Health and Ageing on early intervention programs aimed at reducing youth suicide in 2011 recommended that teachers receive mandatory training on mental health awareness, including specific training to develop their capacity to recognise and assess suicidal risk.[207] It was pointed out to me that while the Australian Government agreed to this in principle, mandatory training was not pursued.

I was provided with some examples of where schools had voluntarily started to do this. For example, in 2014, Rosemount Good Shepherd Youth and Family Services launched the Self-Harm Workshop for Educators that has been designed to promote a better understanding of non-suicidal self-harm as it presents within a school context.[208] This provides teachers with practical strategies to work collaboratively with these students and their families to ensure they receive appropriate support from external mental health professionals. It sits alongside a full day course for educators entitled Mental Health and Young People. Both courses are in keeping with the MindMatters framework, the national mental health initiative for secondary schools. I commend Rosemount Good Shepherd Youth and Family Services for its initiative in this area.

An individual submission by Ms Toni Falk, who conducted a research project into secondary teachers' perceptions of adolescent non-suicidal self-injury as part of a post-graduate diploma in psychology in 2012, told me:

> Despite not feeling well-equipped, when students disclose their wounds, teachers feel duty-bound to intervene, regardless of their level of skill. Therefore, providing staff with training and support is essential if teachers are to be enabled to intervene in the most careful, informed and constructive manner.[209]

In its submission, Rosemount Good Shepherd Youth and Family Services provided the transcript of an interview with a person who engaged in intentional self-harm as a teenager.

Interview provided by Rosemount Good Shepherd Youth and Family Services with a person who intentionally self-harmed as a teenager. This person is now 28 years old.[210]

INTERVIEWER: Young people self-harm to cope with overwhelming emotion or control the feeling of being out of control how do you relate to that?

YOUNG PERSON: I know that for me I didn't quite understand what was going on, it was more about putting words to feelings that I couldn't name, not words I guess, but actions to feelings that I couldn't explain.

Yeah, and all the issues you go through when you're a teenage, it all seems so, they're really intense and it all seems so much more powerful when you look back on those years, and yeah, it's definitely about trying to manage emotions and control things that seem to be out of control.

INTERVIEWER: Some people would see self-harm as attention seeking or as being manipulative, I wondered how you would respond to that:

YOUNG PERSON: Someone once told me that it's not attention seeking, its attention needing. Now whenever I hear someone say its attention seeking, I think well, maybe its not actually seeking, maybe they do actually need some attention and support because nobody does that sort of stuff if they are getting adequate support and there is somebody actually helping them out with what they need. And, as for manipulating, that's the oldest one in the book really, it comes across as manipulative because a young person might go up to a person and tell one person and then they might tell another person, or they might put it on display, but it's more about them saying "I am in so much pain that I don't know how to ask for help. I don't know how to tell you before I do it that I need help." I remember I used to say "well, if you don't do this, then I'm gonna hurt myself", and it wasn't so much that what they were doing would make me hurt myself, it was that I didn't know how to manage those feelings and that's the only way that I could explain it. So, it comes across as that, but that's not actually the primary intention, it just ends up like that sometimes.

INTERVIEWER: So, did you actually tell someone about your self-harming or did people notice?

YOUNG PERSON: I started very young, I started when I was ten and it was a year and a half or two years before somebody actually found out and I ended up telling the school counsellor and of course, she told my parents. I know that when my mum found out that she was really really shocked. Neither of my parents knew what to do with that kind of behaviour and I didn't know how to explain it to them in a way that would calm them down as well.

INTERVIEWER: In terms of teachers in schools, how do you think they should respond if a young person tells them they're self-harming?

YOUNG PERSON: Be compassionate and respectful that the young person deserves some sort of privacy, so it's not like, they shouldn't broadcast it around the school. At the same time, they need to be getting that young person some kind of support. Um, offering to go with them to the school counsellor, perhaps sit with them during that meeting. If they've trusted that teacher enough to disclose that or to open up about self-harm with them, then that teacher really needs to follow through until that young person has enough support. And, it's not that that teacher need to be the sole port of call, it's that they can say, I can't actually help you with the psychological things, but I can be there for moral support.

INTERVIEWER: Mmm, that's a very good distinction actually to make.

YOUNG PERSON: Yes.

INTERVIEWER: So, can I ask you, who or what helped you manage that self-harming behaviour?

YOUNG PERSON: Um, it took a long time for me to get proper help, and I know that from getting inadequate assistance when I was younger, it took longer for me to actually get the right help and for me to continue to seek out the right sort of help. The people for me that made a difference, were those that didn't judge, They just took day by day and said "ok, that's just, you know, a slip up, we'll move on to the next one" rather than saying "that's it, we're going to punish you now." The amount of times that I was punished for a behaviour that I was already punishing myself for things that I hated about myself and that I felt guilty about, having somebody else do that it was like, well, now you're just making me feel like I want to actually do it again. Um, also having someone that I could talk to and trust enough that they would do what needed to be done, but hear me out first. So, say if I needed to, say if my parents needed to find out, or if I needed medication or any of those sorts of things, saying well, "this is what I'm thinking of and this is what I'd like to do, how do you feel about doing that or going ahead with it?" Because, anything that was done behind my back, I was like, well, how can I trust you? How can I believe that you are going to be there and bat in my corner and support me?

INTERVIEWER: So, do you have any other thoughts about how schools have been helpful in terms of this issue?

YOUNG PERSON: Yeah, it's got to be a collaborative approach, you know with teachers and school counsellors and you know, maybe there's an external therapist that gets involved, the parents; everybody working together to ensure that that young person is supported during school hours and out of school hours. Um, and not using punishments I guess, like detentions and suspensions, like I said before, because I know that my school used suspension as a way of managing my behaviour because it was too disturbing for other students and they didn't actually address what was going on for me, or provide that support and I think if a young person is going through so much turmoil in their life, then they need that support to be able to manage while they're going to school or perhaps they do need time off or whatever's going on for that individual young person, rather than having a blanket rule.

INTERVIEWER: Sure. I think you've given us some amazing insights really, are there any final comments you'd like to make?

YOUNG PERSON: Um, not really.

INTERVIEWER: Ok, well thanks XX I think there are some wonderful learnings there for teachers and for school communities

The Menzies School of Health Research submission pointed out to me 'In most communities, schools are under-resourced and ill-equipped to respond to suicidal behaviour and the underlying risks'.[211]

The Menzies School of Health Research is currently trialling Youth Life Skills, a new strength-based approach to emotional learning and development for students at Maningrida Community Education College, in Arnhem Land.[212] This program is being developed for middle years students, as well as for young people who are not attending school. It is also developing an evaluation methodology that is suitable for remote settings, with school programs being designed to align with the health and physical education learning area of the Australian Curriculum.[213]

Repeatedly, I was told that finding effective ways to encourage children and young people to access appropriate help or support for early signs and symptoms of difficulties must be a priority in any research agenda.[214]

headspace stated in its submission to me:

> If the barriers to help-seeking can be addressed, young people experiencing emotional distress are more likely to access help earlier when difficulties first arise. This can help prevent more serious long-term problems from developing, including deliberate self-harm and suicidal behaviours, which may then be more difficult to treat or require more intensive interventions.[215]

I am pleased to report that *Growing Up in Australia:* The Longitudinal Study of Australian Children (LSAC) has recently commenced asking children and young people questions about who and where they could seek help.

The questions that the LSAC asks are provided in Table 4.

Table 4: Questions asked by *Growing Up in Australia:* The Longitudinal Study of Australian Children (LSAC)

Below is a list of people who you might seek help or advice from if you were experiencing a personal or emotional problem.

Have you sought help for personal or emotional problems from any of these in the last 12 months?

You can select more than one. (If you are not using a mouse, press space bar between responses.)

1. Boyfriend or girlfriend
2. Friend (not related to you)
3. Parent / step-parent
4. Brother or sister
5. Other relative / family member
6. Teacher (year advisor, classroom teacher)
7. Other school staff (e.g. school counsellor, nurse, chaplain)
8. Family doctor / GP
9. Mental health professional (e.g. psychologist, psychiatrist)
10. Unrelated adult (18 years or over)
11. Phone help line (e.g. Lifeline, Kids Helpline)
12. Internet
13. Someone else not listed above
14. I have not sought help from anyone
15. I have not had any emotional or personal problems (in the last 12 months)

How likely is it that you would seek help from the following people, if you had a personal or emotional problem during the next 4 weeks?

a. Boyfriend or girlfriend
b. Friend (not related to you)
c. Parent / step-parent
d. Brother or sister
e. Other relative / family member
f. Teacher (year advisor, classroom teacher)
g. Other school staff (e.g. school counsellor, nurse, chaplain)
h. Family doctor / GP
I. Mental health professional (e.g. psychologist, psychiatrist)
j. Unrelated adult (18 years or over)
k. Phone help line (e.g. Lifeline, Kids Helpline)
l. Internet
m. Someone else not listed above

If no answer to above:

So we just want to confirm…

would you seek help from anyone if you had a personal or emotional problem during the next 4 weeks?

This type of information will be very helpful in terms of identifying where supports should be facilitated. As Australian researchers point out:

> The last decade has seen a flurry of productive help-seeking research and program development, but we are a long way from 'being there yet'. We must continue to conduct rigorous help-seeking research that aims to better understand the science of help-seeking.[216]

Summary – barriers that prevent children and young people from seeking help

Barriers were identified in terms of those experienced by the child or young person, those shaped by parents and carers, and those imposed by system constraints.

Particular barriers exist in relation to certain groups of children and young people.

The effect of help-negation reduces the willingness of children and young people to seek help.

Children and young people often receive poor response from accident and emergency departments.

Further research is required to investigate the types of contact that children and young people have with professionals and where the missed opportunities for prevention lie.

3.5.5 Supporting children and young people who are engaging in intentional self-harm, with or without suicidal intent

One of the key areas explored in the literature, the call for submissions and in the expert roundtables was the characteristics of programs and practices that effectively target and support children and young people, both engaging in or at risk of engaging in intentional self-harm, with or without suicidal intent.

(i) A public health model

The 2014 World Health Organisation report on *Preventing Suicide: A Global Imperative* provides a comprehensive overview of suicide prevention activities around the world.[217] This report does not specifically focus on children and young people. The report was developed using a global consultative process 'based on systematic reviews of data and evidence together with inputs from partners and stakeholders'.[218] The report identified a global imperative to prioritise suicide prevention in public health and policy agendas.

The report outlines the current situation in suicide prevention in terms of what is known and what has been achieved.[219] It particularly notes the importance of the interplay between 'biological, psychological, social, environmental and cultural factors in determining suicidal behaviours'.[220] Twenty-eight countries, including Australia, have national suicide prevention strategies, which utilise a multisectoral response to suicide prevention.[221] Such strategies generally cover a range of complementary actions from surveillance, means restrictions, media guidelines, stigma reduction, public awareness raising, skills development and research.[222] The report identifies the key factors in successful national strategies as:

- making suicide prevention a multisectoral priority, with partnerships across health, education, employment, judiciary, housing, social welfare and other sectors
- tailoring for diversity with goals, objectives and interventions customised to specific contexts
- establishing best practices by using evidence based interventions, evaluating pilot projects and targeting programs
- allocating adequate resources
- planning and collaborating with key stakeholders, such as through the creation of a national planning group
- evaluating findings and disseminating the results.[223]

Australia lacks a strategic and coordinated approach that articulates and resources the full suite of interventions required. This is despite the existence of the National Suicide Prevention Strategy, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and a range of other national policy initiatives focused on the wellbeing of children and young people.

The Australian Government advocates a public health model, where promotion, prevention and early intervention are priorities.[224] However, the Australian National Coalition for Suicide Prevention in its response to the 2014 World Health Organisation report on *Preventing Suicide: A Global Imperative*, suggested that:

> In reality, the strategic approach to suicide prevention in Australia is piecemeal, uncoordinated and overly biased on activities falling under the remit of the Department of Health, especially mental health. This must change if we are to significantly reduce the tragedy of suicide. Reducing suicidal behaviour should be seen as a key outcome across a wide range of areas including drug and alcohol, homelessness, domestic violence, family and relationships, justice, employment, veterans and immigration.[225]

The Black Dog Institute introduced its submission by stating 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.[226]

(ii) National and local coordination

The Queensland Mental Health Commission supported the need for coordination in its submission to me, stating that:

> to achieve the breadth and depth of the interventions necessary across the spectrum, integrated policy responses are required, supported through engagement and integration within and across policy sectors at all points of planning rather than at the implementation stage or not at all as is commonly the situation.[227]

The Queensland Mental Health Commission also observed:

> there continues to be an over-emphasis on actions and interventions at the individual level, particularly in terms of crisis or illness responses. That is, primarily a mental illnesses approach rather than a broader and integrated approach.[228]

There are a wide range of highly competent professionals working in this area, including government departments, non-government organisations, academics, researchers, and clinicians. Despite the best intentions of all parties, it is not clear how they always work together in an integrated and collaborative way.

My concerns about this were reinforced in a number of submissions. For example, the NSW Ombudsman advised me:

> there are many government and non-government organisations undertaking work in this area, and it is not always evident whether, and how well, the activities are co-ordinated to minimise duplication of effort and maximise efficacy.[229]

The Queensland Commission for Children and Young People and Child Guardian suggested:

> mechanisms to promote alignment with and enhance suicide prevention activities across all tiers of government as well as the non-government sector are a priority.[230]

A number of states and territories have child and adolescent mental health teams which provide services to children and young people in outreach or clinical settings. It was clear from submissions and discussions that the respective roles and responsibilities and referral pathways between the various government and non-government mental health and other health services were not always well articulated or understood.[231]

The Menzies School of Health Research commented on poor coordination between services:

> Health clinics tend to treat injuries with referral to mental health services on the basis of a clinical diagnosis. [However] the determinants of suicide amongst Indigenous children and young people are social – for example, only one case in our study population had a clinical diagnosis – and many health services in remote settings do not offer social and emotional wellbeing services.
>
> Even when children and young people do seek help, there is often very little or no follow-up available and very little coordination between services resulting in a reduction in the effectiveness of the help that is available.[232]

The Royal Australasian College of Physicians noted that many paediatricians still report a lack of confidence when dealing with children and young people engaging in intentional self-harm, with or without suicidal intent, and suggested that:

> models of care be developed that integrate across paediatric and mental health care services to develop pathways for referral and collaborative management.[233]

The Rosemount Good Shepherd Youth and Family Services provided me with the views of a person who had engaged in self-harming behaviour as a teenager:

> Yeah, it's got to be a collaborative approach, you know with teachers and school counsellors and you know, maybe there's an external therapist that gets involved, the parents; everybody working together to ensure that that young person is supported during school hours and out of school hours. Um, and not using punishments I guess, like detentions and suspensions, like I said before, because I know that my school used suspension as a way of managing my behaviour because it was too disturbing for other students and they didn't actually address what was going on for me, or provide that support and I think if a young person is going through so much turmoil in their life, then they need that support to be able to manage while they're going to school or perhaps they do need time off or whatever's going on for that individual young person, rather than having a blanket rule.[234]

(iii) Evaluating interventions and building the evidence base

The absence of conclusive evidence about the types of programs and practices that work for children and young people was frequently mentioned in submissions and at roundtables.

This lack of evidence base existed across the continuum of intervention responses from resilience building programs to clinical treatments. Orygen Youth Health Research Centre stated in its submission that, whilst much is known about the epidemiology of youth suicide and self-harm, less evidence exists relating to preventative approaches, both in clinical and general population settings'.[235]

Some research suggests that further investigation into cognitive behaviour therapy based interventions and attachment based family therapy interventions may be warranted as these interventions have shown some promise.[236]

The submission by the The Child and Youth Mental Health Service, Children's Health Queensland Hospital commented on the general lack of research regarding interventions for non-suicidal self-harm in children and young people, citing a literature review completed in 2012.[237] This review concluded that:

> Despite an increased interest in non-suicidal self-injury in the literature, few psychotherapeutic treatments have been designed and evaluated specifically for non-suicidal self-injury. Of grave concern is that no treatments have been designed and evaluated specifically for non-suicidal self-injury among adolescents. The dearth of interventions for non-suicidal self-injury among adolescents may be due to the relatively recent interest and recognition of the problem of non-suicidal self-injury among this age group, and may improve with the adoption of non-suicidal self-injury as a psychiatric disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders.[238]

The submission by the Royal Australian and New Zealand College of Psychiatrists commented on the lack of evidence about the effectiveness of interventions, stating that 'Disappointingly most interventions developed to prevent the recurrence of self-harm to date appear to have been no more effective than treatment as usual (which is of itself often limited)'.[239]

(iv) Responding to and preventing intentional self-harm, with or without suicidal intent

Gatekeeper training programs were discussed in numerous submissions made to me.[240] Gatekeeping programs 'aim to equip lay members of the public, as well as various professionals that may encounter at risk individuals, with the key skills needed to recognise those at risk, perform a basic intervention and then assist those they identify in seeking professional help.'[241]

Gatekeepers can include teachers and other school staff, police officers, paramedics, firefighters, general practitioners, youth workers, mental health workers, community nurses, emergency department staff, spiritual and religious leaders, parents and young people. This type of training can be delivered universally as well as selectively.

Orygen Youth Health Research Centre pointed out to me that gatekeeper training has been 'a focus of the national approach to suicide prevention for some time'.[242] However, Orygen Youth Health Research Centre also indicated to me that to date:

> no research has examined the effects of this type of intervention on actual outcomes for young people, for example changes in rates of help-seeking and improved outcomes following help-seeking.[243]

The Menzies School of Health Research told me 'there is almost no reported evidence of its effectiveness in reducing risk factors in young people'.[244] Clearly determining the effectiveness of gatekeeper training programs on the outcomes for children and young people should be prioritised in evaluations of these programs and also in future research.

Building resilience is an important part of any public health model. This was highlighted as critical in many submissions I received, including from Menzies School of Health Research,[245] United Synergies and the National Standby Suicide Bereavement Response Service,[246] Early Childhood Australia,[247] Royal Australian and New Zealand College of Psychiatrists,[248] and Mental Health First Aid Australia.[249]

Given compulsory school education, schools were identified as environments where universal early intervention programs focused on mental health could be embedded as part of the culture and curriculum. Current examples include MindMatters, KidsMatter and KidsMatter Early Childhood initiatives. These three initiatives provide a universal early intervention framework to promote mental health from pre-school to Year 12.

MindMatters is a national mental health promotion initiative for secondary schools that addresses some of the risk and protective factors for suicide. It has high levels of uptake and acceptance across Australian schools.[250] The curriculum materials focus on issues such as resilience, loss and grief, bullying and harassment, understanding of mental illness and reduction of stigma.[251] It was initially introduced to a selection of schools in 2000. MindMatters is currently being updated by beyondblue, with a target of reaching 1,500 secondary schools by 2016.[252] However, the *Final Report of the Evaluation of Suicide Prevention Activities* released in January 2014 found that, 'the evaluation reports produced to date (from 2006 to 2012) do not address the effectiveness or efficiency of MindMatters'.[253] Given its widespread use, it is essential that MindMatters is effectively evaluated.

KidsMatter is a national primary school mental health promotion, prevention and early intervention initiative.[254] KidsMatter is currently being implemented in 2,000 primary schools. It uses a whole-school approach and aims to improve the mental health and wellbeing of primary school students, reduce mental health difficulties amongst students and achieve greater support for students experiencing mental health difficulties.[255] KidsMatter was developed in response to recognising the vulnerabilities and risks of younger children. The early years are a period of rapid brain development when neural circuits and brain architecture are established. The KidsMatter Evaluation Final Report concluded that:

> The outcomes of the KidsMatter trial are consistent with an emerging body of national and international literature that a "whole school" approach can be protective for students, promoting a positive shift in mental health for the whole school population, and helping to enhance academic and social competencies through more positive interactions between all members of the school community.[256]

Having said this, 'the observed impacts varied in size and were not evident in all aspects of KidsMatter'.[257] Furthermore, 'evidence of potential limitations and of possibilities for increasing the effectiveness of KidsMatter also emerged'.[258] This highlights the need for further and more rigorous evaluation.

KidsMatter Early Childhood is a preschool and long day care mental health promotion, prevention and early intervention initiative. It was first trialled in 2010 and is now operating in 225 early childhood settings in Australia. The *KidsMatter Early Childhood Evaluation Report* made similar findings to that of the *KidsMatter Evaluation Final Report*.[259] It also noted that further work is required to better understand the long-term impact of professional learning on staff knowledge, attitudes and behaviour. Future evaluation must be undertaken.

beyondblue works with Early Childhood Australia, the Australian Psychological Society and the Principals Australia Institute to deliver the KidsMatter suite of initiatives. An example of universal early intervention is provided in the case study below.

Case study provided by Early Childhood Australia illustrating the importance of early intervention in the early years[260]

> A four year old child started worrying about his childcare day as soon as he woke. His mum had to work so had no options but to persevere with the enrolment. The educators worked with him and his mum to create a strong relationship, including making a book of photographs of preferred playthings at the centre, his preferred friends and his educators. The educators also created a visual routine so he knew exactly what time his mum would return. They also made sure that he knew he could access the 'quiet area' inside whenever he needed time alone. His mum negotiated with her work so he could phone her if he needed to. These strategies worked well for him and after three months, he no longer needed the additional supports.

A number of other mental health, resilience, and relationship programs are being trialled or used in Australian schools:

- SenseAbility is a strengths based e-learning program developed by beyondblue for children and young people aged 12-18 years that includes modules developed to enhance and maintain emotional and psychological resilience. To date around 66% of all Australian schools have ordered the program.[261]
- Building Respectful Relationships is a Victorian education based resource targeted at adolescents that provides teaching and learning activities around the themes of gender, power, sexual intimacy, respect and personal responsibility.[262]

- Love Bites is a school based domestic and family violence and sexual assault prevention program aimed at children and young people aged 14-16 years. Over 100,000 high school students across Australia have participated in the program.[263]
- KoolKIDS is a self-regulatory intervention developed by the University of Queensland and University of Western Australia to equip children and young people aged 7-10 years to understand their strengths and emotions and develop friendship and empathy skills. It is currently being evaluated by a consortium led through Macquarie University.[264]
- SAFEMinds is a new learning and resource package developed by headspace in partnership with the Victorian Department of Education and Early Childhood. It combines a range of targeting training packages and a resources toolkit to enhance the capacity of schools to identify children and young people with early signs of mental health issues, intervene in informed and sensitive ways and to make appropriate referrals.[265]

These are a selection of the many programs available to promote the health and wellbeing of children and young people. A number of other programs were highlighted, such as those using sport as an engagement platform to promote wellbeing.

It is imperative that all programs are properly evaluated before being introduced more broadly in schools or the community, and that their capacity to complement and build on other existing programs is properly assessed.

Some submissions also supported the introduction of specific non-suicidal self-harm education to school settings. Rosemount Good Shepherd Youth and Family Services argued that:

> Similar to sex education not leading to promiscuity; providing information and responding to questions on non-suicidal self-injury does not cause undue distress among young people, even those already identified as potentially requiring support.[266]

One young person who made a submission to my examination told me:

> There seems to be a fear if you discuss mental health on an open level, more mental health problems are going to arise in students. This is not necessarily the case. I feel it has more to do with how the material is presented.[267]

(v) Online programs and digital technology

Helplines offer a very important service and have the capacity to reach large numbers of children and young people. Children and young people are also able to use these services anonymously.

There are a number of helplines in Australia that children and young people can access either by phone or online, such as Kids Helpline and ReachOut.

Digital technologies are becoming more and more critical for support service delivery and intervention. Digital communication can assist remote health clinics to respond to those children and young people who are at risk, and to follow-up and review those cases where possible.[268]

Online support services enable children and young people to access some form of assistance at any time, and from any location, thus reducing reliance on office-based services. A number of submissions cited online services as being integral to the health and wellbeing of children and young people in rural communities. headspace, for instance, states that the development of their eheadspace program in 2010 was a reflection of the need to offer appropriately accessible services:

> utilising web and telephone-based technology to extend the reach of evidence-based services to those young people who are unable or unwilling to access office-based services, including particularly vulnerable groups such as those in regional and remote communities.[269]

eheadspace is currently providing assistance to around 1,200 young people per month.[270] Two thirds of those young people had not previously accessed mental health services.[271]

The Young and Well Cooperative Research Centre in its submission referred to its development of the Online Wellbeing Centre, which has:

> created a virtual space for young people to access a personalised, ongoing recommendation service for tech-based tools and apps, and is currently being trialled through the Young and Well Towns Project with young people living in the rural region of Murray Bridge in South Australia.[272]

This project aims to explore the barriers to treatment being experienced by young people living outside of major cities in Australia, and presents a method of engagement that builds local community capacity by exploring how technologies can be used to enhance the service offering.

It was noted in a submission from Dr Mareka Frost from Griffith University that:

> Online services may connect young people with professional help online or act as a proximal step to offline help-seeking by providing young people with information, skills, support, intervention or referrals which assist them to access help offline.[273]

Dr Frost went on to indicate that from the sample of 1,463 children and young people involved in the study:

> over 60% of young people reported either a desire for information online that would help them to immediately talk to family, friends or a professional about their self-harm *or* a desire to access support online to begin with, but to eventually speak to someone offline about their self-harm. It is important to note, however, that one third of young people wished to receive all the help that they required through the internet.[274]

This study shows that children and young people have clear ideas about what they need from online services. Consultation with children and young people regarding the development of online and offline support services is critical.

The national *Growing Up Queer* study showed that 98% of young people in the study had access to the internet, 49% saw the internet as a place where they could connect with trusted others, and 78% used the internet as a source of information about sexual and gender identity.[275]

Having said this, at the time of the study, only 24% of young people used the internet to access support services, pointing to greater potential to utilise this medium.[276] Participants in the study reported that face-to-face contact in a 'safe space' was critical to overcoming the physical and social isolation felt by sexually diverse and gender questioning young people.[277]

Summary – supporting children and young people who are engaging in intentional self-harm, with or without suicidal intent

The Australian Government advocates a public health model, where promotion, prevention and early intervention are priorities. However, Australia lacks a strategic and coordinated approach that articulates and resources the full suite of interventions required to reduce non-suicidal self-harm and suicidal behaviour in children and young people.

There is an absence of conclusive evidence about the types of programs and practices that work for children and young people.

Evaluating the effectiveness of gatekeeper training on the outcomes for children and young people should be prioritised.

It is imperative that all programs are properly evaluated before being introduced more broadly in schools or the community, and that their capacity to complement and build on other existing programs is properly assessed.

Online programs, digital technologies and helplines are important services as they have the capacity to reach large numbers of children and young people. The effectiveness of these interventions should be evaluated, taking into account the views of children and young people.

3.5.6 Groups of children and young people with particular vulnerabilities

Some children and young people are disproportionately affected by non-suicidal self-harm and suicidal behaviour. I asked in my call for submissions specifically about children and young people who are Aboriginal and Torres Strait Islanders, those who are living in regional and remote communities, those who are sexuality diverse, transgender, gender diverse and intersex, those from culturally diverse backgrounds, those living with disabilities, and refugee children and young people seeking asylum.

The needs of these particular groups of children and young people, as well as those living in out-of-home care, were raised in my roundtables, in individual consultations and in submissions to my examination, including the need for targeted programs and interventions for these particular groups of children and young people.

(i) Aboriginal and Torres Strait Islanders

Death due to intentional self-harm among Aboriginal and Torres Strait Islander children and young people is significantly higher when compared with those from non-Indigenous backgrounds. This is particularly evident in younger children.[278] [279]

Participants at my roundtables and submissions to my examination advised me that the reasons for the overrepresentation of Aboriginal and Torres Strait Islander children and young people in statistics about intentional self-harm with or without suicidal intent were complex and multifactorial in nature.

The 2014 *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide* collated the voices of 28 Elders from different areas in the Northern Territory, Western Australia and Queensland, providing their perspectives on the key driving issues and effective practices in reducing non-suicidal self-harm and suicidal behaviour among Aboriginal and Torres Strait Islander children and young people.

Aboriginal and Torres Strait Islander Social Justice Commissioner, Mr Mick Gooda, stated:

> What makes this Report different from other mainstream investigations into these issues is that the solutions come from the people. They have not been watered down, marginalised or interpreted by outside "experts" or governments.[280]

In this report, Professor Pat Dudgeon, a Bardi woman of Western Australia and Commissioner with the National Mental Health Commission, described the key drivers behind the high rates of non-suicidal self-harm and suicidal behaviour among Aboriginal and Torres Strait Islander children and young people as:

> the brutal history of colonisation, the inter-generational trauma left by Stolen Generations policy, and ongoing racism, combined with the everyday realities in many Aboriginal communities, such as unemployment, poverty, overcrowding, social marginalisation, and higher access to alcohol and drugs.[281]

These issues were raised in a number of my roundtables as well as in submissions made to my examination.

The NPY Women's Council, which works in an area covering 350,000 square kilometres of the remote cross border of Western Australia, South Australia and the Northern Territory in Central Australia, reported that boredom, hopeless prospects, and a lack of significant role models impact on the health and wellbeing of children and young people. It stated that:

> Hopelessness and despair as well as known use of volatile substances add to the recipe for why children and young people engage in suicidal behaviour in the region.[282]

The Northern Territory Council of Social Service reinforced to me that death due to intentional self-harm must be seen:

> in the context of poverty and disadvantage that many Aboriginal people experience, and particularly for those living in remote communities, where systematic community control, inappropriate services, difficulty accessing services, language and other barriers exist.[283]

The Menzies School of Health Research 2011 report, *Suicide of Children and Youth in the NT 2006-2010*, analysed the coronial files for 18 cases of death due to intentional self-harm and hanging deaths by misadventure from 2006 to 2010, by children and young people under the age of 18 years in the Northern Territory. Of the 18 cases analysed, 17 related to the deaths of Aboriginal and Torres Strait Islander children and young people.[284]

The report found that the majority of children and young people in the study had experienced neglect or abuse within the family context from their early years.[285] Familial transmission of suicide risk, particularly involving parental and sibling suicide, along with early experiences of trauma and substance abuse within communities, was strongly linked to suicide attempts in children and young people.[286]

The Northern Territory Child and Youth Mental Health Service receives referrals from all children and young people aged 0-17 years who present to the Alice Springs Hospital with a suicide attempt or suicidal ideation. It reported that, in the period from 2011 to 2014, between 69% and 75% of referrals to them for 'self-harm behaviour or intent' were identified as Aboriginal children or young people,[287] and that the most common presentation for these children and young people was:

> suicidal behaviour and threats of suicide in the context of drug and alcohol use, relational conflict and usually as an impulsive act to express or gain attention of those around.[288]

Some children and young people also presented with suicidal behaviours or thoughts in the context of ongoing depression or chronic levels of stress, while others (although less common in and around Alice Springs) presented with self-harming behaviour as an expression of their distress without the intention to suicide.[289] Those children and young people in the most common category were reported as frequently living in overcrowded and substandard housing, exposed to domestic violence and drug and alcohol abuse, not attending school and likely to have chronic health concerns.[290]

The information provided to me left me in no doubt about the risk factors for Indigenous children and young people. I know that state and territory governments and the federal government have made significant investments over recent years to address these issues. Despite this, the Kimberley Aboriginal Law and Cultural Centre (KALACC) pointed out, 'suicide rates in the Kimberley are no lower today than when KALACC wrote to Coroner Alistair Hope back in early 2007'.[291]

The submission by AIHW indicated that there are very few Australian or international evaluations on the impact of Indigenous-specific suicide prevention programs on suicide rates.[292] The AIHW recommended that more evaluations of suicide prevention programs are needed to help better inform policymakers and service providers about what works for Indigenous suicide prevention.[293]

The KALACC particularly welcomed my examination because it specifically asked for submissions about specific groups of children and young people. It stated that:

> this is a welcome stance, because not only does it recognise that there are a range of demographic groups within Australia society which are at higher risk of suicide, but it also goes part of the way towards shifting consideration of suicidal behaviour away from a focus on individual persons and towards consideration of communities or sub-communities… to understand the phenomenon, the focus needs to be on the community, not on the individual child or young person.[294]

The KALACC suggested we should be asking why the rates of death due to intentional self-harm are high in some Aboriginal communities and not in others. This point was also made at a number of roundtables.

The 2014 *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide* highlights the situation of Indigenous communities in Canada, which suggests that communities with strong connections to culture experience few or no suicides.[295]

Mr Wayne Bergmann, former CEO of the Kimberley Land Council, Western Australia reports:

> There are clear examples in Canada where communities as a whole have taken responsibility to address youth self-harm. By taking greater control in decision-making, these communities have less alcohol abuse, less suicide, higher employment, higher rates of school attendance, and a healthier and happier society. That's where the real answers lie, in empowering Aboriginal people to address community issues.[296]

Mr Max Dulumunmun Harrison of Yuin, New South Wales claimed that:

> the way forward is to adopt a "community centred" approach to healing that is led by local Elders and which involves building community and cultural strength as a foundation for helping Indigenous youth be stronger, more resilient and more positive about their future.[297]

In his foreword to the 2014 *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide*, Commissioner Gooda stated that:

> having access to traditional knowledge and culture strengthens and reinforces a positive sense of identity, it provides young people a cultural foundation and helps protect them from feelings of hopelessness, isolation and being lost between two worlds.[298]

The Victorian Commission for Children and Young People, where Mr Andrew Jackomos is Commissioner for Aboriginal Children and Young People, pointed out to me that despite the lack of lack evidence about what works for Indigenous children and young people, some key program requirements have been identified in the Victorian Aboriginal Suicide Prevention and Response Action Plan, 2010-2015.[299] These key requirements include the need for:

- programs to be developed by and for the communities for which they are intended
- programs to foster empowerment
- Indigenous Australians to be involved in the consultation, programming, delivery and control of services.[300]

The submission made to me by KALACC cited the *Fitzroy Crossing Regional Partnership Agreement Consultation Findings Report*, which stated that:

> Resilience-based factors that strengthen and protect Aboriginal health and wellbeing have been identified as: connection to land, culture, spirituality, ancestry and family and community. Aboriginal communities have a clear desire to lead their own healing initiatives, based on the value of life, culture and community.[301]

The importance of language and culture in building identity and resilience in Aboriginal children and young people was reported to be one of the most critical protective factors in the 2014 *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide*, with Walmajarri Elder, Mr Joe Brown of Fitzroy Crossing noting:

> We tell these lads their skin group, that's who they are and how they fit together in the community. Language is important. They've got to know this so they know their culture and who they are. If they lose language and connection to culture they become a nobody inside and that's enough to put anyone over the edge.[302]

The submission by KALACC told me that the Yiriman Project of Western Australia is an example of how this is being achieved.[303] The Yiriman Project was established in 2000 and initially implemented in Jarlmadangah Burru Aboriginal Community. The program is currently based out of Fitzroy Crossing, Western Australia under the auspices of KALACC.

Yiriman is an intergenerational, 'on-Country' cultural program, conceived and developed directly by Elders from four Kimberly language groups: Nyikina; Mangala; Karajarri; and Walmajarri. It aims is to 'build stories in young people' and keep them alive and healthy by reacquainting them with 'country'. These four groups have similar cultural, geographical, language and kinship ties across a vast region of traditional lands stretching from the coastline south of Broome, inland to the desert areas south and just east of Fitzroy Crossing, Western Australia.

A review and evaluation of the Yiriman Project by Dr Dave Palmer of Murdoch University described it as:

> one of the country's most impressive stories of local people's attempts to deal with the central and pressing public policy challenge of securing the future for Indigenous young people living in remote communities.[304]

This report also indicated that traditional evaluation methods were not suited to projects of this kind.[305] The submission by KALACC informed me that despite such reinforcement, governments are not open to supporting programs such as Yiriman.[306] It attributes this to culturally based methodologies being marginalised and regarded as peripheral.[307]

Future research, with community engagement, into the Yiriman Project should be undertaken. The Yiriman Project is inter-generational involving not only relationships between young and old members of the community but also the generation in between these two groups who 'provide oversight, often taking part in the more physical activities, and often carrying out the instructions of the senior people'.[308] This way of working is more suited to longitudinal evaluation where the longer-term outcomes can be used to build an evidence base.

Another program, which has been reported positively, is the Family Wellbeing Program. It was developed in the 1990s by a group of Indigenous leaders. It is a 150-hour program for Indigenous people, developed specifically for local Queensland communities. The Lowitja Institute advises that this program is:

> enriched with material from complementary philosophies and empowerment principles and seeks to empower participants through personal transformation that involves harmonising physical, emotional, mental and spiritual aspects of life and applying this to practical, day-to-day living.[309]

Evaluation reports of the Family Wellbeing Program, across a range of settings, suggest that many of the program's participants:

> learned to deal with emotions and avoid conflict, and found more peace in their lives. They were able to analyse situations more carefully, take better care of themselves, give and demand more in their relationships, and participate more actively.[310]

(ii) Children and young people living in rural and remote areas

A recent analysis undertaken by the Australian Institute for Suicide Research and Prevention, using information from the Queensland Child Death Register, found that children and young people who lived in remote areas were significantly more likely to die due to intentional self-harm than by other external causes, when compared to children and young people who lived in metropolitan areas.[311]

This finding was supported by the Young and Well Cooperative Research Centre's first National Survey, yet to be published, which indicates that 49% of children and young people in inner regional areas and 46% in rural and remote areas had experienced 'moderate to very high levels of psychological distress'.[312]

Numerous submissions highlighted the lack of available support services in rural and remote communities, issues of staff shortages and staff housing shortages, and a lack of training for staff to deliver evidence-based services.[313] Those services that do exist may not necessarily reflect the needs or wants of the particular community.

Jesuit Social Services noted in its submission:

> In communities where we work, people have said that they want targeted, culturally safe, suicide prevention activities and that a one-size fits all model will not work for remote communities... Community based wellbeing programs that have been shown to work are those that focus on the social, emotional, cultural and spiritual underpinnings of community wellbeing.[314]

The Northern Territory Council of Social Service reinforced the need for services to be built with the community in mind. It argued that:

> while this may take more time than top down implementation, without this approach it is likely that services will be ineffective and waste further valuable resources and time.[315]

Unfortunately, a lack of funding to commit to research projects that specifically target youth mental health, self-harm and suicide in rural and remote areas has resulted in research undertaken in metropolitan areas being used in rural and remote settings.[316] As Dr Sarah Lutkin noted:

> Funding, policy and programs are often based on data from more populated areas, while models of service are applied to smaller communities with limited flexibility.[317]

The Youth Affairs Council of Western Australia pointed out that the gradual depopulation of rural and remote communities can be a barrier to young people who may be seeking support due to limited availability of essential services.[318]

The Menzies School of Health Research argued that there is a lack of social and emotional wellbeing services available to children and young people in remote communities, with few or no follow-up services available to them.[319]

When investing in services, it is necessary to be mindful of the limited infrastructure available in some very remote locations. This, as Menzies School of Health Research acknowledged, may require investment in 'community resources and programs linked to health and education with an effort to optimise the effectiveness of visiting, mobile services'.[320]

(iii) Children and young people who are sexuality diverse, transgender, gender diverse and intersex

At some roundtables and also in some submissions, it was reinforced to me that many children and young people who are sexuality diverse, transgender, gender diverse and intersex are especially vulnerable to non-suicidal self-harm and suicidal behaviour.

The submission by Twenty10 incorporating the GLCS NSW and the University of Western Sydney (Twenty10) stated that, despite an overall decline in deaths due to intentional self-harm in Australian young people since the mid-1990s, the prevalence of suicide attempts, suicidal ideation and non-suicidal self-harm in young people who are sexuality diverse, transgender, gender diverse and intersex remains stubbornly high.[321]

Little is known about the prevalence of non-suicidal self-harm and suicidal behaviour in intersex children and young people.

The submission by Twenty10 suggested that these children and young people are at heightened risk.[322] Organisation Intersex International Australia told me that children and young people who are intersex face particular risks related to cultural, familial and medical attitudes that focus on intersex bodies conforming to social norms.[323] In particular, surgical and other medical interventions that aim to erase intersex differences can have profound consequences on the physical and mental health of intersex children and young people.[324] Twenty10 emphasised:

- the trauma associated with medical examinations, treatment, and surgical interventions
- the physical difficulties linked with unnecessary childhood genital surgery, including impairment causing genital sensitivity, scarring, urinary issues and chronic pain
- negative body image and problems with sexual intimacy associated with genital difference
- a dissonance between 'surgically assigned' sex at infancy and gender identity.[325]

It is important to point out that sexual orientation, gender identity and/or intersex status do not elevate risk per se, but rather ongoing negative experiences and discrimination can increase the risks.

Some of the risk factors for non-suicidal self-harm and suicidal behaviour experienced by children and young people who are sexuality diverse, transgender, gender diverse and intersex include discrimination, verbal and physical abuse, and victimisation and bullying.[326]

Twenty10 highlighted the multiple layers of risk factors impacting on sexuality diverse, transgender, gender diverse and intersex children and young people and how these intersectionalities may, in turn, influence patterns of non-suicidal self-harm and suicidal behaviour. For example, risk factors can be compounded for children and young people who also identify as Aboriginal or Torres Strait Islander, are from culturally or linguistically diverse backgrounds, or who have a disability.[327]

Intra-family homophobia and transphobia is also a serious risk factor. Family rejection often increases the isolation and despair for children and young people who are sexuality diverse, transgender, gender diverse and intersex. Supportive family relationships have been found to be protective factors against non-suicidal self-harm and suicidal behaviour in children and young people.[328]

Additionally, homophobia and transphobia often occurs in the school environment. The *Writing Themselves In 3* report found that students who had experienced either verbal or physical abuse were 55% more likely to self-harm or attempt suicide.[329] In the *Growing up Queer* study, peers were found to be the most frequent perpetrators of homophobia and transphobia. Homophobia and transphobia perpetrated by teachers is said to have the greatest impact on the lives and wellbeing of children and young people.[330]

Homophobia and transphobia in schools frequently leads to multiple school moves and disrupted learning, or dropping out of school entirely. School policies, practices and curricula must be inclusive of all young people's lives and experiences.

Twenty10 pointed out to me that heterosexism, homophobia and transphobia can contribute to social isolation, poorer mental health outcomes, substance misuse, and other sociocultural and economic problems and conditions, which in turn increase the risk of non-suicidal self-harm and suicidal behaviour.[331]

These issues are further compounded by the social and physical developments that occur within adolescence, major life transitions, identity exploration, relationships, and a growing need for autonomy.[332]

(iv) Children and young people from culturally and linguistically diverse backgrounds

As previously mentioned, there is limited data about the prevalence of non-suicidal self-harm and suicidal behaviour within multicultural communities. However, it is suggested that some children and young people from culturally and linguistically diverse (CALD) backgrounds are vulnerable to environmental risk factors that impact negatively on their mental health.

In its submission, the Centre for Multicultural Youth identified traumatic experience prior to immigration, the stresses of migration, separation from families and communities, settlement in a new country, being 'caught' between cultures, low language proficiency, higher levels of social disadvantage and unemployment as issues faced in CALD communities.[333]

Some children and young people from CALD backgrounds also experience racism at school and in the broader community, which can lead to feelings of isolation and trigger pre-migration trauma.[334]

There is strong evidence to suggest that children and young people from migrant and refugee backgrounds access mental health services at a lower rate than other Australian born children and young people, although their need for such services may be as great or greater.[335]

The Kids Helpline made the point in its submission that its service experienced an underrepresentation of young males with CALD backgrounds engaged in help-seeking activities about suicide and self-harm.[336]

Case study provided by The Phoenix Centre, a member agency of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) and auspiced by the Migrant Resource Centre Southern Tasmania.[337]

A 12 year old Afghani boy who has been in Australia for three years disclosed to his peers that he had been cutting himself and had taken a rope with the intention of hanging himself. His peers spoke to a trusted EAL (English as an Additional Language) teacher. The teacher spoke to the school social worker who spoke to him. He said that he did not want to speak to anyone from the school. He agreed, however, to be visited at school by a counsellor from the Phoenix Centre, acceptable to him because of its association with the Migrant Resource Centre, with which he was familiar. Hi also insisted that his parents and siblings not be informed about his situation or that he was receiving counselling. He did not wish to upset his parents who were already upset by his older brother's behaviour.

The counsellor conducted a suicide assessment which indicated that the client was not in immediate danger. The incident with the rope had occurred several months ago and there had been no similar incidents since then. The client described the context in which this incident occurred. The client said he had difficulty controlling his emotions; as he said, his emotions went 'whoosh'. He would break items nearby, hit out at others, flick light switches on and off, scream and shout. The suicidal behaviour occurred after such an episode of emotional dysregulation, following an argument with his siblings about access to a computer game. His mother intervened, seemingly in favour of his siblings. He ran outside and into the garage where he saw a rope which he threw over a beam. He stood there with the rope around his neck. He thought about if he hanged himself how badly that would impact on his parents. He thought about a favourite teacher at school and how upset she would be if he killed himself. Feeling ashamed, he hid the rope, went inside and did not speak about the incident until he disclosed it to two classmates.

He spoke about the suicidal behaviour when two classmates saw scratches on his arms. He was feeling lonely and confirmed that he had been scratching himself and told them about the incident with the rope. He explained to the counsellor that he did not scratch himself often but did so when he had no one to be with at school. He would feel alone and upset and would scratch himself with scissors. He felt ashamed about doing this. He said it did not hurt and he wasn't sure why he did it.

He and the counsellor worked first on a safety plan: how to keep safe if he felt suicidal again. The counsellor provided psycho-education around suicidal behaviour, e.g. that many people attempt suicide because they are looking for a solution to their pain rather than wishing to end their lives, about impulsivity which is an issue for young people because developmentally they may not be able to grasp the finality of death. The counsellor explored the many reasons why young people might self-harm, identifying it as a maladaptive coping mechanism and looking at other positive coping strategies to use when feeling overwhelmed.

The counsellor created an opportunity for him to talk about the experiences he and his family had had before coming to Australia. He chose not to disclose the details of his experience, only saying that it had been "hard" and that there were aspects of his old life that he missed. He spoke about friends who were still in the refugee camp.

He and the counsellor looked at the impacts of trauma on the developing brain in an age appropriate way, and how the brain could establish new pathways, so that he wouldn't go "whoosh" so often. He learnt to identify emotions, to recognise triggers, body signs for emotions, anger management techniques, and mindfulness techniques such as deep breathing or imagining a calming space which he could go to when feeling distressed.

His priority was to make friends so that issue was explored, using strengths based approach.

The counsellor worked with him for six months, seeing the client during term on a weekly basis. During that time, he reported no further self-harm or suicidal behaviour. He made friends, one of them "Australian", and had been supported by staff to join one of the school soccer teams. He and the counsellor worked on goal setting, providing a future orientation. He made the goal that he wanted to become a sports teacher.

As part of the exit strategy, the counsellor encouraged him to speak with the School Social worker who had referred him whenever he felt in need of support, or contact the counsellor again if in need for further assistance. The counsellor showed him websites that he might find useful: Reach Out, RUOK, Kids Helpline, Youth Beyond Blue, and Bite Back. Other key elements of his recovery included a supportive and inclusive school environment and his spiritual beliefs. He identified participation in the Moslem faith as a source of comfort and strength, feeling very proud when he received a certificate for fasting during Ramadan for the first time.

(v) Children and young people living with disability

Children and young people with disabilities are defined as those with 'long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.[338]

In 2009, AIHW reported that there were 288,300 Australian children and young people aged 0-14 years with some form of disability, with 163,600 of these children and young people living with severe or profound core activity limitation.[339] Corresponding data for children and young people with disabilities aged 15-17 years, in line with the CRC definition of the child, is currently unavailable.[340]

The ACT Community Services Directorate advised me 'children and young people with a severe or profound disability, or who have learning disabilities, are at a higher risk of self-harming behaviour or attempting suicide.'[341]

The submission by the Royal Australasian College of Physicians suggested children and young people with learning and developmental disabilities are particularly vulnerable to mental health problems, including depression, and can face difficulties engaging with complex health service systems and recommendations.[342]

The Australian Psychological Society indicated, in its submission, factors such as chronic illness and physical disability 'are associated with suicidal ideation or attempts, even after controlling for other risk factors'.[343] Other research has also suggested an association between chronic pain and suicidality in children and young people.[344]

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) pointed out to me that siblings of children and young people with disabilities or chronic illnesses are at risk of developing behavioural, mental and physical health problems that, if unaddressed, can increase the risk of longer-term mental health problems.[345]

Siblings Australia reiterated the concerns of RANZCP.[346] Siblings Australia conducted a study on the experiences of siblings, children and young people with disability in 1999, which found that:

> whilst some [siblings] could certainly identify a range of positives, like developing compassion and patience and embracing diversity and a sense of social justice, many also identified the costs to both their physical and mental health. Impacts included depression, anxiety, OCD, eating disorders, social phobia, self-harm, sleep problems and very low self-esteem. Some siblings also talked of previous suicide attempts.[347]

The results of a 2008 research project undertaken by the Australian Institute of Family Studies, found that both siblings and parents of children and young people with disabilities had higher than average rates of depression, regardless of whether or not they play an active caring role.[348]

Given that children and young people with disabilities are at particular risk of non-suicidal self-harm and suicidal behaviour, increased awareness regarding the potential risks, and the implementation of early intervention and prevention strategies to reduce these risks, is essential.[349]

The Young and Well Cooperative Research Centre noted that children and young people with physical, learning or psychological disabilities, or chronic illnesses, may not be able to socially interact in the same way as their peers.[350] Access to the internet, and online communicative technologies, in such instances, may serve as important mechanisms for supporting the mental health and wellbeing of those children and young people who might otherwise be socially isolated. Educational campaigns and services must therefore be designed with the abilities and needs of particular groups of children and young people in mind.[351]

One example of an effective online communication tool for children and young people with disabilities is The Lab, a project that Young and Well Cooperative Research Centre jointly undertook with Project Synthesis.[352] According to Young and Well Cooperative Research Centre, The Lab connects young people with Asperger's Syndrome directly with settings where information technology specialists work and study, so that participants can learn new technology and software skills, improve social interaction skills, and meet new friends who also have Asperger's Syndrome.[353]

The results from The Lab indicate increased health and wellbeing in the participants, in addition to higher social engagement, cessation of harmful behaviour and the development of technical skills.[354]

In order to accurately identify best practice approaches for the development of effective prevention and treatment programs for children and young people with a disability, more research and data collection must be undertaken at the national level.

(vi) Asylum-seeking children and young people

Several of the submissions that I received outlined how young asylum seekers face an accumulation of risk factors including previous trauma, separation from family with little or no prospect of reunification, persecution in countries of refuge, dangerous voyages by boat, long periods of time spent in detention centres, continuing uncertainty about visa status and fear of being sent back to danger.[355]

Some asylum seekers under 18 years of age are born in refugee camps, where basic necessities are scarce, sexual and domestic violence is present, education is disrupted and inadequate, and many witness self-harm and suicide.[356]

Research has shown that the mental health impacts on asylum seekers held in detention can continue to affect them after they have been released into the community.[357]

The detrimental mental health impact of prolonged detention is well documented, including in previous reports by the Australian Human Rights Commission (the Commission). The 2004 National Inquiry into Children in Immigration Detention by the Commission found that children and young people who are detained for long periods in immigration detention facilities are at high risk of serious mental harm,[358] and that at the severe end of the spectrum some made suicide attempts and began to self-harm, such as by cutting themselves, sewing their lips together, or swallowing shampoo.[359]

Between January 2013 and March 2014, there were 128 reported actual self-harm incidents amongst children and young people in closed immigration detention facilities in Australia.[360] The average length of time that a child or young person spent in an immigration detention facility in Australia as at 31 March 2014 was 231 days.[361]

As mentioned in Chapter 1, given the ongoing concerns about children and young people in immigration detention, the Commission undertook another National Inquiry into Children in Immigration Detention in 2014.

Submissions to the National Inquiry into Children in Immigration Detention 2014, which are available on the Commission's website, have noted the detrimental impact of immigration detention on children and young people, including self-harm and suicidal ideation and the lack of appropriate mental health services.[362]

(vii) Children and young people living in out-of-home care

A number of the submissions I received cited placements in out-of-home care as a key risk factor associated with non-suicidal self-harm and suicidal behaviour.[363]

Children and young people in out-of-home care have often faced serious disadvantage early in their lives. As Orygen Youth Health Research Centre pointed out in its submission 'many have multiple and complex needs before, during and after living in care, including higher rates of mental health and substance use disorders and suicide, and greater risks of homelessness and delinquency'.[364]

The submission made to me by Menzies School of Health Research stated:

> many young persons at risk of suicide have been raised in adverse circumstances, with poor quality or disrupted parental care, in some cases amounting to maltreatment and abuse. Many of them will have been the subject of actions by child protection services in early childhood and later in life.[365]

Early Childhood Australia reported how:

> family and parental factors, such as history of parental or family suicide, depression, anxiety, substance abuse, violence, sexual abuse, trauma, harsh parenting style, disruption in development of relationships and secure attachment, divorce or separation place children at risk of poor mental health.[366]

In its submission, Orygen Youth Health Research Centre suggested that the prevalence of suicidal behaviour in this population appears to increase when young people leave out-of-home care.[367] A 2007 study reported that 71% of young people had thought about, or acted on, suicidal thoughts and almost half had attempted suicide either before, or up to five years after, leaving care.[368]

The submission by Menzies School of Health Research advocates targeting high-risk parents, identified through the child protection system, to potentially improve the quality of parenting and family environments in early childhood.[369] This would necessarily involve investigation into the:

> contribution of early childhood adversity to suicide outcomes in order to target child protection intervention and for improvements in prevention targeting early childhood and the ongoing functioning of families.[370]

It is imperative that prevention and support programs tailored for children and young people in out-of-home care placements are developed. This should involve actively listening to the voices of children and young people in out-of-home care settings, and providing culturally appropriate therapeutic and other supports, as an integral part of case planning and management, both during and post-care.

The ACT Community Services Directorate is presently developing an out-of-home care strategy for 2015-2020 that proposes 'the introduction of regular comprehensive wellbeing assessments of children and young people in care'.[371] This is a positive step in terms of listening to, and empowering, children and young people in these settings.

Orygen Youth Health Research Centre is currently conducting a ripple study on improving mental health for children and young people in out-of-home care aged 12-17 years.[372] It is assessing:

> whether a mental health intervention that enhances the therapeutic care roles and capacities of their carers will improve: (i) the consistency and quality of out-of-home care for all young people in the sector, and (ii) access to early intervention when indicated for prevention and treatment of mental illness.[373]

I look forward to the results of this important study.

(viii) Pharmacological concerns

I received a number of submissions that questioned the appropriateness of prescribing retinoid and psychotropic medications to children and young people.

Some of these were from parents who maintained that their child only became suicidal, and died due to intentional self-harm, as a result of the medication.

I am interested in what information is captured about these deaths, how it is recorded, and how it is reported.

I am aware that the Royal Australian and New Zealand College of Psychiatrists is currently leading the development of guidelines for the treatment of self-harm, including for young people with first episode psychosis.[374] This is an area that definitely requires further work and investigation.

Summary – groups of children and young people with particular vulnerabilities

Aboriginal and Torres Strait Islander children and young people, those who are living in regional and remote communities, those who are sexuality diverse, transgender, gender diverse and intersex, those from culturally diverse backgrounds, those living in out-of-home care, those living with disabilities, and refugee children and young people seeking asylum may be particularly vulnerable to non-suicidal self-harm and suicidal behaviour.

Research investigating their particular risks should be undertaken. It is essential to understand the impact of the different risk factors, how they are interrelated, and whether some are more predominant than others.

It is also important for research to examine the effects and impacts of different protective factors on their wellbeing.

3.5.7 The context of the data that I was able to source for my examination

I provide this contextual information because it outlines the conditions under which data was provided and highlights the current impediments to the accurate identification and recording of non-suicidal self-harm and suicidal behaviour in children and young people.

(i) Coding of deaths and hospitalisations due to intentional self-harm

The International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) has been used by ABS since 1997[375] to code incidents of death and episodes of hospitalisation due to purposely self-inflicted poisoning or injury, including attempted suicide.

The International Statistical Classification of Diseases and Related Health Problems, 10th, Australian Modification (ICD-10-AM) was developed by the National Centre for Classification in Health. The classification is used for the coding of diagnoses and external causes of injury and poisoning (including self-inflicted injury or poisoning) in admitted patient records in the National Hospital Morbidity Database (NHMD). The NHMD is collated by AIHW from records provided annually by states and territories. States and territories receive these data from public and private hospitals. The ICD-10-AM classification has been used in AIHW reports since 1999.

The NCIS uses its own codeset that is largely based on the International Classification of External Causes of Injuries, Version 1.2 (ICECI) but has been modified for use in Australia to code incidents of death.[376] The ICECI codeset has not been updated since 2004 and is less detailed than the NCIS codeset.

As a first step, NCIS assigns the intent coding to each case based on the coronial finding. This intent coding, along with other relevant coding, is then reviewed by ABS, which assigns the ICD-10 codes based on the information provided by NCIS. Subsequently, ABS feeds the ICD-10 codes back to NCIS, with NCIS adding the codes to the NCIS cases.

Neither the ICD-10 codes nor the classification system used by NCIS distinguish between intentional self-harm with suicidal intent and intentional self-harm without suicidal intent. Conflating intentional self-harm with suicidal intent and intentional self-harm without suicidal intent makes it hard to construct an accurate picture of what is actually occurring.

The NCIS pointed out to me that:

> [it] provides exclusively information on "intentional self-harm", not on "suicide". The terms are not always accurately distinguished, however every act of "suicide" will classify as an act of "intentional self-harm". As a result, the NCIS chooses to provide a wider scope, which allows researchers to narrow down their criteria to cases, which are relevant to them.[377]

(ii) Constraints on data availability

Obtaining disaggregated data required significant negotiation. Primarily the reason given for this was due to the comparatively small number of children and young people involved and the need to protect their identities.

The *Census and Statistics Act 1905* (Cth) gives ABS authority to collect data for statistical purposes. Under this Act, information supplied to ABS cannot be published or disseminated in a manner that is likely to enable the identification of a particular person or organisation. This Act contains provisions obliging past and present employees of ABS to maintain the secrecy of data collected. A fine of up to $20,400 or a penalty of two years imprisonment, or both, applies to an unauthorised disclosure of information collected under this Act.

The AIHW's main functions relate to the collection and production of health-related and welfare-related information and statistics, and are specified in section 5 of the *Australian Institute of Health and Welfare Act 1987* (Cth). The AIHW operates under a strict privacy regime which has its basis in section 29 of this Act. Personal information held by the AIHW is also protected by the *Privacy Act 1988* (Cth).

The NCIS is governed by a Board of Management, including coronial, public health and national justice representatives. Administrative support is provided by the Victorian Department of Justice. While there is no specific legislation that NCIS is bound by, NCIS operates under a Licence Agreement between it and each of the nine Australian and New Zealand coronial jurisdictions that provide coronial information.

As part of this Licence Agreement, Schedule B (Data Release Principles) specifies that statistical data shall only be released by NCIS according to the following principles:

- The Statistical Data must be non-identifying, and be an accurate and comprehensive representation of the data held in NCIS.
- The Statistical Data should be consistent with the NCIS Data Quality Principles to ensure data quality and reliability.
- Statistical Data that specifically identifies the frequency of deaths in a jurisdiction must be approved for release by the State/Chief Coroner of that jurisdiction (or a nominated delegate) prior to provision to the Requesting Party.

Schedule C (Information Privacy Release Principles) of the Licence Agreement is based on schedules of the *Information Privacy Act 2000* (Vic) and describes the circumstances in which the coronial information may be used. Schedule C of the Licence Agreement includes eight exemption clauses. Two exemption clauses of Schedule C of the Licence Agreement include that an organisation must not use or disclose personal information about an individual for a purpose (the secondary purpose) other than the primary purpose of collection unless 'the use or disclosure is necessary for research, or the compilation or analysis of statistics, in the public interest, other than for publication in a form that identifies any particular individual', or 'the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent a serious threat to public health, public safety, or public welfare'.

I note the comment made by NCIS about my request for data:

> The release of data of such a sensitive nature at this level of detail is quite ground breaking for us. All coronial jurisdictions, while cautious about the release of data, recognise the potential benefit to the community of evidence-based information when addressing very complex issues. While preparing this report we have had some very good discussions with the jurisdictions with very positive results.[378]

In an attempt to work respectfully within these privacy and confidentiality constraints, an aggregated time period of five years was negotiated with ABS and NCIS who provided data for the period 2007 to 2012. The AIHW provided data using the aggregated time period of 2007-2008 to 2012-2013.

There is a time delay in data available from ABS and NCIS due to cases being under coronial investigation and therefore not concluded. The NCIS only provides data on concluded/closed cases.[379]

The ABS indicated in its submission that 'there can be significant time delays (generally of up to three years) before coronial cases are closed and findings made'.[380]

In an attempt to address this time delay issue, ABS includes open cases in its data by using information from NCIS which is available before coronial investigations have concluded. The ABS then re-codes open cases 12 and 24 months later as part of a revisions process so that as new information becomes available it is coded by ABS.

In real terms, this means that the latest data released by ABS in March 2014 includes 2012 preliminary data, 2011 revised data and 2010 final data. The ABS reported in its submission, and also at the research roundtable, that in a recent review 'only 1.4% of preliminary codes needed to be changed during the revisions process because of a disparity with a coronial finding'.[381]

The time delay in data availability was raised as an issue in numerous submissions. The Orygen Youth Health Research Centre particularly commented on the difficulties of 'accessing data in a timely manner'.[382] It impedes the capacity for those who work in this area to be able to respond to issues as they are emerging. The Youth Affairs Council of Western Australia,[383] National Aboriginal and Torres Strait Islander Leadership in Mental Health,[384] Coronial Council of Victoria,[385] and Royal Australian and New Zealand College of Psychiatrists[386] also raised this as an issue.

The inclusion of open and closed cases in the ABS data[387] may account for the difference in the number of deaths due to intentional self-harm provided to me by ABS and NCIS, 393 and 333 respectively. The ABS recorded 60 more deaths due to intentional self-harm than NCIS in the same period. The data provided by NCIS may be an underestimation of the actual number of deaths in children and young people under 18 years of age due to cases of relevance not being included as they are still under coronial investigation.[388]

The need for highly disaggregated information for specific research purposes is clearly understood by those agencies involved in the collection and dissemination of cause of death data. The ABS has been working closely with the Registrars of Births, Deaths and Marriages and state and territory coroners to determine a suitable mechanism for the dissemination of a national unit record file. Negotiation of a sustainable process for the dissemination of unit record data is challenging because of the need to comply with multiple federal and jurisdictional legislation. The sensitive nature of the dataset has necessitated the development of strong data management practices and a rigorous application process to provide adequate protections and ensure appropriate use of the data. However, an agreement between data custodians has been reached and an application process for access to this dataset is now open and is being managed by the Australian Coordinating Registry based in Queensland.

The availability of unit record data is especially important in regards to research on death due to intentional self-harm among children and young people. This dataset could provide access to particular social and demographic characteristics captured at the time of death as well as the cause of death, mechanism of death, age, sex, usual residence, Indigenous status, place of death and country of birth.

It could also provide researchers with information on other conditions identified by a doctor or coroner as being present at the time of death. This unit record information could, in certain circumstances, enable linkage with other datasets, opening possibilities to more fully understand the circumstances of those who have died due to intentional self-harm.

(iii) Underestimation of death due to intentional self-harm

Participants at my roundtables, and some of those who made submissions, raised the underestimation of deaths due to intentional self-harm from under-reporting as a consequence of coroners not making a finding about intent.

The Coronial Council of Victoria told me:

> Issues of capacity are particularly likely to arise for children and young people. Whether or not children can formulate concepts of the finality of death is controversial but it is clear that self-harming behaviour by children and young people, which sometimes leads to death, is a significant problem.[389]

The Queensland Commission of Children and Young People informed me:

> The under-reporting of youth suicide has been a contributing factor to an under-appreciation of childhood suicide. The sensitive nature of suicide has historically been a rationale for not publicly reporting its occurrence in Australia. However, this is no longer valid, as accurate data on the prevalence of youth suicide can not only reduce misinformation amongst media and community stakeholders, but also improve research into prevention and postvention responses for at-risk young people.[390]

The Royal Australian and New Zealand College of Psychiatrists argued that:

> The issue of intent is a complex one…what this has created is a "hidden" group of child suicides, only just now coming to our knowledge through state based data databases (e.g. Queensland and WA). The dilemma is that if a problem is hidden and not publically acknowledged, then there is no public will to find and fund strategies to prevent such suicides.[391]

In the past, the prevailing view was that children and young people lacked the capacity to understand the consequences and irreversibility of their actions. However, this view appears to be changing with many now agreeing that some children and young people do have this capacity.

The Menzies School of Health Research pointed out to me:

> It should not be taken for granted that the consequences of suicide and the absoluteness of death are not unknown to young Aboriginal people so frequently exposed to death, mourning and the permanent absence of people lost to suicide.[392]

Currently, no jurisdiction in Australia requires a coroner to make a specific determination about intent. Reluctance to make a determination is often attributed to not wanting to cause the family further trauma given the stigma associated with death due to intentional self-harm.

This issue was raised by the Senate Community Affairs References Committee in *The Hidden Toll: Suicides in Australia* report of 2010, and it continues to be on the agenda of the National Committee for Standardised Reporting on Suicide.

The NCIS recommended the amendment of coronial legislation in each jurisdiction to require a determination of intent in its submission to the *The Hidden Toll: Suicides in Australia* Inquiry in 2010. This has not happened.

The NCIS told me that it recognises that the determination of an intent of either suicide or intentional self-harm is a complex issue for coroners, but it would help NCIS to capture all cases of relevance and code them correctly if there was standardised reporting of intentional self-harm and if coroners were obliged to determine intent.

Many cases that may be of relevance are coded as undetermined intent if a coroner does not make a determination on intent. This is a complex aspect of coronial investigation but there is a danger of under representation due to the way NCIS is forced to code cases where the intent is not determined.

The Coronial Council of Victoria is currently advocating for a legislative amendment in the Victorian coronial jurisdiction that will require coroners to make a finding of intention.

The Council has also asked the Victorian Attorney-General to:

> raise the issue of standardisation of coronial legislation and/or coronial systems in Australia in the Standing Council on Law, Crime and Community Safety and propose that changes be implemented in parallel in all Australian jurisdictions.[393]

I support this recommendation.

Standardising the input that coroners receive from primary sources, such as police, was also raised in my roundtables. Again, this was a subject that received significant attention in the *The Hidden Toll: Suicides in Australia* Inquiry in 2010.

Following on from the Senate Inquiry, a National Police Form template was developed. However, as pointed out to me by the Coronial Council of Victoria, only four of the eight jurisdictions are using a version of it and only the Australian Capital Territory and Tasmania have implemented electronic transfer to NCIS.[394]

Moving towards using a standardised national reporting form should be a priority in all jurisdictions. The NCIS told me that the non-standard collection of information by Police when reporting a death was problematic and could be assisted by the uniform adoption of a National Police Form, providing more consistent identification of suspected suicide deaths to pathologists and coroners, as well as collecting standard information surrounding the background of the deceased, and reasons for the suspicion of suicide.

Several jurisdictions have implemented a more extensive police form which incorporates many of the fields contained within the standardised form, as well as fields which are specific to their own data collection requirements.[395]

The Menzies School of Health Research suggested to me that:

> To assist coroners in their task of weighing up the likelihood of suicide deaths by school-aged children and young people, the reporting proforma used by police in investigating and recording information about the deceased could be extended to include a separate section for people aged 18 and under. This could include a standard set of questions relevant to this age group and the types of information to be routinely sought from schools, children and families, and health practitioners and services.[396]

This is an excellent suggestion and one that I advocate should be implemented.

Participants at the Australian Capital Territory roundtable and submissions from the Australian Capital Territory raised the issue of poorly completed death certificates.

The ACT Children and Young People Death Review Committee believes that:

> one of the major impediments to the accurate identification of suicidal behaviours in children and young people is the quality and accuracy of the death certificates being completed by the doctors involved in the child or young person's death.[397]

It attributes this to doctors not wishing to upset surviving family members given the stigma associated with this cause of death, relatively inexperienced doctors being responsible for completing the death certificate, and doctors not taking enough time to complete the death certificate accurately and in enough detail.

It suggests better training of doctors in this area and changes to the questions on death certificate forms, so that doctors are required to provide more detailed and accurate information.

Improving the quality of information recorded on death certificates may warrant the development of specific practice guidelines for medical practitioners about how to complete death certificates where suicide is suspected. As ABS notes:

> Medical practitioners have a vital role to play in the production of high quality mortality data, by ensuring complete accurate and detailed information is recorded on the certificate.[398]

Women's Health Victoria recommended that hospital settings and coroners offices be supported with tools to better identify non-suicidal self-harm and suicidal behaviour.[399] I agree with the recommendation made to me by Women's Health Victoria.

Some participants in my roundtables, and some submissions, raised the challenges of accurate data collection on deaths due to intentional self-harm in rural and remote communities. Reasons for this included:

- suicides being inaccurately reported as accidents
- witnesses speaking English as a second language
- hesitation to report deaths due to intentional self-harm or attempted deaths due to intentional self-harm for cultural reasons
- the transient nature of some remote communities.[400]

The submission by the Northern Territory Council of Social Service argued:

> There must be trusting relationships formed between service providers and Aboriginal people over a period of time before people feel safe enough to share personal information.[401]

Some submissions highlighted concerns about the accurate identification and recording of data relating to children and young people who are sexuality diverse, transgender, gender diverse and intersex.[402]

Transgender Victoria pointed out to me that:

> a major barrier for trans people is many might never disclose they are questioning their gender identity before taking their life. We may simply never know how many such situations really exist. Another is that trans and gender diverse people are often made invisible due to reporting systems based on male/female that do not allow for respectful disclosure re gender identity.[403]

The absence of representative data on intersex children and young people makes it impossible to accurately record non-suicidal self-harm and suicidal behaviour in this group.[404]

(iv) Underestimation of intentional self-harm with or without suicidal intent

The AIHW indicates in its most recent publication about hospitalisations for injury and poisoning that only a small proportion of incident injury cases result in admission to a hospital, and that for each hospital admission, many more cases present to emergency departments and are not admitted, or are seen by a general practitioner, or do not receive medical treatment.[405]

This has serious implications in terms of accurate identification and recording of prevalence, incidence, motivating factors, prevention and treatment. The Western Australian Commission for Children and Young People reinforced this and told me:

> the vast majority of young people who self-harm do not present for hospital treatment at all and therefore the…data is most likely an underrepresentation of the actual number of young people intentionally self-harming.[406]

The AIHW also pointed out that:

> In very young children, ascertaining whether an injury was due to intentional self-harm can be difficult and may involve a parent or caregiver's perception of the intent…The age at which self-inflicted acts can be interpreted as intentional self-harm is not well defined and is the subject of debate.[407]

The Rosemount Good Shepherd Youth and Family Services told me:

> We are finding clients have been self-harming from as young as 10 or below and often in Year 6. If data is to be used to achieve the best outcomes, this data will need to examine a younger cohort of students.[408]

(v) The benefit of a national child death and injury database and a national reporting function

In my call for submissions, I asked about the benefits of having a national child death and injury database, and a national reporting function.

Many participants at my roundtables, and submissions which addressed this issue, supported the establishment of a national child death and injury database. Organisations including beyondblue,[409] Black Dog Institute,[410] Australian Psychological Society,[411] Menzies School of Health Research,[412] Youth Affairs Council of Western Australia,[413] Public Health Association Australia,[414] Young and Well Cooperative Research Centre,[415] United Synergies and the National Standby Suicide Bereavement Response Service,[416] The Royal Australian and New Zealand College of Psychiatrists (RANZCP),[417] Child and Youth Mental Health Service, Children's Health Queensland,[418] NSW Government,[419] the Australian Institute of Health and Welfare,[420] National Children's and Youth Law Centre,[421] and the Victorian Commission for Children and Young People[422] advocated for the development of a national child death and injury database.

The ABS commented on the need to ensure that the data gap driving the push for a national database was well understood to fully inform any cost benefit analysis of such an initiative.[423] In addition, ABS commented on the importance of bringing together coherent information from multiple sources to maximise the usefulness and interpretability of the database as an information source.[424]

The AIHW emphasised that:

> More comprehensive data on suicides and attempted suicides is needed to better facilitate better planning of support, prevention and early intervention services. A notable gap exists in reporting the number of suicide-related contacts by ambulance services, mental health crisis teams and the police. A gap also exists in terms of reporting on the services they provide.[425]

As the Australian Psychological Society argued:

> 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.[426]

The Victorian Commission for Children and Young People proposed the development of standardised data sets including:

- the method of self-harm or suicide attempt (including railway suicide attempts)
- the age of the child or young person
- the cultural and/or religious group with which the child or young person identified
- whether the child or young person had an asylum seeker or refugee background
- whether the child or young person was of Aboriginal or Torres Strait Islander background
- whether the child or young person was involved with child protection at the time, or had been previously
- whether the child or young person was in out-of-home care, and if so, what type
- whether the child or young person was involved with youth justice at the time, or had been previously
- whether the child or young person had been involved with mental health services, or had been previously
- whether the child or young person was subject to permanent care or adoption
- whether the child or young person was in immigration detention (held or community), located on the Australian mainland or an alternative, or had been previously
- whether the child or young person was an unaccompanied minor, and if so, whether classified as a ward or non-ward
- whether the child or young person identified as gender diverse or sexuality variant (or alternatively using LGBTIQ classification groups).[427]

The Australian Institute for Suicide Research and Prevention reinforced the need to collect a range of demographic, psychosocial, psychiatric information.[428]

Twenty10 told me:

> sexual orientation and gender identity should be included when collecting data for purposes such as coronial records and reports prepared by police to assist coroners, as well as in other health contexts, where appropriate and relevant. Inclusion of intersex status in these contexts should also be explored, in partnership with intersex communities.[429]

This was reinforced by the Australian National Coalition for Suicide Prevention in its response to the 2014 World Health Organisation report on *Preventing Suicide: A Global Imperative* when it stated:

> national data is not centrally and routinely collected on identification as lesbian, gay, bisexual, transgender, intersex and other sexuality and gender diverse.[430]

The Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) has commenced some work in relation to the development of a national child death database.[431] It is working with AIHW on this.[432] Representatives from each Australian state and territory and New Zealand are members of ANZCDR&PG. The ANZCDR&PG pointed out to me that:

> although each jurisdiction has its own legislation, functions, roles and requirements for reporting, there is consensus among the ANZCDR&PG members that a national child death database and national child death reporting is essential for consistent, statistically sound data to provide the evidence for prevention activities and the full range policy development. Current comparisons of causes and rates of child deaths across the jurisdictions, although completed annually and generally comparable, are not standardised or consistent.[433]

The Menzies School of Health Research noted in its submission that the establishment of such a database should be accompanied by a uniform national standard for identifying and reporting causes of death and injury that is specific to children and young people.[434]

While the benefits of establishing a national child death and injury database are acknowledged, aligning the legislation, functions and requirements for reporting across all the jurisdictions will require extensive coordination and resourcing.

I encourage ANZCDR&PG, in conjunction with AIHW, to continue its work in this area, and for the Australian Government to provide funds to ABS to pursue its work on data linkage for children and young people in the event that this work is cleared to proceed.

Summary – issues relating to data

Data about death and hospitalisation due to intentional self-harm does not distinguish between intentional self-harm with suicidal intent and intentional self-harm without suicidal intent. This makes it hard to construct an accurate picture of what is actually occurring.

Confidentiality and privacy requirements limit the availability of data about death and hospitalisation due to intentional self-harm.

The availability of data is delayed due to the length of coronial investigations, which can take two years or more to finalise.

The availability of unit record data is especially important in regards to research on non-suicidal self-harm, suicidal behaviour and death due to intentional self-harm among children and young people. This dataset would provide access to particular social and demographic characteristics captured at the time of death including cause of death, mechanism of death (in the case of intentional self-harm deaths), age, sex, usual residence, Indigenous status, place of death and country of birth.

There is an underestimation of deaths due to intentional self-harm as a consequence of coroners not making a finding about intent.

Use of a National Police Form would provide more consistent identification of suspected suicide deaths to pathologists and coroners, and capture information surrounding the background of the deceased, and reasons for the suspicion of suicide.

It is important to accurately identify and record data relating to children and young people who are sexuality diverse, transgender, gender diverse and intersex.

Only a small proportion of cases involving intentional self-harm, with or without suicidal intent, result in admission to a hospital, and for each hospital admission, many more cases present to emergency departments and are not admitted, not seen by a general practitioner, or do not receive medical treatment.

While the benefits of establishing a national child death and injury database are acknowledged, aligning the legislation, functions and requirements for reporting across all the jurisdictions will require extensive coordination and resourcing.

The ANZCDR&PG, in conjunction with AIHW, has commenced some work on the development of a national child death database.

3.6 What did the data from NCIS, ABS, AIHW and Kids Helpline tell me?[435]

3.6.1 NCIS data about death due to intentional self-harm

Number of deaths, sex, Indigenous status, age

The data that I sourced from NCIS showed me that 333 children and young people aged 4-17 years died due to intentional self-harm between 1 January 2007 and 31 December 2012. **Approximately 64% were male and 36% were female**. There was an average of 55.5 deaths due to intentional self-harm reported on an annual basis.

Of the 333 children and young people who died due to intentional self-harm, approximately 20% were identified as Aboriginal, less than 1% were identified as Torres Strait Islander, less than 1% were identified as both Aboriginal and Torres Strait Islander, 11% were identified as being unknown in terms of Indigenous status and 69% identified neither as Aboriginal nor Torres Strait Islander.

Of the males, 19% were Aboriginal, 12% were unknown and 69% were neither Aboriginal nor Torres Strait Islander.

Of the females, 21% were Aboriginal, 9% were unknown and 70% were neither Aboriginal nor Torres Strait Islander.

Of those children and young people who were identified as Aboriginal, 2% were in the 4-9 year age range, 2% were in the 10-11 year age range, 9% were in the 12-13 year age range, 38% were in the 14-15 year age range and 49% were in the 16-17 year age range.

Of those who were neither Aboriginal nor Torres Strait Islander, less than 1% were in the 4-9 year age range, none were in the 10-11 year age range, 3% were in the 12-13 year age range, 30% were in the 14-15 year age range and 67% were in the 16-17 year age range.

Of those whose Indigenous status was unknown, 3% were in the 12-13 year age range, 33% were in the 14-15 year age range and 64% were in the 16-17 year age range.

Jurisdictional information

The jurisdictional data from NCIS provided the total number of deaths in each state and territory.

The NCIS asked me to point out that these are only frequencies. In order to achieve appropriate comparisons between states and territories, population numbers should be taken into consideration because an increase in frequency could be impacted by an increase in population rather than by an increase in incident.

Of the 333 children and young people who died due to intentional self-harm, 22% were from New South Wales, 17% were from Victoria, 31% were from Queensland, 5% were from South Australia, 14% were from Western Australia, 2% were from Tasmania, 6% were from the Northern Territory and 2% were from the Australian Capital Territory.

Of the children and young people in **New South Wales**, 69% were male and 31% were female. 3% were in the 12-13 year age range, 38% were in the 14-15 year age range and 59% were in the 16-17 year age range.

Of those in **Victoria**, 64% were male and 36% were female. 3% were in the 12-13 year age range, 29% were in the 14-15 year age range and 67% were in the 16-17 year age range.

Of those in **Queensland**, 63% were male and 37% were female. 1% were in the 4-9 year age range, 2% were in the 10-11 year age range, 7% were in the 12-13 year age range, 27% were in the 14-15 year age range and 63% were in the 16-17 year age range.

Of those in **South Australia**, 71% were male and 29% were female. 6% were in the 4-9 year age range, 29% were in the 14-15 year age range and 65% were in the 16-17 year age range.

Of those in **Western Australia**, 63% were male and 37% were female. 2% were in the 10-11 year age range, 2% were in the 12-13 year age range, 33% were in the 14-15 year age range and 63% were in the 16-17 year age range.

Of those in **Tasmania**, 71% were male and 29% were female. 14% were in the 12-13 year age range, 29% were in the 14-15 year age range and 57% were in the 16-17 year age range.

Of those in the **Northern Territory**, 55% were male and 45% were female. 5% were in the 12-13 year age range, 40% were in the 14-15 year age range and 55% were in the 16-17 year age range.

Of those in the **Australian Capital Territory**, 57% were male and 43% were female. 29% were in the 14-15 year age range and 71% were in the 16-17 year age range.

Mechanisms involved in death due to intentional self-harm

(i) Hanging

Of the 333 children and young people who died due to intentional self-harm, 81%, or **270 deaths, were by hanging. Of these 63% were male and 37% were female**. 19% of deaths due to intentional self-harm by hanging occurred between midnight and 4am, 7% occurred between 4am and 8am, 11% occurred between 8am and noon, 17% occurred between noon and 4pm, 20% occurred between 4pm and 8pm, and 22% occurred between 8pm and midnight. Unknown time accounted for 3%.

Of the 270 children and young people who died due to intentional self-harm by hanging, **41% used rope, string or twine**. Of these, 65% were male and 35% were female. No children died using rope, string or twine in the 4-9 year age range. 1% were in the 10-11 year age range, 3% were in the 12-13 year age range, 26% were in the 14-15 year age range and 70% were in the 16-17 year age range.

19% used a cord of a household appliance or an extension cord. Of these, 66% were male and 34% were female. No children died using a cord of a household appliance or an extension cord in the 4-9 year age range or the 10-11 year age range. 4% were in the 12-13 year age range, 34% were in the 14-15 year age range and 62% were in the 16-17 year age range.

9% used a belt, braces, suspenders or sash. Of these, 56% were male and 44% were female. No children died using a belt, braces, suspenders or sash in the 4-9 year age range. 8% were in the 10-11 year age range, 4% were in the 12-13 year age range, 32% were in the 14-15 year age range and 56% were in the 16-17 year age range.

7% used a dog leash. Of these, 50% were male and 50% were female. No children died using a dog leash in the 4-9 year age range or the 10-11 year age range. 6% were in the 12-13 year age range, 33% were in the 14-15 year age range and 61% were in the 16-17 year age range.

5% used a necktie or scarf. Of these, 31% were male and 69% were female. 8% were in the 4-9 year age range, none were in the 10-11 year age range, 8% were in the 12-13 year age range, 46% were in the 14-15 year age range and 38% were in the 16-17 year age range.

3% used a pressured hose or pipe. Of these, 71% were male and 29% were female. No children died using a pressured hose or pipe in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 29% were in the 14-15 year age range and 71% were in the 16-17 year age range.

2% used bedding or bedclothes. Of these, 83% were male and 17% were female. No children died using bedding or bedclothes in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 17% were in the 14-15 year age range and 83% were in the 16-17 year age range.

2% used a strap or webbing. Of these, 50% were male and 50% were female. No children died using a strap or webbing in the 4-9 year age range or the 10-11 year age range. 17% were in the 12-13 year age range, 50% were in the 14-15 year age range and 33% were in the 16-17 year age range.

2% used a chain. All of these children and young people were male. No children died using a chain in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 25% were in the 14-15 year age range and 75% were in the 16-17 year age range.

1% used cloth or material. Of these, 33% were male and 67% were female. No children died using cloth or material in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 67% were in the 14-15 year age range and 33% were in the 16-17 year age range.

1% used a shirt, blouse, t-shirt, trousers, slacks, jacket, coat or outerwear. Of these, 67% were male and 33% were female. No children died using a shirt, blouse, t-shirt, trousers, slacks, jacket, coat or outerwear in the 4-9 year age range or the 10-11 year age range. 33% were in the 12-13 year age range, 33% were in the 14-15 year age range and 33% were in the 16-17 year age range.

1% used a shoelace or shoe buckle. All of these children and young people were female. No children died using a shoelace or shoe buckle in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 67% were in the 14-15 year age range and 33% were in the 16-17 year age range.

I note that 8% of the deaths due to intentional self-harm by hanging were categorised as 'other'. All primary objects involved in a hanging death with a prevalence of less than three were summarised in the 'other' category. These instances include, but not exclusively, the involvement of draperies, curtains, cleaning appliance hoses or fixtures, clothesline, cables, and toy sports equipment.

(ii) Struck by a moving object

Of the 333 children and young people who died due to intentional self-harm, **5% died by being struck by a moving object. Of these, 69% were male and 31% were female**.

No children died by being struck by a moving object in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 38% were in the 14-15 year age range and 62% were in the 16-17 year age range.

13% of deaths due to intentional self-harm by being struck by a moving object occurred between midnight and 4am, none occurred between 4am and 8am, 13% occurred between 8am and noon, 6% occurred between noon and 4pm, 44% between 4pm and 8pm and 25% between 8pm and midnight.

81% of these deaths involved being struck by a train. Of these, 69% were male and 31% were female. 46% were in the 14-15 year age range and 54% were in the 16-17 year age range.

19% of these deaths involved being struck by a heavy truck not elsewhere classified, including a range of heavy transport vehicles but not including semi-trailers. Of these, 67% were male and 33% were female. All were in the 16-17 year age range.

(iii) Intentional self-harm fall

Of the 333 children and young people who died due to intentional self-harm, **4% died from an intentional self-harm fall**. Of these, 69% were male and 31% were female.

No children died due to an intentional self-harm fall in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 31% were in the 14-15 year age range and 69% were in the 16-17 year age range.

8% of deaths due to an intentional self-harm fall occurred between midnight and 4am, 23% occurred between 4am and 8am, 15% occurred between 8am and noon, 15% occurred between noon and 4pm, 23% between 4pm and 8pm, and 8% between 8pm and midnight. Unknown time accounted for 8%.

23% of these deaths involved a balcony or roof. Of these, 33% were male and 67% were female. All were in the 16-17 year age range.

23% of these deaths involved a bridge. Of these, 67% were male and 33% were female. 33% were in the 14-15 year age range and 67% were in the 16-17 year age range.

23% of these deaths involved a cliff. Of these, 67% were male and 33% were female. All were in the 16-17 year age range.

I note that 31% of the deaths due to intentional self-harm falls were categorised as 'other'. All primary objects involved in intentional self-harm falls with a prevalence of less than three were summarised in the 'other' category. These instances include, but not exclusively, the involvement of other specified building components or fittings and windows.

(iv) Firearms

Of the 333 children and young people who died due to intentional self-harm, **4% died by a firearm. Of these, 77% were male and 23% were female**.

No children died due to intentional self-harm by firearm in the 4-9 year age range or the 10-11 year age range. 8% were in the 12-13 year age range, 46% were in the 14-15 year age range and 46% were in the 16-17 year age range.

15% of deaths due to intentional self-harm by firearm occurred between midnight and 4am, 31% occurred between 4am and 8am, 23% occurred between 8am and noon, 15% occurred between noon and 4pm, none between 4pm and 8pm, and 15% between 8pm and midnight.

62% of these deaths involved a rifle. Of these, 75% were male and 25% were female. 13% were in the 12-13 year age range, 50% were in the 14-15 year age range and 38% were in the 16-17 year age range.

23% of these deaths involved a shotgun. Of these, 67% were male and 33% were female. 33% were in the 14-15 year age range and 67% were in the 16-17 year age range.

15% of these deaths involved an unspecified firearm or related item.

(v) Pharmaceutical substance for human use

Of the 333 children and young people who died due to intentional self-harm, **2% died by a pharmaceutical substance for human use (PSHU)**.

This category includes prescription and illicit drugs. The involvement of a prescription drug does not suggest whether the drug of interest was prescribed to the deceased or if they got hold of it by diverted means. Of these deaths, 71% were male and 29% were female.

No children died due to intentional self-harm by PSHU in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range. 43% were in the 14-15 year age range and 57% were in the 16-17 year age range.

14% of deaths due to intentional self-harm by PSHU occurred between midnight and 4am, 14% occurred between 4am and 8am, none occurred between 8am and noon, none occurred between noon and 4pm, 14% between 4pm and 8pm, and 43% between 8pm and midnight. Unknown time accounted for 14%.

71% of those who died used multiple substances. They were all male. 40% were in the 14-15 year age range and 60% were in the 16-17 year age range.

29% used a single substance.

Illicit drugs were used in one death whereas all the other incidents involved prescription drugs only.

Alcohol was not involved in any of the deaths due to intentional self-harm by PSHU.

(vi) Plastic bag asphyxia

Of the 333 children and young people who died due to intentional self-harm, **2% died by plastic bag asphyxia**.

Of these, 50% were male and 50% were female. No children died due to intentional self-harm by plastic bag asphyxia in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range.

33% were in the 14-15 year age range and 67% were in the 16-17 year age range. 17% of deaths due to intentional self-harm by plastic bag asphyxia occurred between midnight and 4am, none occurred between 4am and 8am, 17% occurred between 8am and noon, 17% occurred between noon and 4pm, 33% between 4pm and 8pm, and 17% between 8pm and midnight.

All instances of plastic bag asphyxia involved a plastic bag as the primary object.

(vii) Motor vehicle exhaust poisoning

Of the 333 children and young people who died due to intentional self-harm, **1% died by motor vehicle exhaust poisoning**.

Of these, all were male and all were in the 16-17 year age range. 33% of deaths due to intentional self-harm by motor vehicle exhaust poisoning occurred between midnight and 4am, none occurred between 4am and 8am, 33% occurred between 8am and noon, 33% occurred between noon and 4pm, none between 4pm and 8pm, and none between 8pm and midnight.

(viii) Other mechanisms

Of the 333 children and young people who died due to intentional self-harm, 1% died from stabbing involving a knife, 1% by carbon monoxide poisoning by burning charcoal in a closed environment and less than 1% from drowning in the open sea or ocean. The number of deaths due to these individual mechanisms of intentional self-harm is less than three and so further breakdown by sex and age cannot be provided.

Incident location of intentional self-harm

(i) Home

Of the 333 children and young people who died due to intentional self-harm, **76% died due to intentional self-harm which occurred at home**. Of these, 62% were male and 38% were female.

The home was the incident location of intentional self-harm in all of the deaths in the 4-9 year age range and all of the deaths in the 10-11 year age range.

It accounted for 86% in the 12-13 year age range, 79% in the 14-15 year age range and 73% in the 16-17 year age range.

16% of deaths due to intentional self-harm occurring at home occurred between midnight and 4am, 9% occurred between 4am and 8am, 12% occurred between 8am and noon, 18% occurred between noon and 4pm, 19% between 4pm and 8pm, and 23% between 8pm and midnight. Unknown time accounted for 3%.

(ii) Countryside

7% of deaths were due to intentional self-harm occurring in the countryside. Of these, 67% were male and 33% were female. No deaths in the 4-9 year age range or the 10-11 year age range were due to intentional self-harm occurring in the countryside.

The countryside accounted for the incident location of intentional self-harm in 14% of deaths in the 12-13 year age range, 4% in the 14-15 year age range and 9% in the 16-17 year age range.

17% of deaths due to intentional self-harm occurring in the countryside occurred between midnight and 4am, none occurred between 4am and 8am, 13% occurred between 8am and noon, 25% occurred between noon and 4pm, 38% between 4pm and 8pm, and 4% between 8pm and midnight. Unknown time accounted for 4%.

(iii) Transport area

5% of deaths were due to intentional self-harm occurring in a transport area. A transport area includes underground stations, railway stations, railway lines and streets or roads.[436]

Of these deaths, 69% were male and 31% were female. No deaths in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range were due to intentional self-harm occurring in a transport area. A transport area accounted for the incident location of intentional self-harm in 6% of deaths in the 14-15 year age range and 5% in the 16-17 year age range.

19% of deaths due to intentional self-harm occurring in a transport area occurred between midnight and 4am, none occurred between 4am and 8am, 13% occurred between 8am and noon, 6% occurred between noon and 4pm, 44% between 4pm and 8pm, and 19% between 8pm and midnight.

(iv) Recreational area, cultural area or public building

4% of deaths were due to intentional self-harm occurring in a recreational area, cultural area or public building. Of these, 77% were male and 23% were female. No deaths in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range were due to intentional self-harm occurring in a recreational area, cultural area or public building. 8% were in the 14-15 year age range and 92% in the 16-17 year age range.

46% of deaths due to intentional self-harm occurring in a recreational area, cultural area or public building occurred between midnight and 4am, 8% occurred between 4am and 8am, 15% occurred between 8am and noon, none occurred between noon and 4pm, 8% between 4pm and 8pm, and 23% between 8pm and midnight.

(v) Public highway, freeway, street or road

3% of deaths were due to intentional self-harm occurring on a public highway, freeway, street or road. Of these, 70% were male and 30% were female.

No deaths in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range were due to intentional self-harm occurring on a public highway, freeway, street or road. 40% were in the 14-15 year age range and 60% in the 16-17 year age range.

10% of deaths due to intentional self-harm occurring on a public highway, freeway, street or road occurred between midnight and 4am, 20% occurred between 4am and 8am, 20% occurred between 8am and noon, 10% occurred between noon and 4pm, 10% between 4pm and 8pm, and 20% between 8pm and midnight. Unknown time accounted for 10%.

(vi) Farm or other place of primary production

1% of deaths were due to intentional self-harm occurring on a farm or other place of primary production. Of these, 75% were male and 25% were female.

No deaths in the 4-9 year age range, the 10-11 year age range or in the 12-13 year age range were due to intentional self-harm occurring on a farm or other place of primary production. 25% were in the 14-15 year age range and 75% in the 16-17 year age range.

No deaths due to intentional self-harm occurring on a farm or other place of primary production occurred between midnight and 4am, 25% occurred between 4am and 8am, 25% occurred between 8am and noon, none occurred between noon and 4pm, 50% between 4pm and 8pm, and none between 8pm and midnight.

(vii) Educational area

1% of deaths were due to intentional self-harm occurring in a school or educational area. Of these, 67% were male and 33% were female. All deaths were in the 14-15 year age range.

33% of deaths due to intentional self-harm occurring in a school or educational area occurred between midnight and 4am, none occurred between 4am and 8am, none occurred between 8am and noon, 33% occurred between noon and 4pm, none between 4pm and 8pm, and none between 8pm and midnight. Unknown time accounted for 33%.

(viii) Other

I note that 3% of the deaths were due to intentional self-harm occurring in a location categorised as 'other'. All locations of intentional self-harm with a prevalence of less than three were summarised in the 'other' category. These instances include, but not exclusively, commercial non-recreational areas, medical service areas, and industrial or construction areas.

3.6.2 ABS data about death due to intentional self-harm

The data I sourced from ABS showed me that 393 children and young people aged 5-17 years died due to intentional self-harm between 2007 and 2012. The ABS pointed out to me that the data continued to be under a revision process and included both open as well as closed coronial cases.

Data cells with small values were randomly assigned to protect the confidentiality of individuals. Data was presented in five-year groupings due to the relatively small number of deaths each year. This also aids in reducing the volatility associated with annual figures. Data was provided about Indigenous status for New South Wales, Queensland, South Australia, Western Australia and the Northern Territory only. Identification of persons as Indigenous varies between jurisdictions, and these five jurisdictions have been found to have both sufficient levels of identification and sufficient numbers of death to support mortality analysis.

Number of deaths, sex, age

Of the 69 deaths in the 5-14 year age range, 54% were male and 46% were female. 84% of deaths in the 5-14 year age range were due to intentional self-harm by hanging.

Of the 324 deaths in the 15-17 year age range, 66% were male and 34% were female. 79% of deaths in the 15-17 year age range were due to intentional self-harm by hanging.

Across the total number of children and young people who died due to intentional self-harm, 64% were male and 36% were female.

Jurisdiction, sex, Indigenous status

Of the 83 deaths in **New South Wales**, 19% were in the 5-14 year age range and 81% were in the 15-17 year age range. Of these, 11% were Indigenous, 87% were non-Indigenous and 1% had an unknown Indigenous status. 51% of deaths in New South Wales were in greater Sydney and 49% were in the rest of New South Wales. Of the deaths in greater Sydney, 64% were male and 36% were female. Of the deaths in the rest of New South Wales, 71% were male and 29% were female.

Of the 112 deaths in **Queensland**, 16% were in the 5-14 year age range and 84% were in the 15-17 year age range. Data cells with small values were randomly assigned to protect the confidentiality of individuals so percentages relating to Indigenous status cannot be specified. The ABS data indicated that 27 deaths were by Indigenous children and young people, 78 deaths were by non-Indigenous children and young people, and 4 deaths were by children and young people with an unknown Indigenous status. The data from ABS about Indigenous status does not account for 4 deaths in Queensland. 32% of deaths in Queensland were in greater Brisbane and 69% were in the rest of Queensland. Of the deaths in greater Brisbane, 61% were male and 39% were female. Of the deaths in the rest of Queensland, 66% were male and 34% were female.

Of the 19 deaths in **South Australia**, 11% were in the 5-14 year age range and 89% were in the 15-17 year age range. Data cells with small values were randomly assigned to protect the confidentiality of individuals so percentages relating to Indigenous status and region of usual residence cannot be specified. The ABS data indicated that 1 death was by an Indigenous child and 15 deaths were by non-Indigenous children and young people. The data from ABS about Indigenous status does not account for 3 deaths in South Australia.

Of the 52 deaths in **Western Australia**, 13% were in the 5-14 year age range and 87% were in the 15-17 year age range. Of these, 31% were Indigenous, 63% were non-Indigenous and 6% had an unknown Indigenous status. 58% of deaths in Western Australia were in greater Perth and 42% were in the rest of Western Australia. Of the deaths in greater Perth, 63% were male and 37% were female. Of the deaths in the rest of Western Australia, 59% were male and 41% were female.

Of the 25 deaths in the **Northern Territory**, 24% were in the 5-14 year age range and 76% were in the 15-17 year age range. All of these deaths were by Indigenous children and young people. Data cells with small values were randomly assigned to protect the confidentiality of individuals so percentages relating to region of usual residence cannot be specified.

Of the 8 deaths in **Tasmania**, 38% were in the 5-14 year age range and 63% were in the 15-17 year age range. Data cells with small values were randomly assigned to protect the confidentiality of individuals so percentages relating to region of usual residence cannot be specified.

Of the 87 deaths in **Victoria**, 18% were in the 5-14 year age range and 82% were in the 15-17 year age range. 61% of deaths in Victoria were in greater Melbourne and 39% were in the rest of Victoria. Of the deaths in greater Melbourne, 55% were male and 45% were female. Of the deaths in the rest of Victoria, 71% were male and 29% were female.

With respect to the **Australian Capital Territory**, data cells with small values were randomly assigned to protect the confidentiality of individuals. This means that percentages relating to deaths in age ranges or area of usual residence cannot be specified.

I note the data provided to me by ABS about Indigenous status is based on five jurisdictions as the quality of Indigenous identification in mortality data is only considered acceptable in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory.[437]

Mechanisms involved in death due to intentional self-harm

(i) Hanging

Of the 393 children and young people who died due to intentional self-harm, **80%, or 315 children and young people died by hanging**. Of these, 63% were male and 37% were female. 18% were in the 5-14 year age range and 82% were in the 15-17 year age range.

(ii) Falls

4% died from intentional self-harm by falls. Of these, 67% were male and 33% were female. 7% were in the 5-14 year age range and 93% were in the 15-17 year age range.

(iii) Firearms

4% died from intentional self-harm by firearms. Data cells with small values were randomly assigned to protect the confidentiality of individuals so percentages relating to sex and age range cannot be specified.

(iv) Poisoning

4% died from intentional self-harm by poisoning. Data cells with small values were randomly assigned to protect the confidentiality of individuals so percentages relating to sex and age range cannot be specified.

(v) Drowning

Less than 1% died from intentional self-harm by drowning. Data cells with small values were randomly assigned to protect the confidentiality of individuals so percentages relating to sex and age range cannot be specified.

(vi) Other mechanisms

8% died due to intentional self-harm by other mechanisms. The category included the potential for deaths by explosive material, by smoke, fire and flames, by steam, hot vapours and hot objects, by blunt object, by jumping or lying before a moving object, and by unspecified means. Of these, 65% were male and 35% were female. 16% were in the 5-14 year age range and 84% were in the 15-17 year age range.

3.6.3 AIHW data about hospitalisation for intentional self-harm

Number of hospitalisations, sex, Indigenous status, age

Data I sourced from AIHW showed me that there were **18,277 hospitalisations for intentional self-harm in children and young people aged 3-17 years** between 2007-2008 and 2012-2013. Of these 18,277 hospitalisations, 80% were for females and 20% were for males.

7% of hospitalisations involved Indigenous children and young people and 93% involved other Australians. 'Indigenous' includes hospitalisations where Indigenous status was reported as Aboriginal but not Torres Strait Islander, Torres Strait Islander but not Aboriginal, and Aboriginal and Torres Strait Islander. 'Other Australians' includes hospitalisations for which Indigenous status was not reported. Of the 1,248 hospitalisations for Indigenous children and young people, 1% were in the 3-9 year age range, 28% were in the 10-14 year age range and 72% were in the 15-17 year age range. Of the 17,029 hospitalisations for other Australians, less than 1% were in the 3-9 year age range, 20% were in the 10-14 year age range and 80% were in the 15-17 year age range.

Area of usual residence by Indigenous status, age and sex

Of the 1,248 hospitalisations involving **Indigenous children and young people**, 34% lived in major cities, 47% lived in regional areas and 19% lived in remote areas. 'Regional' includes inner regional Australia and outer regional Australia. 'Remote' includes remote Australia and very remote Australia.

Of the 17,029 hospitalisations for **other Australian children and young people**, 64% lived in major cities, 34% lived in regional areas and 2% lived in remote areas.

3,690 episodes, or 20% of all hospitalisations, involved male children and young people. Of these, 58% were males living in major cities, 37% were males living in regional areas and 4% were males living in remote areas. Of hospitalisations for males living in major cities, less than 1% were in the 3-9 year age range, 16% were in the 10-14 year age range and 84% were in the 15-17 year age range. Of hospitalisations for males living in regional areas, 1% were in the 3-9 year age range, 17% were in the 10-14 year age range and 82% were in the 15-17 year age range. Of hospitalisations for males living in remote areas, 1% were in the 3-9 year age range, 28% were in the 10-14 year age range and 71% were in the 15-17 year age range.

14,587 episodes, or 80% of all hospitalisations, involved female children and young people. Of these, 63% were females living in major cities, 34% were females in regional areas and 3% were females in remote areas. Of hospitalisations for females living in major cities, less than 1% were in the 3-9 year age range, 21% were in the 10-14 year age range and 79% were in the 15-17 year age range. Of hospitalisations for females living in regional areas, less than 1% were in the 3-9 year age range, 23% were in the 10-14 year age range and 79% were in the 15-17 year age range. Of hospitalisations for females living in remote areas, 1% were in the 3-9 year age range, 25% were in the 10-14 year age range and 74% were in the 15-17 year age range.

Socioeconomic status of area of residence

Data on hospitalisations involving children and young people was disaggregated using the Index of Relative Socio-economic Disadvantage (IRSD). The IRSD is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area. Unlike the other indexes, this index includes only measures of relative disadvantage. A low score on this index indicates a high proportion of relatively disadvantaged people in an area.[438] Each of the quintiles, or the five economic groups, represents approximately 20% of the national population.

Of the 18,277 hospitalisations involving children and young people, 23% were in the lowest socioeconomic group, 22% were in the second lowest group, 21% were in the third lowest group, 18% were in the fourth lowest group and 16% were in the fifth lowest group.

Of the 1,248 hospitalisations involving **Indigenous children and young people**, 40% were in the lowest socioeconomic group, 27% were in the second lowest group, 20% were in the third lowest group, 8% were in the fourth lowest group and 5% were in the fifth lowest group.

Hospitalisations for intentional self-poisoning

Of the 18,277 hospitalisations involving children and young people, 82% were due to intentional self-poisoning. Of these, 18% were for males and 82% were for females. Of the hospitalisations for intentional self-poisoning, less than 1% were in the 3-9 year age range, 21% were in the 10-14 year age range and 79% were in the 15-17 year age range. The data provided by AIHW included 10 categories of intentional self-poisoning.

Of the 7,644 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **nonopioid analgesics, antipyretics and anti-rheumatics**, 13% were for males and 87% were for females. Of these, less than 1% were in the 3-9 year age range, 21% were in the 10-14 year age range and 78% were in the 15-17 year age range.

Of the 4,979 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified**, 22% were for males and 78% were for females. Of these, less than 1% were in the 3-9 year age range, 18% were in the 10-14 year age range and 82% were in the 15-17 year age range.

Of the 1,279 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **other and unspecified drugs, medicaments and biological substances**, 21% were for males and 79% were for females. Of these, 1% were in the 3-9 year age range, 25% were in the 10-14 year age range and 74% were in the 15-17 year age range.

Of the 395 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **narcotics and psychodysleptics (hallucinogens) not elsewhere classified**, 23% were for males and 77% were for females. Of these, less than 1% were in the 3-9 year age range, 12% were in the 10-14 year age range and 88% were in the 15-17 year age range.

Of the 340 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **other and unspecified chemicals and noxious substances**, 26% were for males and 74% were for females. Of these, none were in the 3-9 year age range, 29% were in the 10-14 year age range and 71% were in the 15-17 year age range.

Of the 139 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **other drugs acting on the autonomic nervous system**, 22% were for males and 78% were for females. Of these, no hospitalisations were in the 3-9 year age range, 26% were in the 10-14 year age range and 74% were in the 15-17 year age range.

Of the 110 hospitalisations involving children and young people due to **alcohol**, 42% were for males and 58% were for females. Of these, none were in the 3-9 year age range, 22% were in the 10-14 year age range and 78% were in the 15-17 year age range.

Of the 55 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **organic solvents and halogenated hydrocarbons and their vapours**, 29% were for males and 71% were for females. Of these, 2% were in the 3-9 year age range, 44% were in the 10-14 year age range and 55% were in the 15-17 year age range.

Of the 48 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **pesticides**, 33% were for males and 67% were for females. Of these, none were in the 3-9 year age range, 29% were in the 10-14 year age range and 71% were in the 15-17 year age range.

Of the 42 hospitalisations involving children and young people due to intentional self-poisoning by and exposure to **other gases and vapours**, 57% were for males and 43% were for females. Of these, none were in the 3-9 year age range, 26% were in the 10-14 year age range and 74% were in the 15-17 year age range.

Hospitalisations for other mechanisms of intentional self-harm

(i) Sharp object

Of the 2,262 hospitalisations involving children and young people due to intentional self-harm by **sharp object**, 26% were for males and 74% were for females. Of these, less than 1% were in the 3-9 year age range, 21% were in the 10-14 year age range and 79% were in the 15-17 year age range.

(ii) Hanging, strangulation and suffocation

Of the 552 hospitalisations involving children and young people due to intentional self-harm by **hanging, strangulation and suffocation**, 50% were for males and 50% were for females. Of these, 2% were in the 3-9 year age range, 26% were in the 10-14 year age range and 72% were in the 15-17 year age range.

(iii) Jumping from a high place

Of the 49 hospitalisations involving children and young people resulting from intentional self-harm by **jumping from a high place**, 45% were for males and 55% were for females. Of these, 2% were in the 3-9 year age range, 14% were in the 10-14 year age range and 84% were in the 15-17 year age range.

(iv) Smoke, fire and flames

Of the 48 hospitalisations involving children and young people due to intentional self-harm by **smoke**, **fire and flames**, 38% were for males and 62% were for females. Of these, none were in the 3-9 year age range, 23% were in the 10-14 year age range and 77% were in the 15-17 year age range.

(v) Jumping or lying before a moving object

Of the 35 hospitalisations involving children and young people due to intentional self-harm by **jumping or lying before a moving object**, 54% were for males and 46% were for females. Of these, no hospitalisations were in the 3-9 year age range, 14% were in the 10-14 year age range and 86% were in the 15-17 year age range.

(vi) Blunt object

Of the 32 hospitalisations involving children and young people due to intentional self-harm by **blunt object**, 38% were for males and 62% were for females. Of these, 3% were in the 3-9 year age range, 19% were in the 10-14 year age range and 78% were in the 15-17 year age range.

(vii) Crashing of motor vehicle

Of the 27 hospitalisations involving children and young people due to intentional self-harm by **crashing of motor vehicle**, 56% were for males and 44% were for females. All hospitalisations were in the 15-17 year age range.

(viii) Drowning and submersion

Of the 12 hospitalisations involving children and young people due to intentional self-harm by **drowning and submersion**, 17% were for males and 83% were for females. Of these, none were in the 3-9 year age range, 17% were in the 10-14 year age range and 83% were in the 15-17 year age range.

(ix) Steam, hot vapours and hot objects

Of the 12 hospitalisations involving children and young people due to intentional self-harm by **steam, hot vapours and hot objects**, 50% were for males and 50% were for females. All hospitalisations were in the 15-17 year age range.

(x) Handgun discharge

There was one hospitalisation for intentional self-harm by **handgun discharge** in a male child.

(xi) Other specified means

Of the 132 hospitalisations involving children and young people due to intentional self-harm by **other specified means**, 49% were for males and 51% were for females. Of these, 4% were in the 3-9 year age range, 28% were in the 10-14 year age range and 68% were in the 15-17 year age range.

(xii) Unspecified means

Of the 84 hospitalisations involving children and young people due to intentional self-harm by **unspecified means**, 24% were for males and 76% were for females. Of these, no hospitalisations were in the 3-9 year age range, 23% were in the 10-14 year age range and 77% were in the 15-17 year age range.

Incident location of intentional self-harm

(i) Home

53% of all hospitalisations, or 9,635 episodes, involving children and young people were due to **intentional self-harm occurring at home**. Of these, 20% were for males and 80% were for females. Less than 1% were in the 3-9 year age range, 22% were in the 10-14 year age range and 78% were in the 15-17 year age range.

(ii) Unspecified place of occurrence/not reported

37% of all hospitalisations, or 6,707 episodes, involving children and young people were due to **intentional self-harm occurring in an 'unspecified place of occurrence/not reported'**. Of these, 20% were for males and 80% were for females. Less than 1% were in the 3-9 year age range, 18% were in the 10-14 year age range and 81% were in the 15-17 year age range.

(iii) School, other institution and public administrative area

5% of all hospitalisations, or 995 episodes, involving children and young people were due to **intentional self-harm occurring at a school, other institution and public administrative area**. Of these, 18% were for males and 82% were for females. Less than 1% were in the 3-9 year age range, 23% were in the 10-14 year age range and 76% were in the 15-17 year age range.

(iv) Residential institution

2% of all hospitalisations, or 332 episodes, involving children and young people were due to **intentional self-harm occurring in a residential institution**. Of these, 28% were for males and 72% were for females. Less than 1% were in the 3-9 year age range, 25% were in the 10-14 year age range and 75% were in the 15-17 year age range.

(v) Other specified place of occurrence

2% of all hospitalisations, or 278 episodes, involving children and young people were due to **intentional self-harm occurring in an 'other specified place of occurrence'**. Of these, 26% were for males and 74% were for females. There were no hospitalisations involving the 3-9 year age range, 24% were in the 10-14 year age range and 76% were in the 15-17 year age range.

(vi) Street or highway

1% of all hospitalisations, or 152 episodes, involving children and young people were due to **intentional self-harm occurring on a street or highway**. Of these, 45% were for males and 55% were for females. There were no hospitalisations involving the 3-9 year age range, 13% were in the 10-14 year age range and 87% were in the 15-17 year age range.

(vii) Trade and service area

1% of all hospitalisations, or 160 episodes, involving children and young people were due to **intentional self-harm occurring in a trade and service area**. Of these, 23% were for males and 77% were for females. There were no hospitalisations in the 3-9 year age range, 16% were in the 10-14 year age range and 84% were in the 15-17 year age range.

(viii) Sports and athletics area

Less than 1% of all hospitalisations, or 12 episodes, involving children and young people were due to **intentional self-harm occurring at a sports and athletics area**. Of these, 33% were for males and 67% were for females. There were no hospitalisations in the 3-9 year age range, 17% were in the 10-14 year age range and 83% were in the 15-17 year age range.

(ix) Industrial and construction area

Less than 1% of all hospitalisations, or four episodes, involving children and young people were due to **intentional self-harm in an industrial and construction area**. Of these, 75% were for males and 25% were for females. There were no hospitalisations in the 3-9 year age range, 25% were in the 10-14 year age range and 75% were in the 15-17 year age range.

(x) Farm

Less than 1% of all hospitalisations, or two episodes, involving children and young people were due to **intentional self-harm occurring on a farm**. All of these hospitalisations were for females. There were no hospitalisations in the 3-9 year age range, 50% were in the 10-14 year age range and 50% were in the 15-17 year age range.

3.6.4 Kids Helpline data about children and young people seeking help

The Kids Helpline is Australia's only national 24/7, confidential support and counselling service specifically for children and young people aged 5-25 years. It offers counselling support via phone, email and a real-time web platform.

For the purpose of my examination, Kids Helpline prepared a detailed analysis of the information that it collected during 2012 and 2013 relating to children and young people aged 5-17 years.

Through the submission made by Kids Helpline to this examination, I was able to access the voices of children and young people aged 5-17 years. The Kids Helpline collects information directly stated by children and young people to the service.[439]

Contacts from children and young people aged 5-17 years relating to suicide

During 2012 and 2013, Kids Helpline responded to 80,142 contacts from children and young people aged 5-17 years that involved the provision of counselling.[440] 14% of these, or 11,180 contacts, were assessed by counsellors as involving a child or young person with current thoughts of suicide.[441] Of these 11,180 contacts, 5,451 were in 2012 and 5,729 were in 2013.[442]

As well as recording the assessment by counsellors about contacts from children and young people, Kids Helpline also records the issues directly stated by children and young people at the point of contact. During 2012 and 2013, Kids Helpline responded to 10,033 contacts from children and young people aged 5-17 years who directly stated that suicide was one of their main concerns.[443]

In 6,703 contacts, suicide was directly stated as the main concern.[444] Of these 6,703 contacts, 3,190 were in 2012 and 3,513 were in 2013. The Kids Helpline indicated that the increase in the proportion of contacts from 2012 to 2013, where suicide was directly stated as the main concern, was statistically significant, $p < .05$.[445]

Of the 6,703 contacts from children and young people who directly stated that suicide was their main concern, 54.44%, or 3,649 contacts, were recorded as having **suicide as the only concern discussed**.[446] 45.46%, or 3,054 contacts, were recorded as having **suicide as the main concern along with additional concerns**.[447]

The additional concerns where suicide was the main concern are shown in Table 5. I note that the number of additional concerns, 3,606, is greater than the number of contacts recorded as having additional concerns, 3,054. This is due to it being possible to record multiple concerns for each individual contact.

Table 5: Number and type of coexisting concerns discussed when suicide is the main concern for children and young people under 18 years[448]

2012		2013	
Additional Concern	**Number**	**Additional Concern**	**Number**
Mental health	480	Mental health	409
Self-injury and self-harm	369	Self-injury and self-harm	396
Child-parent relationships	268	Child-parent relationships	240
Relationships with friends and peers	152	Emotional wellbeing	207
Emotional wellbeing	143	Bullying	116
Bullying	124	Relationships with friends and peers	92
Grief	96	Self-image	89
Relationship with partner	84	Grief	65
Physical abuse	79	Physical abuse	62
Other family relationships	76	Other family relationships	59

Reasons for contact

Of the 6,703 contacts during 2012 and 2013 from children and young people who directly stated that suicide was their main concern, 73.42% of contacts in 2012 and 75.01% of contacts in 2013 were about **suicidal thoughts and fears**.[459] Where sex was recorded and suicide was stated as the main concern, 71.8% of contacts from males and 74.56% of contacts from females were about suicidal thoughts and fears.[450]

15.58% of contacts in 2012 and 13.64% in 2013 were about **concerns for another person**:[451]

- Where sex was recorded and suicide was stated as the main concern, 17.08% of contacts from males and 14.21% of contacts from females were about concerns for another person.[452]
- The Kids Helpline indicated that the higher proportion of contacts from males compared with females about concerns for another person was statistically significant, $p < .05$.[453]
- The Kids Helpline also indicated that the overall decrease in the proportion of contacts from 2012 to 2013 about concerns for another person was statistically significant, $p < .05$.[454]

7.93% of contacts in 2012 and 6.60% in 2013 were about **immediate intention**:[455]

- Where sex was recorded and suicide was stated as the main concern, 8.48% of contacts from males and 7.08% of contacts from females were about immediate intention.[456]
- The Kids Helpline indicated that the decrease in the proportion of contacts from 2012 to 2013 about immediate intention was statistically significant, $p < .05$.[457]

2.38% of contacts in 2012 and 3.96% in 2013 were about a **current attempt at the time of contact**:[458]

- Where sex was recorded and suicide was stated as the main concern, 1.55% of contacts from males and 3.44% of contacts from females were about a current attempt at the time of contact.[459]
- The Kids Helpline indicated that the higher proportion of contacts from females compared with males about a current attempt at the time of contact was statistically significant, $p < .05$.[460]
- The Kids Helpline also indicated that the increase in the proportion of contacts from 2012 to 2013 about a current attempt at the time of contact was statistically significant, $p < .05$.[461]

0.69% of contacts in 2012 and 0.79% in 2013 were about **seeking information**.[470] Where sex was recorded and suicide was stated as the main concern, 1.08% of contacts from males and 0.71% of contacts from females were about seeking information.[463]

The reasons for children and young people aged 5-17 years contacting Kids Helpline where suicide was the main concern are shown in Table 6.

Table 6: Reasons for children and young people aged under 18 years contacting about suicide as their main concern in 2012 and 2013[464]

Reason for Contact	2012		2013	
	Number	%	Number	%
Seeking information	22	0.69%	28	0.79%
Concerned about another person	497	15.58%	479	13.64%
Suicidal thoughts or fears	2,342	73.42%	2,635	75.01%
Immediate intention	253	7.93%	232	6.60%
Current attempt at the time of contact	76	2.38%	139	3.96%
Total	3,190	100%	3,513	100%

Sex and age

The sex of the child or young person was recorded in 6,600 of the 6,703 contacts during 2012 and 2013 from children and young people who directly stated that suicide was their main concern.[465] Of these contacts, where sex was recorded, **87.32%, or 5,763 contacts, were from females and 12.68%, or 837 contacts, were from males**:[466]

- Female children and young people who directly stated that suicide was their main concern were in the 7-17 year age range.[467] 93.86% of contacts from females were in the 13-17 year age range.[468]
- Males were in the 6-17 year age range.[469] Contacts from males increased with age.[470]
- The average age of females and males was 14.97 years at the time of contacting Kids Helpline.[471]

Of the **contacts from females** who directly stated that suicide was their main concern, 52.87% contacted Kids Helpline online and 47.13% by phone.[472] The Kids Helpline indicated that the higher proportion of online contacts by females compared with males was statistically significant, $p < .05$.[473]

Of the **contacts from males**, 33.09% contacted Kids Helpline online and 66.91% by phone.[474] The Kids Helpline also indicated that the higher proportion of phone contacts by males compared with females was statistically significant, $p < .05$.[475]

Location by year, age, sex, mode of contact

Data about the location of the child or young person was recorded in 3,174 of the 6,703 contacts during 2012 and 2013 from children and young people who directly stated that suicide was their main concern.[476]

Of these contacts where location data was recorded, 62.73%, or 1,991 contacts, were from children and young people in **capital cities**.[477] 8.76%, or 278 contacts, were from **other metropolitan areas**:[478]

- Contacts from children and young people in capital cities and other metropolitan areas were in the 9-17 year age range.[479]
- Of these contacts, where sex was recorded, 89.35% were from females and 10.65% were from males.[480]
- 7.42% made contact by phone and 62.58% made contact online.[481]
- The Kids Helpline indicated that a higher proportion of contacts came from males in capital cities and other metropolitan areas compared with rural centres and areas. This was said to be statistically significant, $p < .05$.[482]
- The Kids Helpline also indicated that a higher proportion of contacts were online from children and young people in capital cities and other metropolitan areas compared with rural centres and areas. This was said to be statistically significant, $p < .05$.[483]

27.25%, or 865 contacts, were from **rural centres and areas**:[484]

- Contacts from children and young people in rural centres and areas were in the 8-17 year age range.[485]
- Of these contacts, where sex was recorded, 93.48% were from females and 6.52% were from males.[486]
- 42.08% made contact by phone and 57.92% made contact online.[487]
- The Kids Helpline indicated that there was a higher proportion of contacts from females compared with males in rural centres and areas and this was statistically significant, $p < .05$.[488]
- The Kids Helpline also indicated that there was a higher proportion of contacts by phone from children and young people in rural centres and areas compared with contacts from capital cities and other metropolitan areas and this was statistically significant, $p < .05$.[489]

1.26%, or 40 contacts, were from **remote centres and areas**:[490]

- Contacts from children and young people in remote centres and areas were in the 13-17 year age range.[491]
- Of these contacts, where sex was recorded, 90% were from females and 10% were from males.[492]
- 32.5% made contact by phone and 67.5% made contact online.[493]
- Although the number of contacts is small, Kids Helpline indicated that the increase in the proportion of contacts from 2012 to 2013 by children and young people in remote centres and areas was statistically significant, $p < .05$.[494]

Indigenous children and young people

Of the 6,703 contacts during 2012 and 2013 from children and young people who directly stated that suicide was their main concern, 129 contacts were from children and young people who identified as **Aboriginal** and four contacts were from children and young people who identified as **both Aboriginal and Torres Strait Islander**.[495]

Of these 133 contacts, the sex of the child or young person was recorded in 130 contacts.[496] **97.69%, or 127 contacts, were from females and 2.31%, or three contacts, were from males**.[497]

Aboriginal and Torres Strait Islander children and young people who directly stated that suicide was their main concern were in the 12-17 year age range,[498] with 90.55% of contacts in the 14-16 year age range.[499]

71.43% made contact by phone and 28.57% made contact online.[500]

Data about the **location** of the child or young person was recorded in 89 of the 133 contacts during 2012 and 2013:[501]

- 77.53%, or 69 contacts, were from Aboriginal and Torres Strait Islander children and young people in capital cities and other metropolitan areas.[502]
- 21.35%, or 19 contacts, were from rural towns.[503]
- 1.12%, or one contact, was from a remote area.[504]

Of the 133 contacts during 2012 and 2013 from Aboriginal and Torres Strait Islander children and young people who **directly stated that suicide was their main concern**:

- 83.46%, or 111 contacts, were about suicidal thoughts and fears.[505]
- 7.52%, or 10 contacts, were about immediate intention.[506]
- 5.26%, or seven contacts, were about concerns for another person.[507]
- 3.01%, or four contacts, were about a current attempt at the time of contact.[508]
- 0.75%, or one contact, was about seeking information.[509]

Children and young people with a culturally and linguistically diverse background

Of the 6,703 contacts during 2012 and 2013 from children and young people who directly stated that suicide was their main concern, 5.26%, or 353 contacts, were from children and young people who identified as being from a **culturally and linguistically diverse background**.[510]

Of these 353 contacts, the sex of the child or young person was recorded in 350 contacts.[511] **81.71%, or 286 contacts, were from females and 18.29%, or 64 contacts, were from males**.[512]

The 353 contacts from children and young people who identified as being from a culturally and linguistically diverse background who directly stated that suicide was their main concern were in the 9-17 year age range,[513] with 80.45% of contacts in the 14-17 year age range.[514]

55.81% made contact by phone and 44.19% made contact online.[515]

Data about the **location** of the child or young person was recorded in 161 of the 353 contacts during 2012 and 2013:[516]

- 79.50%, or 128 contacts, were from children and young people in capital cities and other metropolitan areas.[517]
- 14.29%, or 23 contacts, were from children and young people in rural towns.[518]
- 6.21%, or 10 contacts, were from children and young people in remote areas.[519]

Of the 353 contacts during 2012 and 2013 from children and young people who identified as being from a culturally and linguistically diverse background who **directly stated that suicide was their main concern**:

- 76.20%, or 269 contacts, were about suicidal thoughts and fears.[520]
- 11.33%, or 40 contacts, were about concerns for another person.[521]
- 8.78%, or 31 contacts, were about immediate intention.[522]
- 2.55%, or nine contacts, were about a current attempt at the time of contact.[523]
- 1.13%, or four contacts, were about seeking information.[524]

Contacts with children and young people aged 5-17 years relating to self-injury and self-harm

Of the 80,142 contacts during 2012 and 2013 from children and young people aged 5-17 years which involved the provision of counselling,[525] 23% of these, or 18,737 contacts, were assessed by counsellors as involving a child or young person who self-injures and self-harms.[526] Of these 18,737 contacts, 9,451 were in 2012 and 9,286 were in 2013.[527]

As well as recording the assessment by counsellors about contacts from children and young people, Kids Helpline also records the issues directly stated by children and young people at the point of contact. During 2012 and 2013, Kids Helpline responded to 8,117 contacts from children and young people aged 5-17 years who directly stated that self-injury and self-harm was one of their main concerns.[528]

In 4,380 contacts, self-injury and self-harm was directly stated as the main concern.[529] Of these 4,380 contacts, 2,112 were in 2012 and 2,268 were in 2013.[530]

Of the 4,380 contacts from children and young people who directly stated that self-injury and self-harm was their main concern, 49.43%, or 2,165 contacts, were recorded as having **self-injury and self-harm as the only concern discussed**.[531] 50.57%, or 2,215 contacts, were recorded as having **self-injury and self-harm as the main concern along with additional concerns**.[532]

The additional concerns where self-injury and self-harm was the main concern are shown in Table 7. I note that the number of additional concerns, 2,541, is greater than the number of contacts recorded as having additional concerns, 2,215. This is because multiple concerns can be recorded for individual contacts.

Table 7: Number and type of coexisting concerns discussed when self-injury and self-harm is the main concern for children and young people under 18 years[533]

2012		2013	
Additional Concern	**Number**	**Additional Concern**	**Number**
Suicide	275	Suicide	238
Mental health	258	Mental health	228
Child-parent relationships	205	Emotional wellbeing	186
Emotional wellbeing	192	Child-parent relationships	152
Relationships with friends and peers	116	Bullying	96
Self-image	82	Relationships with friends and peers	89
Bullying	73	Self-image	80
Grief	50	Body image	53
Other family relationships	47	Relationship with partner	43
Relationship with partner	43	Other family relationships	35

Reasons for contact

Of the 4,380 contacts during 2012 and 2013 from children and young people who directly stated that self-injury and self-harm was their main concern, 39.16% of contacts in 2012 and 40.30% of contacts in 2013 were about **talking through consequences and/or alternative coping strategies**:[534]

- Where sex was recorded and self-injury and self-harm was stated as the main concern, 30.9% of contacts from males and 40.63% of contacts from females were about talking through the consequences and/or alternative coping strategies.[535]
- The Kids Helpline indicated that there was a lower proportion of contacts concerned with talking through the consequences and/or alternative coping strategies from children and young people in capital cities and other metropolitan areas compared with those in rural centres and areas. The Kids Helpline stated that this was statistically significant, $p < .05$.[536]

36.03% of contacts in 2012 and 32.67% in 2013 were about **getting help to resist thoughts and urges to injure**.[537] Where sex was recorded and self-injury and self-harm was stated as the main concern, 32.56% of contacts from males and 34.41% of contacts from females were about getting help to resist thoughts and urges to injure.[538]

12.45% of contacts in 2012 and 15.12% of contacts in 2013 were made by children and young people who stated that they were **concerned about another person**:[539]

- Where sex was recorded and self-injury and self-harm was stated as the main concern, 23.92% of contacts from males and 12.89% of contacts from females were about concerns for another person.[540]
- The Kids Helpline indicated that a higher proportion of contacts about concerns for another person were made by children and young people in capital cities and other metropolitan areas compared with those in rural centres and areas. The Kids Helpline stated that this was statistically significant, $p < .05$.[541]

6.2% of contacts in 2012 and 6% in 2013 were about **concerns other people had for a child or young person who was engaging in self-injury and self-harm behaviour**.[542] Where sex was recorded and self-injury and self-harm was stated as the main concern, 4.98% were contacts from males and 6.25% were contacts from females.[543]

3.41% of contacts in 2012 and 4.01% in 2013 were about **concerns where injury at the time of contact required medical assistance**.[544] Where sex was recorded and self-injury and self-harm was stated as the main concern, 2.99% of contacts were from males and 3.74% were from females.[545]

2.75% of contacts in 2012 and 1.90% in 2013 were about **seeking information**.[546] Where sex was recorded and self-injury and self-harm was stated as the main concern, 4.65% of contacts from males and 2.08% of contacts from females were about seeking information.[547]

The reasons for children and young people aged 5-17 years contacting Kids Helpline where self-injury and self-harm was the main concern are shown in Table 8.

Table 8: Reasons for children and young people aged under 18 years contacting about self-injury and self-harm in 2012 and 2013[548]

Reason for Contact	2012		2013	
	Number	%	Number	%
Seeking information	58	2.75%	43	1.90%
Concerned about another person	263	12.45%	343	15.12%
Contacting to help resist thoughts and urges to injure	761	36.03%	741	32.67%
Talking through consequences and/or alternative coping strategies	827	39.16%	914	40.30%
Others are concerned about client's self-injuring and self-harming behaviour	131	6.20%	136	6.00%
Concerned that injury at the time of contact requires medical assistance	72	3.41%	91	4.01%
Total	2,112	100%	2,268	100%

Sex and age

The sex of the child or young person was recorded in 4,288 of the 4,380 contacts during 2012 and 2013 from children and young people who directly stated that self-injury and self-harm was their main concern.[549] Of these contacts, where sex was recorded, **92.98%, or 3,987 contacts, were from females and 7.02%, or 301 contacts, were from males**:[550]

- Female and male children and young people who directly stated that self-injury and self-harm was their main concern were in the 9-17 year age range.[551]
- 92.78% of contacts from females and 94.35% of contacts from males were in the 13-17 year age range.[552]
- The average age of females was 14.73 years at the time of contacting Kids Helpline, and the average age of males was 15.06 years.[553]

Of the **contacts from females** who directly stated that self-injury and self-harm was their main concern, 59.22% contacted Kids Helpline online and 40.78% by phone.[554]

Of the **contacts from males**, 44.85% contacted Kids Helpline online and 55.15% by phone.[555] The Kids Helpline indicated that there was a higher proportion of online contacts from females compared with males which was statistically significant, $p < .05$.[556] The Kids Helpline also stated that there was a higher proportion of phone contacts from males than females which was statistically significant, $p < .05$.[557]

Location by year, age, sex, mode of contact

Data about the location of the child and young person was recorded in 2,100 of the 4,380 contacts during 2012 and 2013 from children and young people who directly stated that self-injury and self-harm was their main concern.[558]

Of these contacts where location data was recorded, 62.86%, or 1,320 contacts, were from children and young people in **capital cities**.[559] 6.62%, or 139 contacts, were from **other metropolitan areas**:[560]

- Contacts from children and young people in capital cities and other metropolitan areas were in the 9-17 year age range.[561]
- Of these contacts, where sex was recorded, 91.86% were from females and 8.14% were from males.[562]
- 29.61% made contact by phone and 70.39% made contact online.[563]
- The Kids Helpline indicated that the decrease in the proportion of contacts from 2012 to 2013 by children and young people in capital cities and other metropolitan areas was statistically significant, $p < .05$.[564]
- The Kids Helpline also indicated that the higher proportion of contacts from males in capital cities and other metropolitan areas compared with those in rural centres and areas, was statistically significant, $p < .05$.[565]
- The Kids Helpline further indicated that the higher proportion of contacts online from children and young people in capital cities and other metropolitan areas compared with rural centres and areas, was statistically significant, $p < .05$.[566]

29.86%, or 627 contacts, were from **rural centres and areas**:[567]

- Contacts from children and young people in rural centres and areas were in the 9-17 year age range.[568]
- Of these contacts, where sex was recorded, 96.94% were from females and 3.06% were from males.[569]
- 36.04% made contact by phone and 63.96% made contact online.[570]
- The Kids Helpline indicated that the increase in the proportion of contacts from 2012 to 2013 by children and young people in rural centres and areas was statistically significant, $p < .05$.[571]
- The Kids Helpline also indicated that there was a higher proportion of contacts from females in rural centres and areas compared with capital cities and other metropolitan areas. The Kids Helpline stated that this was statistically significant, $p < .05$.[572]
- The Kids Helpline further indicated that the higher proportion of contacts by phone from children and young people in rural centres and areas compared with capital cities and other metropolitan areas, was statistically significant, $p < .05$.[573]

0.67%, or 14 contacts, were from **remote centres and areas**:[574]

- Contacts from children and young people in remote centres and areas were in the 13-17 year age range.[575]
- Of these contacts, where sex was recorded, all were from females.[576]
- 28.57% made contact by phone and 71.43% made contact online.[577]
- Although the number of contacts was small, Kids Helpline indicated that the increase in the proportion of contacts from 2012 to 2013 by children and young people in remote areas was statistically significant, $p < .05$.[578]

Indigenous children and young people

Of the 4,380 contacts during 2012 and 2013 from children and young people who directly stated that self-injury and self-harm was their main concern, 41 contacts were from children and young people who identified as **Aboriginal** and four contacts were from children and young people who identified as **both Aboriginal and Torres Strait Islander**.[579]

Of these 45 contacts, the sex of the child or young person was recorded in 44 contacts.[580] **95.45%, or 42 contacts, were from females and 4.55%, or two contacts, were from males**.[581]

Aboriginal and Torres Strait Islander children and young people who directly stated that self-injury and self-harm was their main concern were in the 12-17 year age range.[582]

64.44% made contact by phone and 35.56% made contact online.[583]

Data about the **location** of the child or young person was recorded in 23 of the 45 contacts during 2012 and 2013:[584]

- 91.3%, or 21 contacts, were from Aboriginal and Torres Strait Islander children and young people in capital cities and other metropolitan areas.[585]
- 8.7%, or two contacts, were from rural towns.[586]
- No contacts were recorded from children and young people in remote areas.

Of the 45 contacts during 2012 and 2013 from Aboriginal and Torres Strait Islander children and young people who **directly stated that self-injury and self-harm was their main concern**:

- 46.67%, or 21 contacts, were about contacting to help resist thoughts and urges to injure.[587]
- 40%, or 18 contacts, were about talking through consequences and/or alternative coping strategies.[588]
- 13.33%, or six contacts, were about the concerns other people had in relation to the self-injuring and self-harming behaviour of the child or young person contacting Kids Helpline.[589]

Children and young people with culturally and linguistically diverse backgrounds

Of the 4,380 contacts during 2012 and 2013 from children and young people who directly stated that self-injury and self-harm was their main concern, 4.56%, or 200 contacts, were from children and young people who identified as being from a **culturally and linguistically diverse background**.[590]

Of these 200 contacts, the sex of the child or young person was recorded in 198 contacts.[591] **89.9%, or 178 contacts, were from females and 10.1%, or 20 contacts, were from males**.[592]

The 200 contacts from children and young people who identified as being from a culturally and linguistically diverse background and who directly stated that self-injury and self-harm was their main concern were in the 10-17 year age range.[593]

62% made contact by phone and 38% made contact online.[594]

Data about the **location** of the child or young person was recorded in 109 of the 200 contacts during 2012 and 2013:[595]

- 81.65%, or 89 contacts, were from children and young people in capital cities and other metropolitan areas.[596]
- 18.35%, or 20 contacts, were from children and young people in rural towns.[597]
- No contacts were recorded from children and young people in remote areas.

Of the 200 contacts during 2012 and 2013 from children and young people who identified as being from a culturally and linguistically diverse background and who **directly stated that self-injury and self-harm was their main concern**:

- 42%, or 84 contacts, were about contacting to help resist thoughts and urges to injure.[598]
- 36.5%, or 73 contacts, were about talking through consequences and/or alternative coping strategies.[599]
- 10.5%, or 21 contacts, were about concerns for another person.[600]
- 6.5%, or 13 contacts, were from other people who were concerned about a child or young person who was engaging in self-injuring and self-harming behaviour.[601]
- 4%, or eight contacts, were about concerns where injury at the time of contact required medical assistance.[602]
- 0.5%, or one contact, was about seeking information.[603]

3.7 What does the data tell us?

3.7.1 Death due to intentional self-harm

Obtaining this national data has been a very important part of my examination. As noted before, NCIS provided me with national data that has previously not been published. I hope that the release of this data will assist those who are working with and/or involved with children and young people.

The data provided to me by NCIS and ABS confirmed that hanging was the most frequently used mechanism of intentional self-harm leading to death in children and young people across all age ranges. According to NCIS, 89% of children and young people aged 4-13 years died by hanging, 80% of those aged 14-15 years and 81% of those aged 16-17 years died by hanging.

While hanging has been predominantly associated with males, it is now the most common mechanism used by females. While NCIS data showed that males were 1.7 times more likely than females to die by this mechanism, the proportion of females who died by hanging was higher than the proportion of males. 85% of females died by this mechanism compared with 81% of males.

Given the prevalence of hanging, investigating ways to prevent it should be prioritised.

However, this is very challenging. Previously, suicide prevention has focused on restricting access to commonly used methods, such as:

- changing the maximum paracetamol pack size sold by Australian retailers other than pharmacies from 25 to 20 in September 2013
- erecting safety precautions at potential jumping sites
- licensing, storage and safe keeping requirements for firearms being prescribed in all states and territories.

Unfortunately, restricted access to the means for hanging is not possible and the ease of availability to means makes hanging receptive to impulsivity.

The submission by the Child Death and Serious Injury Review Committee of South Australia emphasised:

> hanging is a method of "high lethality" and…is almost impossible to "restrict access to means" when these can be pieces of rope, electrical cable, garden hose, shoe laces or handbag and straps.[604]

The submission by Menzies School of Health Research highlighted the lethality of hanging and the ease of availability.[605]

The Royal Australian and New Zealand College of Psychiatrists told me that 'Young people have a poor understanding of the potential lethality of methods of self-harm'.[606]

International research suggests:

> Prevention strategies should focus on countering perceptions of hanging as a clean, painless and rapid method that is easily implemented. However, care is needed in the delivery of such messages as some individuals could gain information that might facilitate fatal implementation. Detailed research needs to focus on developing and evaluating interventions that can manage this tension…further research is required to verify existing perceptions about hanging and to explore in detail the origins of these and the full range of sources and knowledge that people draw upon and are influenced by when planning a suicide attempt.[607]

The NCIS data also showed that 76% of deaths in children and young people were due to intentional self-harm occurring in the home. Increasing the awareness of primary caregivers about risk factors and warning signs is essential. The continued implementation of universal suicide prevention strategies aimed at raising public awareness, encouraging help-seeking behaviour and challenging stigma associated with suicide may assist with this.

The submission by the Black Dog Institute highlighted to me that the community has:

> low to moderate levels of suicide literacy, with the greatest deficits in the identification of the signs and symptoms of suicide and the risk factors associated with it.[608]

The Black Dog Institute also emphasised:

> Family and friends have poor knowledge of the signs of suicide and lack knowledge about how and in what circumstances they should act.[609]

The NCIS data showed that five children died due to intentional self-harm in the 4-11 year age range, 14 died in the 12-13 year age range, 106 died in the 14-15 year age range and 204 died in the 16-17 year age range.

The percentage increase between those in the 4-11 year age range and those in the 12-13 year age range is 180%. The percentage increase between the 12-13 year age range and the 14-15 year age range is 657%. The percentage increase between the 14-15 year age range and the 16-17 year age range is 96%.

The 180% increase between those in the 4-11 year age range and those in the 12-13 year age range happens when many children are transitioning from primary school to secondary school, accompanied by the onset of puberty. The increase of 657% between those who are in the 12-13 year age range and those in the 14-15 year age range occurs when many are entering or experiencing puberty. This is not to impute a definitive biological age to the onset of puberty, which can 'vary depending on genetic, environmental, and social influences'.[610] However, the data provided by NCIS suggests that the transition between childhood and adolescence may be a time where targeted interventions are warranted.

Developments in neuroscience and functional Magnetic Resonance Imaging suggest there is a second wave of rapid brain development in the middle years of childhood and adolescence.[611] Research in this area indicates that the greatest changes to the parts of the brain responsible for functions such as self-control, judgement, emotions and organisation occur between puberty and adulthood.[612] This, too, has implications for the kinds of interventions that might be delivered to children and young people during these years.

Typically, in the past, data about death due to intentional self-harm involving those under 15 years of age have been merged together as one group without differentiating between childhood and adolescence. However, as Soole, Kõlves and De Leo argue, 'Children and adolescents might warrant separate consideration'.[613] Indeed, they differ in terms of physical, sexual, cognitive and social development:

> Arguably, failure to delineate differences and similarities in suicide-related factors for childhood and adolescence can have scientific and clinical implications, hindering the understanding of child suicide and the development of targeted suicide prevention.[614]

Previously, nationally disaggregated data for those under 15 years of age has not been available. The importance of its continued availability cannot be underestimated and must be prioritised.

Most children and young people died by hanging between 8pm and midnight, followed by 4pm and 8pm, noon and 4pm, midnight and 4am, 8am and noon, and 4am and 8am. The time of some deaths was unknown. It is not possible to draw conclusions or predict patterns in relation to these identified time periods as the spread across the time periods was relatively even. Given that children and young people die due to intentional self-harm across all time periods, there is a clear need for twenty-four hour support services.

According to NCIS, 58 children and young people died by mechanisms other than hanging. There was 1 death in the 12-13 year age range by a mechanism other than hanging, 21 deaths in the 14-15 year age, and 36 deaths in the 16-17 year age range by a mechanism other than hanging. As children and young people grow older, more mechanisms become available to them and some of them utilise these other means.

While most die due to intentional self-harm occurring at home, approximately 18% of those aged 14-15 years chose other locations, predominately transport areas. This increased to 24% for those aged 16-17 years, with intentional self-harm leading to death in this age range mainly occurring in the countryside, transport areas and recreational areas, cultural areas or public buildings. The data that I obtained did not cross tabulate the mechanism of intentional self-harm by location. It is important that future work investigates this correlation as it may provide insights to assist in preventing access to means.

Aboriginal and Torres Strait Islanders represent only 3% of Australia's population,[615] yet the data provided to me by ABS shows they accounted for 28.1% of all the recorded deaths in children and young people under 18 years of age due to intentional self-harm.

The data provided to me by NCIS shows that Indigenous children and young people accounted for 80% of deaths in the 4-11 year age, 42.9% of deaths in the 12-13 year age range, 24.5% of deaths in the 14-15 year age range and 15.3% of deaths in the 16-17 year age range.

The significant overrepresentation of Indigenous children and young people requires a comprehensive whole of government response.

In May 2013, the Australian Government National Aboriginal and Torres Strait Islander Suicide Prevention Strategy recognised the need to build the evidence base and disseminate information about effective suicide prevention interventions for Indigenous Australians.[616] In June 2013, the Australian Government National Health and Medical Research Council opened a targeted call for research into suicide prevention in Aboriginal and Torres Strait Islander youth, due to the priority and urgency of the need for research in this area.[617] In September 2014, four new National Health and Medical Research Council grants, which aim to help intervene in the high rates of Indigenous youth suicide were announced by the Minister for Health, the Hon Peter Dutton MP. This is critical research.

It was not possible for ABS to provide a breakdown by ethnicity, culture, educational attainment, and socio-economic status at the time of my request. However, ABS indicated to me in its submission that it:

> has been examining options to deliver this type of information and believes that it will be possible through data linkage. The ABS is actively engaging with relevant data custodians to highlight the value of this type of study and garner agreement on a way forward. Further consultation with other stakeholders is also required as this work is currently unfunded. While there may yet be challenges faced in progressing this study, the potential benefits are clear.[618]

In the event that this work is cleared to proceed, I would strongly support funding being made available.

Some excellent work is currently underway by the Telethon Kids Institute,[619] which is using linked data and a life-course approach to understand the developmental pathways to intentional self-harm, with or without suicidal intent, in children and young people. To link the data, the Telethon Kids Institute in Western Australia is collaborating with a number of state government departments, including the Western Australian Departments of Health, Education, Child Protection and Family Support, Corrective Services, Communities, Aboriginal Affairs, Treasury, Housing, Attorney-General, the Disability Services Commission, School Curriculum and Standards Authority, the Mental Health Commission and Police.

The project has established the process of linking together de-identified longitudinal, population-based data collected and stored by these Western Australian government departments with an aim to create a cost-effective research, policy planning and evaluation resource. The findings of this project have not yet been published. I commend this initiative.

3.7.2 Hospitalisation for intentional self-harm

The data provided by AIHW showed that there were 18,277 hospitalisations for intentional self-harm involving children and young people aged 3-17 years between 2007-2008 and 2012-2013. 82% of these hospitalisations were due to intentional self-poisoning.

Of the hospitalisations for intentional self-poisoning, less than 1% were in the 3-9 year age range, 21% were in the 10-14 year age range and 79% were in the 15-17 year age range.

Clearly as children and young people age, their capacity to know about the effects of self-poisoning and to obtain the means to self-poison increases.

As mentioned before, those children and young people who engage in intentional self-harm, with or without suicidal intent, may only experience hospitalisation because they cannot manage their injury without medical intervention. The AIHW reports:

> A small proportion of all incident injury cases result in admission to a hospital. For each hospital admission, many more cases present to emergency departments and are not admitted, or are seen by a general practitioner (Harrison & Steenkamp 2002). A larger number of generally minor cases do not receive medical treatment. In addition, a smaller number of severe injuries that quickly result in death go unrecorded in terms of hospital separations, but are captured in mortality data.[620]

The data that AIHW provided to me only includes those children and young people who experienced hospitalisation. It does not include non-admitted patient care provided in outpatient services or elsewhere.

The data provided by AIHW included 10 categories of intentional self-poisoning. Females were significantly more likely to be hospitalised for intentional self-poisoning. Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics was the most frequently used means, followed by antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified, and then by other and unspecified drugs, medicaments and biological substances.

Restricting access to means is known to be an effective suicide prevention strategy. Restricting access to the means used for intentional self-poisoning offers similar potential. While the maximum paracetamol pack size sold by Australian retailers other than pharmacies changed from 25 to 20 (500 mg tablets/capsules/caplets) in September 2013, it may be that further restrictive measures are required. Treatment for paracetamol overdose usually occurs in Australian hospitals when 10 g (20 tablets) have been consumed.[621]

In 1998, the UK government introduced legislation that reduced the maximum pack size of all non-effervescent tablets and capsules containing aspirin (acetylsalicylic acid) or paracetamol that can be sold or supplied from outlets other than registered pharmacies from 25 to 16 tablets.[622] Further restriction could be considered in Australia. Age identification requirements may also assist in restricting access to means.

Females aged 0-17 years account for 80% of all hospitalisations for intentional self-harm. Proportionally, 82% of these females are hospitalised due to intentional self-poisoning. 87% of these females are hospitalised due to intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics,

Limited research on intentional self-poisoning by female children and young people has been conducted in Australia. A number of international studies support the AIHW data, which shows higher incidences of non-fatal intentional self-poisoning in female compared with male children and young people. These studies also highlight the fact that intentional self-poisoning behaviour in female children and young people predominantly occurs during adolescence.[623]

The reason for the heightened incidences of non-fatal intentional self-poisoning in female adolescents is not known. Some research suggests that the earlier physical and mental maturation of girls, as well as gender differences in emotional and behavioural problems, may be contributing factors in non-fatal self-harming behaviour among female adolescents.[624] More research is required to better understand this gender discrepancy.

3.7.3 Seeking help for intentional self-harm, with or without suicidal intent

The number of contacts made to Kids Helpline was very encouraging as it shows that some children and young people are engaging in help-seeking using phone and online counselling services.

Each year, Kids Helpline seeks the views of children and young people about the quality and effectiveness of the service. In 2013, 778 children and young people participated in an online survey regarding their satisfaction and perceived effectiveness of Kids Helpline. Around 81% of respondents agreed they had increased ideas about how to deal with their problems as a result of their contact. Around 65%, or 381 respondents, stated they felt more able to deal with their problems after the contact.

Sadly, I know that the number of contacts is not representative of the greater number of children and young people who need assistance. The Kids Helpline pointed out to me:

> Unfortunately telephone and online counseling providers are unable to meet existing demand. In 2013 Kids Helpline had capacity to respond to only 60% of contacts. Additional financial support to increase the capability of telephone and online counseling services is required.[625]

Given we know that children and young people utilise these types of services and find them helpful, I strongly encourage the Australian Government to increase its financial support for these services.

The data provided to me by NCIS showed that approximately 64% of deaths due to intentional self-harm were male children and young people. It is concerning to see that there were significantly fewer contacts to Kids Helpline from male children and young people when compared with contacts from females. While contacts by male children and young people did increase with age, the overall number of contacts from males in all age ranges was consistently lower when compared with females. The reluctance of male children and young people to engage is not a new finding.[626]

The continued prevalence of poor help-seeking in males shows that we are not being effective in addressing it. Given the substantially higher rates of deaths due to intentional self-harm in males, this situation is disturbing.

Engaging male children and young people in help-seeking is crucial, and concerted effort is needed to address this. Actively targeting male children and young people, and promoting help-seeking as a positive life skill and a sign of strength should be prioritised. Research which focuses on discerning what inhibits and what facilitates help-seeking in male children and young people is needed to assist in overcoming this reluctance.

The Kids Helpline data also suggested that, proportionally, the contacts from male children and young people were more likely to be about seeking information and discussing their concerns for another person. It is unknown how many of these contacts were actually seeking information for themselves or discussing concerns that really related to their own personal circumstances, as opposed to the circumstances of another person. Knowing more about the underlying features of this could inform the strategies used to engage with male children and young people.

The data provided by Kids Helpline also showed how children and young people, depending on their sex and cultural background, had different preferences in terms of their mode of contact to seek help. Female children and young people tended to make contact online whereas male children and young people predominantly contacted Kids Helpline via phone.

Aboriginal and Torres Strait Islander children and young people, and those from culturally and linguistically diverse backgrounds, also preferred to contact Kids Helpline by phone.

Knowing how children and young people prefer to make contact is essential for tailoring services to their needs. More research that directly involves children and young people is required in this area. The need for direct consultation with children and young people was pointed out to me in a number of submissions. The ACT Children and Young People Death Review Committee stated that:

> The Committee believes children and young people need to be spoken to about all aspects of self-harm and suicide, including barriers to seeking assistance. Many of the barriers to seeking assistance identified by adults may not necessarily be what children and young people identify as barriers.[627]

There was a pattern of concerns in the contacts to Kids Helpline from children and young people:

- Where contact was made about suicide with other concerns, self-injury and self-harm was one of the other main concerns.
- Suicidal thoughts and fears were the primary concerns raised by children and young people who identified suicide as their primary concern.
- Where contact was made about self-injury and self-harm, one of the other frequently cited concerns was suicide.
- Talking through the consequences and/or alternative coping strategies were the foremost concerns of children and young people who identified self-injury and self-harm as their primary concern.

Regardless of whether the main contact was about suicide or self-injury and self-harm, the leading concerns raised by children and young people were about mental health, child-parent relationships and emotional wellbeing.

This type of information is invaluable and should inform the ways that resources and interventions are developed and targeted to children and young people.[628]

Focusing on the concerns identified through the contacts by children and young people is important because this may assist us to know how we can effectively meet their needs.

The Northern Territory Council of Social Service told me:

> Valuing the contributions young people make to society and ensuring that there are legitimate pathways for young people's views to be actively heard will make a marked difference to the overall mental health and incidence of suicide currently experienced.[629]

The data I received from NCIS, ABS, AIHW and Kids Helpline has been invaluable and has informed some of my recommendations.

3.7.4 Where to from here?

I hope that my examination of non-suicidal self-harm and suicidal behaviour can be a blueprint for identifying some of the issues that can inform the development of a specific national research agenda for children and young people who are engaging in non-suicidal self-harm and suicidal behaviour.

The submission by the Black Dog Institute recommended the development of a 'new national suicide prevention research agenda for children and young people'.[630]

The Orygen Youth Health Research Centre made a similar recommendation and pointed out to me:

> one of the key things lacking in Australia's approach to the prevention of suicide and self-harm among young people is a truly strategic approach towards developing a research agenda which can be used to inform best practice.[631]

The submission by Orygen Youth Health Research Centre also told me:

> Australia has numerous organisations with specific expertise in youth suicide prevention, including [Orygen Youth Health Research Centre], headspace, and the Young and Well Cooperative Research Centre that together hold the expertise and infrastructure to lead the way in a collaboration of this nature.[632]

Currently the Standing Committee on Child and Youth Health is developing the National Child and Youth Strategic Framework (the National Strategic Framework). The National Strategic Framework is an Australian Health Ministers' Advisory Council funded project and is being progressed through its Community Care and Population Health Principal Committee.

The National Strategic Framework will assist in developing national service strategies that outline roles and responsibilities and establish priorities. The National Strategic Framework could make establishing a national research agenda for children and young people engaging in non-suicidal self-harm and suicidal behaviour a focus area.

Health goals and targets for Australian children and young people were initially developed in 1992. Youth suicide was included in Goal 1, which focused on reducing preventable premature mortality. For 20 years, these strategic goals have guided work to improve the health of children and young people in Australia.

The views of stakeholders are now being sought to help identify the current key issues and necessary priorities to improve the health and wellbeing of children and young people in Australia. A Discussion Paper has been released in conjunction with a survey. Feedback from the survey will inform the first draft of the new National Strategic Framework. Youth suicide is included as a continuing concern in the Discussion Paper.

Intentional self-harm, with or without suicidal intent, is not referred to in the Discussion Paper. Given the evidence of the increasing rates of intentional self-harm, with or without suicidal intent, it would seem reasonable to identify it as an area of emerging concern and include it in the revised goals and targets.

It is anticipated that the new National Strategic Framework will be completed by March 2015. Associate Professor Elisabeth Murphy, as the Co-Chair of the Standing Committee on Child and Youth Health, has asked me to organise a consultation with the Australian Children's Commissioners and Guardians to assist in identifying key issues and priorities to improve the health and wellbeing of children and young people in Australia. I have also written to the Chair of the Community Care and Population Health Principal Committee to ask about the possibility of me joining a relevant working group for the new National Strategic Framework.

In August 2013, the Coalition's Policy for Efficient Mental Health Research and Services was released. This policy indicated that, if elected, the Coalition would provide $18 million over four years to Orygen Youth Health Research Centre to establish and operate a National Centre for Excellence in Youth Mental Health.[633]

In May 2014, the federal budget allocated $18 million over four years to Orygen Youth Health Research Centre to establish the National Centre for Excellence in Youth Mental Health. In its media release, the Australian Government stated:

> once established, the centre will undertake clinical trials; invest in research; provide training, support and information to mental health clinicians and service planners; and develop new ways to treat people.[634]

At the time that this report went to press, Orygen Youth Health Research Centre was negotiating its contract with the Australian Government in terms of what it would be expected to deliver over the four years. The Orygen Youth Health Research Centre suggested to me that:

> the new National Centre of Excellence in Youth Mental health will provide leadership, through activities and resources that increase and improve Australia's research capacity in youth mental health and provide advice to Government on development and improvement of evidence informed strategies to improve youth mental health services and outcomes with optimal utilisation of resources.[635]

Given that intentional self-harm and suicide were raised as priorities in the Coalition's pre-election policy on mental health,[636] I am hopeful that non-suicidal self-harm and suicidal behaviours in children and young people will be included as part of the work of the National Centre for Excellence in Youth Mental Health.

The work of the National Centre for Excellence in Youth Mental Health, in conjunction with the new National Strategic Framework for Child and Youth Health, could set the foundations for developing a national research agenda for children and young people engaging in non-suicidal self-harm and suicidal behaviour.

I note that Orygen Youth Health Research Centre mainly focuses on children and young people aged 12-25 years. It will be important that in any national research agenda the interests of children and young people under 12 years of age are also considered by those with the necessary expertise.

As part of my examination, I wrote to the Minister for Health, the Hon Peter Dutton MP, to ask about actions taken by the Australian Government since June 2011 to address the recommendations contained in the reports, *The Hidden Toll: Suicide in Australia*[637] and *Before it's too late*.[638] I thank the Hon Peter Dutton MP for his comprehensive response and commend the Australian Government for its continued commitment. My letter and his response are contained in Appendix 9. I look forward to meeting with the Hon Peter Dutton MP to discuss my key findings and recommendations.

3.7.5 Summary of key findings

Some of the key findings of my examination include:

- **The inconsistent use of terms and definitions to describe the range of thoughts, communications, and behaviours that are related to non-suicidal self-harm, suicidal behaviours and death due to intentional self-harm**.

  These definitional issues present significant challenges for those working in the field. Researchers cannot easily compare their study populations and research findings, and clinicians have difficulty translating research findings into practical applications.[639] Differentiating self-harm with and without suicidal intent is essential to building precise understandings of these behaviours as well as how non-suicidal self-harm relates to, and influences, suicidality.[640]

  Neither the ICD-10 codes nor the classification system used by NCIS distinguish between intentional self-harm with suicidal intent and intentional self-harm without suicidal intent. Conflating intentional self-harm with suicidal intent and intentional self-harm without suicidal intent makes it difficult to construct an accurate picture of what is actually occurring.

- **Understanding the multiplicity of risk factors is central to effectively targeting and supporting children and young people**.[641]

  While there is a growing body of knowledge about the risk factors that increase the likelihood of suicidal behaviour and non-suicidal self-harm, 'much less is known about *how* or *why*' they engage in these behaviours.[642]

  We do not know whether they develop as a result of multiple interrelated risk factors or only one or two predominant vulnerabilities, or whether specific combinations of risk factors can accurately predict intentional self-harming behaviour with or without suicidal intent.[643]

  Suicidal thoughts and fears were the predominant concerns raised by children and young people who identified suicide as their primary concern. Talking through the consequences and/or alternative coping strategies were the foremost concerns of children and young people who identified self-injury and self-harm as their primary concern.

  Building knowledge about this 'will help us to start to make sense of the many risk factors that have been identified, and will yield the most clinically useful information'.[644] Currently, 'most studies examine bivariate, linear associations between individual risk factors and self-harm'.[645] Research that simultaneously considers multiple risk factors is required.[646]

  Domestic and family violence was raised as a risk factor requiring further research.

- Similarly, **while knowledge about possible protective factors is increasing, we do not sufficiently understand the impact of the different protective factors**, how they are interrelated, whether some are more predominant than others or whether specific combinations offer more protection.

- **There is a dearth of research involving the direct participation of children and young people**.

  The National Statement on Ethical Conduct in Human Research guides research in this area.[647] Recent studies have shown that participation in research related to suicide prevention appears to have no iatrogenic effects among participants.[648] Research proposals to Ethics Committees should highlight this.

- **Empirical evidence is lacking in terms of the psychological mechanisms underlying suicide clusters**.[649] Overall, the risk factors for cluster suicide are not dissimilar from those associated with individual adolescent suicide.[650] This means they are not particularly helpful in assisting to identify those children and young people who may be most at risk of becoming part of a suicide cluster.

  It is suggested that psychological mechanisms may include contagion, imitation, suggestion, social learning theory and assortative relating, but it is argued that 'there is no firm evidence that these mechanisms operate in cluster formation. It would seem reasonable to infer that multiple mechanisms operate together, and that the main mechanism is different for different settings and populations. Which mechanism, if any, is dominant in any particular cluster is unknown'.[651]

- **There is limited evidence about the incidence and mechanisms leading to clustering of intentional self-harm without suicidal intent**.

- **There is no solid evidence base documenting the effectiveness of postvention services**. A review of the literature on postvention strategies delivered to children and young people in response to suicide clusters concluded that, with so few evaluations of postvention responses, it was difficult to draw firm conclusions about the effectiveness of these strategies on the reduction of suicide risk or death due to intentional self-harm.[652]

  The general lack of evaluation of programs, strategies, and services was also raised in the *Evaluation Report of the National Suicide Prevention Program* published in 2014.[653] The report noted that a lack of outcome data made it difficult for projects to demonstrate their effectiveness.

- **There is insufficient empirical evidence on the effectiveness of gatekeeping training programs on actual outcomes for children and young people**.[654] The Menzies School of Health Research told me 'there is almost no reported evidence of its effectiveness in reducing risk factors in young people'.[655] Determining the effectiveness of gatekeeper training programs on the outcomes for children and young people should be prioritised in evaluations of these programs and also in future research.
- **Where children and young people present to an accident and emergency department, there is a genuine opportunity to connect with them and facilitate follow-up intervention**. A set of Guidelines for the Management of Deliberate Self Harm in Young People were developed by the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists in 2000. The extent to which these guidelines have been adopted or how they impact on practice is unknown but this is an area that requires follow-up and evaluation.
- **Not enough is known about the online communicability of non-suicidal self-harm**, including examinations of the processes by which communications initiate, reinforce, and/or help to extinguish non-suicidal self-harm.[656]
- **Poorly completed death certificates impede the accurate identification of intentional self-harm resulting in death by suicide**. Some roundtable participants and submissions from the Australian Capital Territory raised this issue.
- **Given the prevalence of hanging, investigating ways to prevent it should be prioritised**. The data provided to me by NCIS and ABS confirmed that hanging was the most frequently used mechanism of intentional self-harm leading to death in children and young people across all age ranges. According to NCIS, 89% of children and young people aged 4-13 years died by hanging. 80% of those aged 14-15 years and 81% of those aged 16-17 years died by hanging.

  While hanging has been predominantly associated with males, it is now the most common mechanism used by females. Previously, suicide prevention has focused on restricting access to commonly used methods. Unfortunately, restricted access to the means for hanging is not possible. Detailed research is required to verify existing perceptions about hanging and to explore in detail how these perceptions influence children and young people when planning a suicide attempt.[657]
- **Increasing the awareness of primary caregivers about risk factors and warning signs is essential**. The NCIS data showed that 76% of deaths in children and young people were due to intentional self-harm occurring in the home.
- **The continued implementation of universal suicide prevention strategies aimed at raising public awareness, encouraging help-seeking behaviour and challenging stigma associated with suicide may assist with this**. The submission by the Black Dog Institute highlighted to me that the community has 'low to moderate levels of suicide literacy, with the greatest deficits in the identification of the signs and symptoms of suicide and the risk factors associated with it'.[658] The Black Dog Institute also emphasised that 'Family and friends have poor knowledge of the signs of suicide and lack knowledge about how and in what circumstances they should act'.[659]
- **Restricting access to the means used for intentional self-poisoning could prevent intentional self-harm in children and young people**. The data provided by AIHW showed that there were 18,277 hospitalisations for intentional self-harm in children and young people aged 3-17 years between 2007-2008 and 2012-2013. 82% of these hospitalisations were due to intentional self-poisoning. Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics was the most frequently used means, followed by antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified, and then by other and unspecified drugs, medicaments and biological substances. Restricting access to means is known to be an effective suicide prevention strategy.

- **Finding effective ways to encourage children and young people to access appropriate help or support for early signs and symptoms of difficulties must be a priority**.[660]

  headspace stated:

  > If the barriers to help-seeking can be addressed, young people experiencing emotional distress are more likely to access help earlier when difficulties first arise. This can help prevent more serious long-term problems from developing, including deliberate self-harm and suicidal behaviours, which may then be more difficult to treat or require more intensive interventions.[661]

  Some children and young people are seeking help from Kids Helpline. Of the 80,142 contacts during 2012 and 2013 from children and young people aged 5-17 years, which involved the provision of counselling,[662] 11,180 contacts were assessed by counsellors as involving a child or young person with current thoughts of suicide,[663] and 18,737 contacts were assessed by counsellors as involving a child or young person who self-injures and self-harms.[664]

  There were significantly fewer contacts to Kids Helpline made by male children and young people when compared with contacts made by female children and young people.

  While contacts by male children and young people did increase with age, the number of contacts remained comparatively low. Engaging male children and young people in help-seeking behaviour is crucial, and concerted effort is needed to address this.

  Female children and young people tended to make contact online whereas male children and young people mainly contacted Kids Helpline via phone. Aboriginal and Torres Strait Islander children and young people and those from culturally and linguistically diverse backgrounds also preferred to contact Kids Helpline by phone.

  Knowing how children and young people prefer to make contact is essential for tailoring services to their needs. More research that directly involves children and young people is required in this area.

  Where contact was made to Kids Helpline about suicide with other concerns, self-injury and self-harm was one of the other main concerns. Where contact was made about self-injury and self-harm, one of the other frequently cited concerns was suicide.

  Suicidal thoughts and fears were the predominant concerns raised by children and young people who identified suicide as their primary concern. Talking through the consequences and/or alternative coping strategies were the foremost concerns of children and young people who identified self-injury and self-harm as their primary concern.

  Regardless of whether the main contact was about suicide or self-injury and self-harm, the leading concerns raised by children and young people were about mental health, child-parent relationships and emotional wellbeing.

  This type of information is invaluable and should inform the ways that resources and interventions are developed and targeted to children and young people.[665]

Recommendations

I make the following recommendations based on the public health model where:

> suicide prevention begins with surveillance to define the problem and to understand it, followed by the identification of risk and protective factors (as well as effective interventions), and culminates in implementation, which includes evaluation and scale-up of interventions and leads to revisiting surveillance and the ensuing steps.[666]

1. Establish a national research agenda for children and young people engaging in non-suicidal self-harm and suicidal behaviour through the new National Strategic Framework for Child and Youth Health. This should be supported by the soon to be established National Centre for Excellence in Youth Mental Health. This research agenda should prioritise:
    - the standardisation of terms and definitions to describe the range of thoughts, communications, and behaviours that are related to intentional self-harm, with or without the intent to die
    - understanding the multiplicity of risk factors central to effectively targeting and supporting children and young people
    - understanding the impact of different protective factors, how they are interrelated, whether some are more predominant than others, or whether specific combinations offer more protection
    - the direct participation of children and young people in research about intentional self-harm, with or without suicidal intent
    - understanding the psychological mechanisms underlying suicide clusters
    - understanding incidence and mechanisms leading to clustering of intentional self-harm without suicidal intent
    - evaluating the effectiveness of postvention services
    - evaluating the effectiveness of gatekeeping training programs on actual outcomes for children and young people
    - increasing the awareness of primary caregivers about risk factors and warning signs
    - investigating ways to restrict access to the means used for intentional self-poisoning in children and young people
    - finding effective ways to encourage children and young people to access appropriate help or support for early signs and symptoms of difficulties.
2. Strengthen and develop surveillance of intentional self-harm, with or without suicidal intent, through:
    a. The Australian Government funding an annual report on deaths due to intentional self-harm involving children and young people aged 0-17 years using the agreement reached between the Australian Bureau of Statistics; the Registrars of Births, Deaths and Marriages; and state and territory coroners on the dissemination of unit record data.

    b. The Australian Institute of Health and Welfare including a section using disaggregated data about hospitalisations for intentional self-harm involving children and young people aged 0-17 years in its regular series on hospitalisations for injury and poisoning in Australia.

    c. The Australian and New Zealand Child Death Review and Prevention Group continuing its work in relation to the development of a national child death database, in conjunction with the Australian Institute of Health and Welfare, and providing an annual progress report.

3. Collect national data on children and young people who die due to intentional self-harm through:

    a. The use of the standardised National Police Form, in all jurisdictions, by 2015. This should include an electronic transfer to the National Coronial Information System. A plan to monitor the outcomes of all jurisdictions using the standardised National Police Form should be developed, and the possibility of incorporating a range of demographic, psychosocial and psychiatric information specific to children and young people should be investigated.

    b. The Standing Council on Law, Crime and Community Safety putting the issue of standardisation of coronial legislation and/or coronial systems on its agenda. Standardisation should require that where all state and territory coroners find a death under investigation to be caused by an action of the deceased, the coroner must make a further finding of intent, based on the evidence, to clarify whether the deceased intended to take the action which caused his or her death; the deceased lacked capacity to recognise that his or her action would cause his or her death but death was a reasonably foreseeable consequence of the action; or it is not clear from the evidence whether the deceased intended to cause his or her death.

4. The Royal Australian and New Zealand College of Psychiatrists should review and, where appropriate, update its Guidelines for the Management of Deliberate Self Harm in Young People (2000).

Conclusion

Clearly, much remains to be done in the area of intentional self-harm, with or without the intention to die, for children and young people aged 0-17 years.

While we have some understandings, there is too much that we still do not know. This limits our capacity to respond in ways that will prevent children and young people from engaging in non-suicidal self-harm and suicidal behaviour.

Fundamentally, we 'lack an accurate means of predicting these behaviours and an effective method of preventing them'.[667]

This is compounded by the complexities inherent in data collection and the restricted access to data that is collected.

Establishing a national research agenda will provide a structure for moving forward. Standardisation of coronial legislation and/or coronial systems in Australia, and all jurisdictions using the standardised National Police Form, will assist with data collection.

I look forward to reporting on the progress of my recommendations in my 2015 report to Parliament.

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