SELF-HARM AND HELP-SEEKING AMONG ABORIGINAL AND TORRES STRAIT CHILDREN AND YOUNG PEOPLE

by Megan Mitchell and Mick Gooda

INTRODUCTION

Despite making up less than three per cent of the population, Aboriginal and Torres Strait Islander children and young people represent 28.1 per cent of the suicide deaths by children under 18. The gross overrepresentation of Indigenous children is one of the disturbing findings of the Australian Human Rights Commission's examination of suicide and self-harm among children and young people in Australia. The reasons why Indigenous children engage in self-harming behaviours is complex, multifactorial and poorly understood. Some commentators point to the fact that many Indigenous children are living in substandard conditions, are exposed to trauma and violence, are disengaged from the community, school, and culture, and generally lack hope for their futures. Many Indigenous children are unwilling or unable to seek help through mainstream channels and have limited access to recreational opportunities or mental health supports. Targeted, robust research is required to better understand suicide and self-harming among Indigenous children and young people, to identify ways to encourage help seeking, and evaluate the effectiveness of interventions.

EXAMINATION INTO SUICIDE AND SELF-HARM AMONG CHILDREN AND YOUNG PEOPLE, WITH OR WITHOUT SUICIDAL INTENT

Early in 2014 it emerged that suicide had become the leading cause of death for 15-24 year olds. This development, along with anecdotal evidence that the level of self-harming among children had grown to alarming levels, led the Australian Human Rights Commission to conduct a national investigation into the issue for children and young people under 18. Article 19 of the *Convention on the Rights of the Child* ('*CRC*'), which Australia ratified 25 years ago, gives to every child the right to live free from all forms of violence,[1] including '… self-inflicted injuries, suicidal thoughts, suicide attempts and actual suicide'.[2] The United Nations Committee on the Rights of the Child has interpreted article 19 as a 'civil right and freedom' which places an 'immediate and unqualified obligation' on the State to 'undertake all possible measures' to realise the rights of the child.[3]

Taking a rights-based approach, the Commission's examination involved a call for public submissions, a series of expert roundtables, the analysis of key data and engagement with children and young people at risk through supported processes. The public submissions process specifically asked about Aboriginal and Torres Strait Islander children and children living in out-of-home care because of the known vulnerabilities of these particular groups. Roundtables focusing on Aboriginal and Torres Strait Islander children and young people were held in Sydney, Perth, Darwin and Alice Springs.

As part of the project, new data about death and hospitalisation due to intentional self-harm in children was sourced from the National Coronial Information System ('NCIS'), Australian Bureau of Statistics ('ABS') and the Australian Institute of Health and Welfare ('AIHW').

The voices of children and young people were accessed through data provided by Kids Helpline about issues children and young people raised in contacts to the Helpline, and also from submissions directly from children and young people.

KEY FINDINGS RELATING TO ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

Death due to intentional self-harm among Aboriginal and Torres Strait Islander children and young people is significantly higher compared with their non-Indigenous counterparts. This is particularly evident in younger children.[4]

The data provided by the ABS showed that Indigenous children and young people account for 28.1 per cent of all deaths due to intentional self-harm in children under 18.[5] NCIS data showed that Indigenous children and young people accounted for 80 per cent of deaths in the 4-11 year age, 42.9 per cent of deaths in the 12-13 year age range, 24.5 per cent of deaths in the 14-15 year age range and 15.3 per cent of deaths in the 16-17 year age range.[6] NCIS data also showed a 657 per cent increase in the number of deaths due to intentional self-harm in all children when comparing the 12-13 year age range with the 14-15 year age range.

HOSPITALISATION FOR INTENTIONAL SELF-HARM

Data sourced from 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.[7] Seven per cent of hospitalisations involved Indigenous children and young people and 93 per cent involved other Australians. Of the 1248 hospitalisations recorded for Indigenous children and young people, 1 per cent were in the 3-9 year age range, 28 per cent were in the 10-14 year age range and 72 per cent were in the 15-17 year age range. Of the 17 029 hospitalisations for other Australians, less than 1 per cent were in the 3-9 year age range, 20 per cent were in the 10-14 year age range and 80 per cent were in the 15-17 year age range.

The primary reason for hospitalisation related to self-poisoning, signifying that the vast majority of self-harming behaviour does not result in a visit to a hospital.[8]

KIDS HELPLINE DATA

Of the 6703 contacts to Kids Helpline during 2012 and 2013 from children and young people who directly stated that suicide was their main concern, 129 contacts (less than 0.02 per cent) 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. Of these 133 contacts, the sex of the child or young person was recorded in 130 contacts. Almost 98 per cent were from females and 2.3 per cent were from males.

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, with 90.55 per cent of contacts in the 14-16 year age range. Seventy one per cent made contact by phone and 28.57 per cent made contact online.

Where available the data showed that 77.53 per cent of calls were from Aboriginal and Torres Strait Islander children and young people in capital cities and other metropolitan areas; 21.35 per cent were from rural towns, and 1.12 per cent, or one contact, was from a remote area.

The majority of Aboriginal and Torres Strait Islander children and young people who directly stated that suicide was their main concern indicated that they had suicidal thoughts and fears.[9]

FACTORS CONTRIBUTING TO SELF-HARM AMONG ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN

Participants at the roundtables and submissions to the examination advised that the reasons for the overrepresentation of Aboriginal and Torres Strait Islander children and young people in statistics about intentional self-harm were complex and multifactorial in nature.

The 2014 *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide* ('Elders Report') collated the voices of 28 Elders from different areas in the Northern Territory ('NT'), Western Australia ('WA') and Queensland ('Qld'), providing their perspectives on key issues and effective practices in reducing non-suicidal self-harm and suicidal behaviour among Aboriginal and Torres Strait Islander children and young people.[10]

In the report, Professor Pat Dudgeon, a Bardi woman of WA 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.[11]

The NPY Women's Council, which works in an area covering 350 000 square kilometres of the remote cross border of WA, South Australia and 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. They 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.'[12]

The Menzies School of Health Research 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 by children and young people under the age of 18 years in the NT. Of the 18 cases analysed, 17 related to the deaths of Aboriginal and Torres Strait Islander children and young people.[13] 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.[14] 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.[15]

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, 69-75 per cent of referrals to them for 'self-harm behaviour or intent' were identified as Aboriginal children or young people,[16] 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.'[17]

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.[18] 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.[19] Despite significant investments over recent years to address these issues, 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'.[20]

WHAT INTERVENTIONS WORK FOR ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN?

The AIHW confirmed that there are very few Australian or international evaluations on the impact of Indigenous-specific suicide prevention programs on suicide rates.[21] 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.[22] KALACC have stated that:

> this is a welcome stance, because not only does it recognise that there are a range of demographic groups within Australian 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.[23]

A number of commentators 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. The Elder's Report highlights the situation of Indigenous communities in Canada, which suggests that communities with strong connections to culture experience few or no suicides.[24] Mr Wayne Bergmann, former CEO of the Kimberley Land Council stated:

> 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.[25]

Mr Max Dulumunmun Harrison of the Yuin Nation, 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.[26]

In his foreword to the Elder's Report, 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.[27]

The submission to the Commission 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.[28]

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 Elder's Report, with Walmajarri Elder, Mr Joe Brown of Fitzroy Crossing, WA 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.[29]

The submission by KALACC stated that the Yiriman Project of WA is an example of how this is being achieved.[30] The Yiriman Project was established in 2000 and initially implemented in Jarlmadangah Burru Aboriginal Community. The program is currently based out of Fitzroy Crossing under the auspices of KALACC. Yiriman is an intergenerational, 'on-Country' cultural program, conceived and developed directly by Elders from four Kimberley 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.

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.'[31] This review also indicated that traditional evaluation methods were not suited to projects of this kind.[32] The submission by KALACC indicated that despite such reinforcement, governments are not open to supporting programs such as Yiriman.[33] It attributes this to culturally based methodologies being marginalised and regarded as peripheral.[34]

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 said the 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.[35]

Evaluation reports of the Family Wellbeing Program, across a range of settings, suggest that many of the program's participants 'were able to analyse situations more carefully, take better care of themselves, give and demand more in their relationships, and participate more actively.'[36]

BARRIERS TO HELP SEEKING BY ABORGINAL AND TORRES STRAIT ISLANDER CHILDREN

The Northern Territory Council of Social Service reinforced that the barriers preventing Aboriginal and Torres Strait Islander children and young people from seeking help for intentional self-harm must be seen in the context and experience of Aboriginal poverty and disadvantaged.[37] As many Indigenous children may be disengaged from school, the Northern Territory Council of Social Service suggested:

> 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.[38]

Language may also be a barrier to Indigenous children and young people seeking assistance. Although many Aboriginal children living in remote areas can speak two or three different Indigenous languages, they may find it difficult to communicate in English.[39] As the NT Council of Social Service pointed out:

> 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.[40]

Language barriers were also raised by the NPY Women's Council who shared 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.

CONCLUSIONS AND RECOMMENDATIONS

It is clear from our investigation that the significant overrepresentation of Indigenous children and young people requires a comprehensive well-coordinated whole of government response. This should include the full suite of service interventions (from early intervention to clinical treatments), a robust research agenda, and a strong evidence base around what works. The Menzies School of Health Research commented in particular on the current state of 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.[41]

The principal recommendation from the *2014 Children's Rights Report* was that a national research agenda for Indigenous and non-Indigenous children and young people engaging in non-suicidal self-harm and suicidal behaviour should be established. The research agenda should prioritise issues such as: the standardisation of terms and definitions; the multiplicity of risk factors central to effectively targeting and supporting children and young people; the impact of different protective factors; the direct participation of children and young people in research; the psychological mechanisms underlying suicide clusters; incidence and mechanisms leading to clustering; the effectiveness of postvention services; the effectiveness of gatekeeping training programs; awareness of primary caregivers about risk factors and warning signs; ways to restrict access to the means used

for intentional self-poisoning; encouraging help seeking among children and young people.

Given the unique issues faced by Aboriginal and Torres Strait Islander children targeted research is required. In this context, the work of the National Aboriginal and Torres Strait Islander Suicide Prevention Project Evaluation ('ATSISPEP') to be completed later this year, is critical. 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. 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. 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.

It is equally important that other ongoing initiatives such as the Research Centre for Excellence in Suicide Prevention ('CRESP') and the National Centre for Excellence in Youth Mental Health adequately prioritise research into the needs of Aboriginal and Torres Strait Islander children and young people.

The National Children's Commissioner will in her next statutory report to Parliament follow-up on how the Australian Government has responded to the *2014 Children's Rights Report* and its recommendations about intentional self-harm in children under 18. The National Children's Commissioner has also assumed an advisory role with CRESP and ATSISPEP to promote children's rights in suicide prevention research.

If you or anyone you know needs urgent help please contact Lifeline on 13 11 14 or the Kids Helpline on 1800 55 1800. Support is also available through www.headspace.org.au and www.beyondblue.org.au.

Megan Mitchell is the National Children's Commissioner. She has extensive experience in issues facing children and young people, having worked with children from all types of backgrounds, including undertaking significant work with vulnerable children.

Mick Gooda is the Aboriginal and Torres Strait Islander Social Justice Commissioner. As a Commissioner he advocates for the recognition of the rights of Aboriginal and Torres Strait Islander peoples in Australia and seeks to promote respect and understanding of these rights among the broader Australian community. Mick is a descendent of the Gangulu people of central Queensland.

1 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 19.

2 Committee on the Rights of the Child, *General Comment No 13: The Right of the Child to Freedom From All Forms of Violence*, UN Doc CRC/C/GC/13 (18 April 2011) para 28.

3 Ibid para 65.

4 D De Leo, J Sveticic and A Milner, 'Suicide in Indigenous people in Queensland, Australia: Trends and Methods, 1994–2007' (2011) 45 *Australian and New Zealand Journal of Psychiatry* 532, 534; Australian Institute for Suicide Research and Prevention, Submission 95 to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People,* May 2014, 4.

5 Australian Human Rights Commission, *Children's Rights Report 2014* (2014), 151.

6 Ibid.

7 Ibid 133.

8 Ibid 152.

9 Ibid 142.

10 People Culture Environment, *The Elders' Report into Preventing Indigenous Self-harm and Youth Suicide* (2014) <https://bepartofthehealing.org/EldersReport.pdf>.

11 Ibid 5.

12 Ngaanyatjarra Pitjantjatjatjara Yankunytjatjara Women's Council (Aboriginal Corporation), Submission 128 to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People,* 16 June 2014, 15.

13 G Robinson, S Silburn, B Leckning, Menzies Centre for Child Development and Education, *Suicide of Children and Youth in the NT, 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee* (2012) 41.

14 Menzies School of Health Research, Submission 102 to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People,* 2 June 2014, 2.

15 G Robinson, S Silburn, B Leckning, above n 13, 41.

16 Central Australian Mental Health Service, Department of Health, Northern Territory, Submission 99, to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People,* May 2014, 6.

17 Ibid 2.

18 Ibid.

19 Ibid 3.

20 Kimberley Aboriginal Law and Cultural Centre, Submission 31 to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People*, 17 May 2014, 2.

21 Australian Institute of Health and Welfare, Submission 114 to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People,* 3 June 2014.

22 Ibid.

23 Kimberley Aboriginal Law and Cultural Centre, above n 20, 4.

24 People Culture Environment, above n 10, 16.

25 Ibid 15.

26 Ibid 10.

27 Ibid 4.

28 Kimberley Aboriginal Law and Cultural Centre, above n 20, 5.

29 People Culture Environment, above n 10, 9.

30 Kimberley Aboriginal Law and Cultural Centre, above n 20, 8-9.

31 D Palmer, Kimberley Aboriginal Law and Culture Centre, *Yiriman is like a school for our young people: the Yiriman Project. Three-year Evaluation 2010-2012 Report Two: 2011* (2012) 124.

32 Ibid 5.

33 Kimberley Aboriginal Law and Cultural Centre, above n 20, 9.

34 Ibid 3.

35 Lowitja Institute, Submission 85 to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People,* 2 June 2014, 2.

36 Ibid.

37 Northern Territory Council of Social Service, Submission 77 to Australian Human Rights Commission, *National Children's Commissioner's Examination into Intentional Self-harm, With or Without Suicidal Intent, in Children and Young People,* June 2014, 9.

38 Ibid.

39 Ibid 10.

Yampurriparri and Tapalinga, 2014
Karina Coombes
Acrylic on linen
1800mm x 1200mm

These paintings depict the Tiwi story of the shooting star, or Yamparriparri. Yamparriparri are viewed by Tiwi people as a very bad omen, a type of demon similar to a vampire. The custom on the Tiwi Islands when a shooting star is observed is to spit several times on the ground to mitigate potential bad luck. Tapalinga is the general Tiwi term for a star, or group of stars in the night sky.