Evidence to Action Note
March 2024

Family and Community Services Insights, Analysis and Research (FACSIAR)

Supporting young people involved with child protection services who are at risk of self-harm and suicide

Findings from the NSW Child Development Study

Snapshot

- In 2022, suicide was one of the leading causes of death in Australia for children and young people aged 17 years and below, and hospitalisations for intentional self-harm in this age group have risen steadily over the past decade.[1,2]
- Findings from the NSW Child Development Study (NSW-CDS) show that children and young people who are in contact with child protection services or in out-of-home care are much more likely to engage in self-harm and think about suicide than their peers without child protection service contact.
- The Study found that incidents of self-harm and suicide attempts often come to the attention of child protection services before a child or young person presents to public health services (e.g., emergency department, mental health ambulatory service or hospital admission).
- The Child protection helpline is often notified about incidents of self-harm and suicidal ideation at an earlier age and in higher numbers for boys than health services. This highlights the important role that child protection services play in reducing the risk of self-harm and suicide.
- This Evidence to Action Note explains how the Department and Communities and Justice (DCJ) responds to reports of self-harm and suicidal ideation, and includes advice for practitioners working with children and young people at risk.

Introduction

Self-harm and suicidal ideation (thinking about or planning suicide) in children and young people can be devastating for the child or young person, their families or carers, and they are more common among young people known to child protection services, especially those placed in out-of-home care.[3,4] This Evidence to Action Note summarises the key findings from two published research articles from the NSW Child Development Study (NSW-CDS): “Self-harm and suicidal ideation in children and adolescents in contact with child protection services”, and “Self-harm and suicidal ideation among young people is more often

recorded by child protection than health services in an Australian population cohort".[5,6] The results show that the risk of self-harm and suicidal ideation for children and young people up to the age of 18 years increases with every step of their involvement with child protection services or out-of-home care, and that these issues often first come to the attention of child protection rather than health services. The Evidence to Action Note also discusses the implications for policy and practice.

Why is this research important?

Crisis support services, 24 hours, 7 days

We are aware that the information in this Evidence to Action Note might cause distress. If this happens to you, please consider contacting one of the crisis support service below:

- Lifeline: 13 11 14
- Suicide Call Back Service: 1300 659 467
- Beyond Blue: 1300 224 636
- 13YARN: 13 92 76
- MensLine Australia: 1300 789 978
- Kids Helpline: (for young people aged 5 to 25 years): 1800 551 800

In 2022, 77 young people aged 17 years and below took their own lives in Australia. The majority of them (83.1%) were between 15 and 17 years.[7] Youth suicide rates are particularly high among young males, Aboriginal and Torres Strait Islander people, and people living in regional and socio-economically disadvantaged communities.[8] An additional 7,609 children and young people (hereafter young people), aged 19 years and below, were admitted to hospital for intentional self-harm in Australia in 2021–22. Three quarters of all young people hospitalised for self-harm were between 15 and 19 years old, and two thirds were females. Self-harm is less common in children and adolescents 14 years and younger, but numbers have increased nationally from 1,136 in 2019-20 to 1,875 in 2021-2022.[9,10] It is estimated that only around one in eight young people who self-harm present to a hospital, which means that these numbers likely only represent the tip of the iceberg. Most instances of self-harm may not come to the attention of health services at all.[11]

Self-harm and suicidal ideation and behaviours are related but different issues. Suicidal ideation refers to thinking about, considering, or planning suicide. It is generally estimated that there are around 25 suicide attempts for each person who dies by suicide.[12] Self-harm often describes intentionally injuring one's body by cutting, burning, hitting, scratching, or overdosing on prescribed or illicit drugs, most often without the intention to die (commonly referred to as non-suicidal self-injury).[13] In general, people self-harm as a way of coping. People often talk about harming themselves to relieve, control or express distressing feelings, thoughts or memories. Most people who self-harm are not trying to kill themselves, but there is a chance that they may hurt themselves more than they intended to. This increases their risk of accidental suicide. People who repeatedly self-harm may also become suicidal and feel hopeless and trapped.[14]

Self-harm and suicidal ideation share common risk factors, including a history of trauma and abuse. The Australian Childhood Maltreatment Study found that three in ten (30.5%) of their 3,500 study participants who were aged 16–24 years reported having self-harmed at some time in their life.

Young people with a history of child maltreatment were 3.5 times more likely to have self-harmed in the previous 12 months and 4.5 times more likely to have attempted suicide in the previous 12 months than their peers without a child maltreatment history.[15]

The NSW-CDS research findings are important because they can help raise awareness and identify opportunities for early interventions and targeted mental health supports to prevent self-harm and suicide attempts among this vulnerable cohort.

What data did this research use from the NSW-CDS?

The NSW-CDS is a longitudinal population study of life-course risk and resilience for mental health and well-being among a cohort of 91,597 NSW children, most of whom were born between 2002 and 2005. It links administrative records from multiple NSW and federal agencies spanning health, education, child protection and criminal justice.

Self-harm and suicide-related incidents from birth to 18 years of age were able to be drawn from multiple sources, including emergency department, inpatient hospital admission and mental health ambulatory, child protection and police administrative records. These were used to describe the patterns of service contact for self-harm and suicidal ideation among children and young people in NSW.

Children and young people in the Study who had been reported to child protection services were allocated into mutually exclusive subgroups based on the highest level of child protection response they had received. For example, if a child or young person had a recorded out-of-home care placement and a substantiated risk-of-significant harm (ROSH) report, they were placed in the 'out-of-home care' group.

The three levels of child protection services were:

Out-of-home care placement: children with at least one placement in out-of-home care. This was deemed the highest service response, as it may reflect more severe maltreatment of the child or the inability of a family to continue caring for their child.

Substantiated ROSH report: instances of actual or risk of significant harm verified by child protection case workers but not resulting in removal of the child from their family. A child is deemed to be at risk of significant harm if the circumstances causing concern for their safety, welfare or wellbeing are sufficiently serious to warrant a response by a statutory authority, with or without the consent of their family.

Non-ROSH or unsubstantiated ROSH report: Reports that either did not meet the threshold for risk of significant harm or that did meet the threshold initially but no actual or risk of harm was determined during follow-up by case workers, or where the report was not further investigated due to resource constraints.

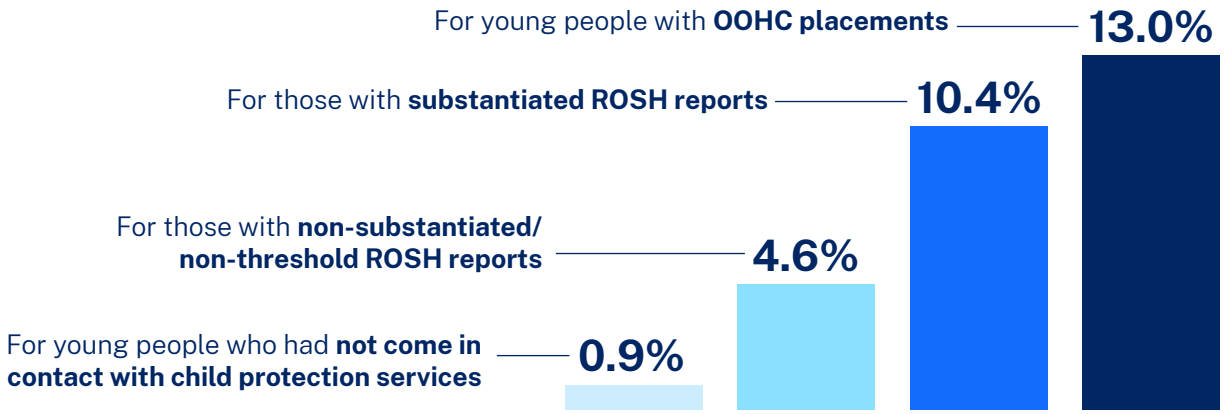
What did the NSW-CDS find?

There are associations between all levels of child protection contact and self-harm and suicidal ideation in young people

In the first paper, titled "Self-harm and suicidal ideation in children and adolescents in contact with child protection services",[6] the NSW-CDS researchers found that by the age of 17 years, 2,233 (2.4%) of their study participants had incidents of self-harm or suicidal ideation captured in health records (i.e., emergency departments, inpatient hospital admissions and mental health ambulatory services). There were 866 incidents of self-harm and 1,367 incidents of suicidal ideation (without self-harm) among this cohort. There were twice as many instances of self-harm or suicidal ideation recorded for girls (1,505) than for boys (728).

Contact with child protection services was recorded for 1,671 young people with medical records of self-harm or suicidal ideation incidents (74.8%). This means that three quarters of young people with recorded self-harm and suicidal ideation accessing public health care were young people who had experienced contact with child protections services. The greater the level of child protection services received by a young person, the more likely they were to be recorded in health records with a self-harm or suicidal ideation incident. The proportion of young people in the NSW-CDS with one or more records of self-harm or suicidal ideation by 17 years (referred to as 'cumulative incidence') was less than 1 in 100 (0.9%) for those who had no contact with child protection services, 1 in 20 (4.6%) for those with non-threshold or non-substantiated ROSH reports, 1 in 10 (10.4%) for those with substantiated ROSH reports and 1 in 8 (13.0%) for young people with out-of-home care placements.

The cumulative incidence of self-harm or suicidal ideation by 17 years recorded by emergency departments, admitted patient records or mental health ambulatory services was:

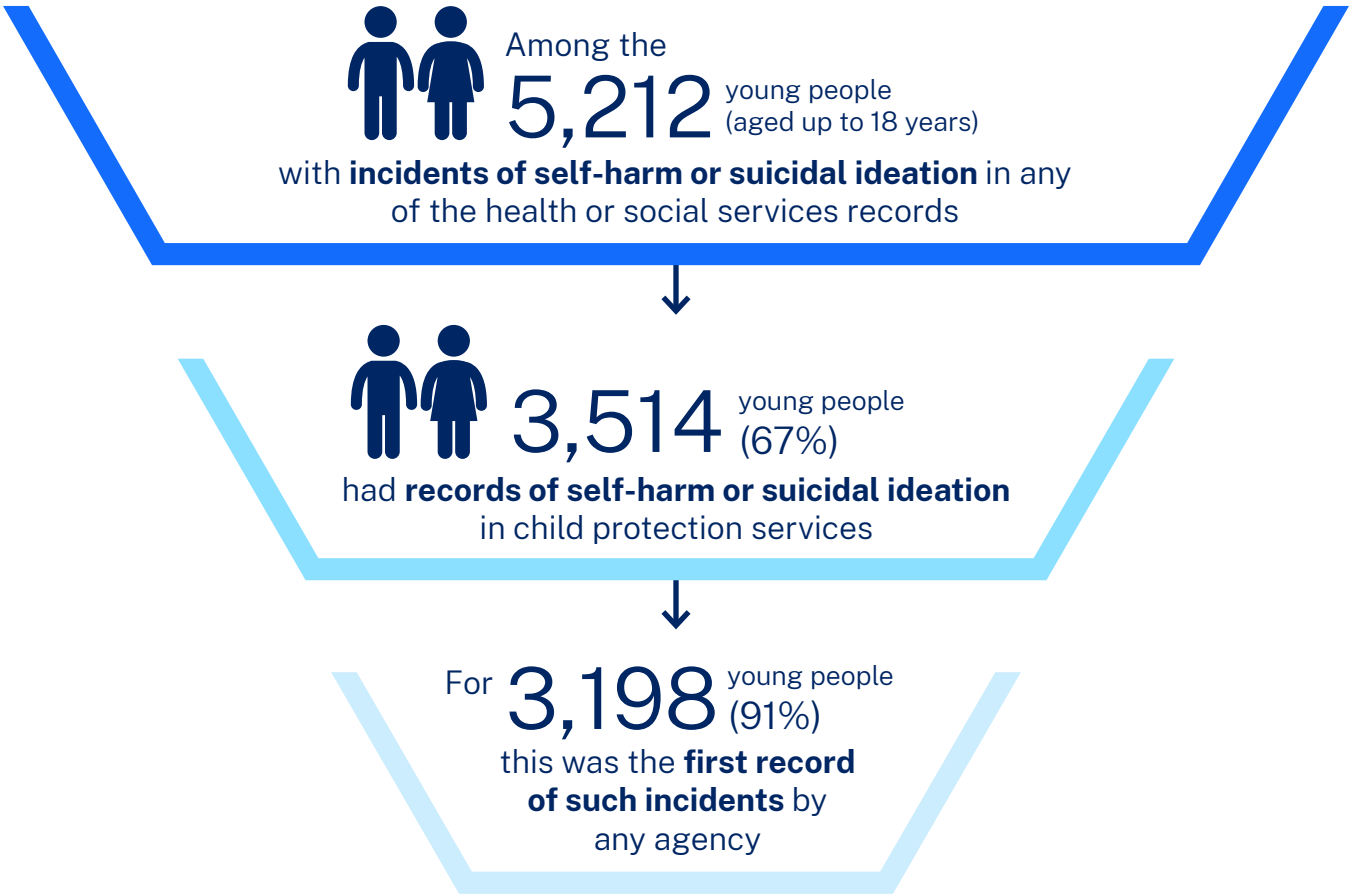


There are two important limitations of the first paper summarised above. Firstly, as stated previously, not all incidents of self-harm or suicidal ideation are captured in administrative health records. This means that the actual incidence of self-harm or suicidal ideation is likely to be much higher if data from community health professionals such as general practitioners, psychologists, or Aboriginal health services are included. Furthermore, the paper is descriptive, and no causal inferences can be made regarding the impact of child protection service contact on the likelihood of self-harm or suicidal ideation. This means that it cannot be claimed that child protection service involvement directly causes self-harm or suicidal ideation, only that they are associated events. Other factors may play a role as well.

Self-harm and suicidal ideation among young people are often reported to child protection services first

The second paper from the NSW-CDS is titled "Self-harm and suicidal ideation among young people is more often recorded by child protection than health services in an Australian population cohort".[5] In this paper, the NSW-CDS researchers looked for instances of self-harm or suicidal ideation for their cohort of young people in the available health records (emergency department presentations, hospital admissions and mental health ambulatory services), and in police and child protection services records. Looking through this broader lens (not just the health records), they found that 5,212 (5.7%) of all children and young people up to the age of 18 years in their sample had records for incidences of self-harm or suicidal ideation in health, child protection or police records. Many of the children and young people in this cohort had multiple entries. Of the 5,212 children and young people with a service contact recorded for self-harm or suicidal ideation, almost two thirds (3,514 or 67.4%), had been reported to child protection services for these issues. For the vast majority of those reported to child protection services (3,198 or 91.0%), this was the first record of such incidents recorded by any agency included in the NSW-CDS dataset.

The graph below illustrates these findings:



The NSW-CDS researchers also found that young people who were reported to child protection services as their first point of contact for self-harm and suicidal ideation tended to be younger, with a median age just under 14 years. In comparison, those whose first contact was with one of the three health services, or the police, had a median age that was closer to 15 years. Self-harm and suicidal ideation were found to be uncommon in children under 12 years. Girls were around two to three times more likely than boys to access health services for self-harm or suicidal ideation, but both boys and girls were reported in equal numbers to child protection services for these issues. This challenges the dominant view, largely coming from health service data, that self-harm is an issue predominantly affecting girls.[16]

Among young people with child protection contact for reported self-harm and suicidal ideation, only around a quarter (26.2%) also had a contact with a health service for these concerns. For around 1 in 10 (9%) of the children reported to child protection services for self-harm or suicidal ideation, the health service contact was made before the report to a child protection helpline, and for around 1 in 6 (17.2%) accessing a health service came afterwards – on average 349 days later than the report to child protection services. While this may indicate a lack of timely referrals from child protection to health services, it needs to be highlighted that potential contacts with private mental health practitioners, such as psychologists, psychiatrists, mental health nurses and Aboriginal health professionals are not captured in NSW-CDS data. It is therefore not possible to determine how many young people were referred from child protection services to private mental health services. However, it is nevertheless an important finding that a significant number of young people may come to the attention of child protection services without subsequent attention from health or mental health services for these issues.

The likelihood of having an entry for self-harm or suicidal ideation in any of these human services records was higher for some groups. For example, young people in regional and remote areas were 1.7 times more likely to have a record of self-harm or suicidal ideation; those whose parents had a history of criminal offending were 3.5 times more likely, and young people whose parents had a mental health disorder were four times more likely to have an instance of self-harm or suicidal ideation recorded by any agency. Young people from Aboriginal families were five times more likely to have a record for self-harm or suicidal ideation than non-Aboriginal young people. This is likely influenced by the on-going impacts for Aboriginal communities of colonisation, including social marginalisation, intergenerational trauma and individual as well as community levels of psychological distress.

Some young people were more likely to have a record for self-harm or suicidal ideation:

1.7x

more likely for young people in regional and remote areas

3.5x

more likely for young people whose parents had a history of offending

4x

more likely for young people whose parents had a mental health disorder

5x

more likely for young people from Aboriginal families

What does this mean for policy and practice?

The NSW-CDS research highlights the important role that child protection services can play in helping to reduce and prevent self-harm and suicide in young people. Young people at risk are more likely to be reported to child protection services than to secondary health services. The CDS data does not tell us how many young people receive support from primary health services for their mental health concerns. They do come to the attention of child protection services at a younger age and in equal numbers for girls and boys.

How does DCJ support young people that are reported to the Child Protection Helpline for self-harm or suicidal ideation?

When there is a concern that a child or young person is self-harming or thinking about taking their life someone in their networks, for example a teacher, a GP or a school counsellor may make a report to the DCJ Child Protection Helpline (13 21 11 - open 24 hours/7 days). DCJs role is to determine if the child is at risk of significant harm (ROSH) and to take appropriate action to keep them safe if they are at risk. The Helpline staff will ask detailed questions to carefully assess the situation. If they believe that the young person is engaging in behaviours that present a risk of significant harm to himself or herself and a parent or carer is not found to be providing adequate supervision and care, the report will be screened in and forwarded to the relevant Community Services Centre (CSC) for follow up. The young person may be at ROSH where the parent or caregiver is not responding to their medical needs (i.e., mental health needs), even if there are no other issues. In case of immediate danger, Helpline staff will ensure an ambulance is called.

The CSC will determine if the report should be progressed for further action and investigation. If the report is allocated, the caseworker at the CSC will contact relevant parties. When speaking with the young person, they will explore the young person's thoughts, feelings and actions in a safe and culturally responsive way to understand suicide and self-harm risk at the current point in time.If risk of significant harm is substantiated, caseworkers will identify and plan actions to keep the young person safe and ensure that they get the supports they need, in particular mental health supports. This may include a safety plan tailored to each young person's strengths and needs that outlines ways to cope when they are experiencing difficult thoughts or feelings about self-harm and/or suicide. It includes warning signs, reasons for living, ways to make the environment safe and a list of individual coping strategies as well as where and who they can go to for support. A psychologist from DCJs Psychological and Specialist Services can assist with this process. Wherever possible, caseworkers will also draw on the cultural knowledge of internal and external Aboriginal practitioners and community members or multicultural caseworkers to be able to support the young person in a culturally safe way. Risk of suicide and self-harm is dynamic and can change rapidly, it is therefore important that caseworkers continue check in with the young person and their support networks to ensure that they are safe and receiving the supports they need.

Based on the assessed needs and supports already in place, the caseworker may refer the young person to a community mental health service (such as Headspace) or DCJs Psychological and Specialist Services (for those in out-of-home care). For DCJ staff, the mental health practice kit on working with children and young people at risk of suicide and self-harm is available on Casework Practice.

DCJ supports young people in out-of-home care at risk of self-harm and suicide

DCJs Psychological and Specialist Services supports for young people in out-of-home care at risk of self-harm and sucide include:

- Clinical intervention services provide evidence-based interventions for children and young people and work with the broader network around them including carers, service providers, schools and casework teams. They offer a range of assessment services, as well as a range of intervention modalities such as positive behavioural support, Parent-Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), and group interventions and training (e.g., parenting and carer support, social skills groups).
- The LINKS Trauma Healing Service provides trauma-focused, evidence-based, support to children and young people in out-of-home care. LINKS is not just about psychology – it is about supporting children in a holistic way. Multidisciplinary teams include speech pathologists, occupational therapists, Aboriginal mental health clinicians and psychiatrists. They help children overcome behavioural and emotional issues and post-traumatic stress. There are four LINKS teams operating in Penrith, Newcastle, Western NSW and the Illawarra.
- The Elver program is a unique multidisciplinary and trauma-informed service designed to fill a gap in services delivery for children and young people in out-of-home care. Elver addresses the complex developmental and mental health needs of children in residential or intensive therapeutic care by impacting the child, their immediate care system and the broader DCJ, NGO, and NSW Health systems. The team includes a lead clinician, consultant psychiatrist, clinical psychologist, occupational therapist, speech pathologist, clinical nurse consultant, and social worker. Elver also provide seminars about trauma and supporting children's clinical needs.
- DCJ has introduced intensive therapeutic care (ITC) to support children and young people (over the age of 12 years) with high and complex needs who are unable to be supported in foster care or require specialised and intensive supports to maintain stability in their care arrangements. ITC provides a therapeutic residential care response to help children and young people recover from the complex impacts of trauma, abuse, neglect, separation from families and other forms of adversity, which may result in behaviours that present a risk to themselves and others. The care team and the Therapeutic Specialist work to address behavioural, emotional, psychological, educational and physical needs of children and young people.

The NSW Government is collaborating to reduce the risk of self-harm and suicide for children and young people in out-of-home care

- The Out-of-Home Care Health Pathway is a joint initiative of DCJ and NSW Health. The program acknowledges that a child or young person's experience of abuse and trauma prior to entering care can significantly impact on their physical, developmental and psychological health and wellbeing. The program aims to improve health outcomes through the provision and coordination of health assessments, interventions, monitoring and review of their health needs. Children undergo a primary health assessment, which looks at physical, developmental, psychosocial and mental health domains. Where mental health issues are identified, children are referred to a professional for further assessment and treatment. A Health Management Plan is developed and reviewed annually or earlier as needed.
- A cross-agency Out-of-Home Care Mental Health Reference Group has been established to oversee development of a cross-agency strategic framework and implementation plan to enhance the coordination, care, and access to mental health services across NSW for children and young people in care and those at risk of entering care.

Important information about suicide and self-harm for those working with children and young people

Myths and facts about suicide

Myth	Fact
Asking a person if they want to die or are suicidal will encourage them to do it.	Asking about suicide does not put the idea into someone's head. Rather, it provides an opportunity to talk about feelings and thoughts which may help lower anxiety and reduce the likelihood.
If a person attempts suicide and survives, they will not make another attempt.	Young people who have attempted suicide are 18 times more likely to try it again and are 40 times more likely to die by suicide in the future. In the three months following an attempt, a young person is at most risk of dying by suicide.
Once a person has decided to die by suicide there's no way you can stop them.	Suicides can be prevented, and people can be helped to stay alive. Immediate practical help such as staying with the person, encouraging them to talk and helping them build plans for the future, can be extremely helpful at preventing them from dying by suicide.
Suicide attempts are just attention-seeking, 'cries for help' or 'acting out.'	Many people who attempt suicide go on to later die from suicide. The attempt may be a rehearsal and is a worrisome warning sign. Someone who has attempted suicide may well be in profound distress and this should not be ignored.
Only a trained professional, like a psychologist, can provide suicide intervention.	All people who interact with those in crisis can help them by way of emotional support and encouragement. You do not need to be a professional to be able to ask someone if they are thinking of suicide, and then helping them to get the help they need to stay alive. Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.
Most young people who think about dying by suicide never ask for help.	Evidence shows that young people often tell their school peers their thoughts and plans or may share things through social media.
People who talk about suicide when under the influence of alcohol or drugs do not need to be taken seriously.	Anyone who talks about suicide should be taken seriously. Alcohol and other drugs are involved in many suicides and increase the risk significantly.

Source: DCJ Casework Practice – 'Suicide and self-harm'

Warning signs that a young person is self-harming

- wearing long sleeves or covering up (not due to religious reasons)
- low self esteem
- unexplained injuries such as cuts, burns, bruises
- changes in mood
- unwillingness to participate in events/activities which require less body coverage (e.g., swimming)
- inappropriate dress for seasons (e.g., long sleeves and jumpers in warm weather)
- relationship problems
- overuse of wrist bands or jewellery
- changes in sleeping or eating patterns
- explanations for injuries seem implausible or could only account for one instance, not all (e.g. “my kitten scratched me” or “I fell over and grazed myself”).

Source: DCJ Casework Practice – ‘Suicide and self-harm’

More information about the NSW-CDS Study

For more information about the original research, you can contact the NSW-CDS.

The original research papers are:

O’Hare, K, Watkeys, O, Dean, K, Tzoumakis, S, Whitten, T, Harris, F, Laurens, KR, Carr, VJ, & Green, MJ 2023, ‘Self-harm and suicidal ideation among young people is more often recorded by child protection than health services in an Australian population cohort’, *Australian & New Zealand Journal of Psychiatry*, vol. 57, no. 12, pp. 1527–1537, viewed 7 October, 2023, DOI 10.1177/00048674231179652.

O’Hare, K, Watkeys, O, Harris, F, Dean, K, Carr, VJ, & Green, MJ, 2023, ‘Self-harm and suicidal ideation in children and adolescents in contact with child protection services’, *Medical Journal of Australia*, vol. 218, no. 11, pp. 526-527, viewed 7 October, 2023, DOI 10.5694/mja2.51898.

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Endnotes

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