Queensland Family and Child Commission
Submission

To: **Queensland Mental Health Commission** **Date:** **17 May 2017**

Topic: **Renewal of the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019***

The Queensland Family and Child Commission (QFCC) is pleased to provide a submission to the Queensland Mental Health Commission (QMHC) on its discussion paper, *A Renewed Plan for Queensland: Reviewing the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019 to Improve Mental Health and Wellbeing* (Discussion Paper).

The QFCC supports the QMHC adopting an integrated and collaborative approach to achieving the Strategic Plan's long-term outcomes. The QFCC is pleased to note the QMHC's progress in implementing the Strategic Plan's actions to date and its commitment to continued reform.

This submission provides the QFCC's feedback in relation to the consultation questions posed in the Discussion Paper regarding the impact of mental illness and suicide.

Preventing and reducing the impact of suicide on Queenslanders

The QFCC supports:

- current responses to preventing and reducing the impact of suicide that are evidence-based and focus on vulnerable groups.

The QFCC recommends:

- a youth-focussed prevention strategy be developed, with the involvement of young people
- root cause analysis (RCA) findings be shared with agencies that have a role in death review
- postvention assistance be provided to Aboriginal and Torres Strait Islander communities
- postvention assistance be provided to affected young people, where a young person in out-of-home care has suicided
- non-state school sector be engaged with prevention strategies by sharing learnings from strategies implemented in state schools, and
- technology be utilised to reach youths at risk of suiciding.

1. What should the Strategic Plan focus on?
The current areas of focus identified in the Suicide Prevention Action Plan seem appropriately comprehensive.

However, the QFCC recommends unpacking the strategy further, and specifically developing a youth-focussed strategy, which would allow for mapping of the actions against the particular vulnerabilities of the group and identification of gaps and opportunities in prevention and intervention. The QFCC recommends young people should be involved in any development of a youth-focussed strategy.

2. What is likely to make the greatest difference?
An ongoing commitment to evidence-based actions and a focus on groups who are over-represented in suicide rates is likely to make a difference. The QFCC notes the *Queensland Suicide Prevention Action Plan 2015-2017* prioritised a stronger, more accessible evidence base and focussed support for vulnerable groups.

The QFCC also notes the characteristics of youth suicide, and therefore approaches to prevention, may differ from all population figures. Aboriginal and Torres Strait Islander over-representation in suicide rates is more dramatic amongst children under 18 years than the overall population. Over the last three years, the suicide rate for Aboriginal and Torres Strait Islander children was 3.1 times the rate for non-Indigenous children. This is compared to a figure of 1.6 for the overall population.[1]

However, male over-representation in suicide rates is less dramatic amongst the child population than the overall population. Over the last 3 years, the suicide rate for male children was 1.5 times the rate for female children. This is compared to a figure of 3.0 for the overall population.[2]

3. What has worked well?
An approach which has worked well is the arrangement between the QFCC and the Department of Education and Training (DET) whereby the QFCC notifies DET of student deaths which were possible suicides. This approach supports postvention in state schools.

The Queensland Suicide Prevention Health Taskforce (Taskforce) is an example of a positive approach to the provision of cross-sectoral health services. The Taskforce is a partnership between Hospital and Health Services, Primary Health Networks and people with lived experience of the impact of suicide. The Taskforce's purpose is to develop strategies, services and programs to be used in mental health service delivery.[3]

4. What is currently being done that works or could be improved?
Death reviews by various agencies allow for identification of systemic issues and provide a valuable information source for research. Information sharing currently occurs between relevant agencies allowing, for example, the QFCC to build the evidence base in the Queensland Child Death Register on the circumstances and characteristics of youth suicide deaths. Annual reporting by the QFCC identifies trends and issues in child mortality, and researchers are also able to access detailed data in order to conduct in-depth studies of causal and protective factors.

Where a person is receiving mental health treatment suicides, service agencies may conduct root cause analysis (RCA). A potential improvement would be sharing RCA reports, if conducted, with other agencies with a death review role.

5. What specific actions need to be taken for vulnerable groups?
The following gaps and opportunities have been identified:

- Postvention assistance provided to Aboriginal and Torres Strait Islander communities following a suicide, particularly of a young person. Postvention should focus on preventing and managing contagion.
- Postvention assistance provided to affected children and young people, siblings and carers following the suicide of a young person who is in out-of-home care.

[1] QFCC (2017), *Annual Report: Deaths of children and young people, Queensland, 2015–16*.
[2] Ibid.
[3] State of Queensland (Queensland Health), 2016. "Suicide Prevention Health Taskforce: Phase 1 Action Plan," p.6, accessed 21 April 2017, http://www.healthinfonet.ecu.edu.au/uploads/resources/32739_32739.pdf

- Engage with the non-state school sector to share learnings from suicide prevention and intervention activities currently being implemented in state schools.

A youth-focussed strategy could also explore opportunities better suited to young people, such as using new technologies and social media channels. Mobile phone applications could be used as a means of engaging and supporting children and young people at risk of suicide. Younger people are comfortable using this technology to access health information.[4] They are also comfortable with disclosing personal information in this context as they may believe it protects their confidentiality.[5] This could be a cost-effective way of supporting children and young people living in regional and remote communities who are at risk of suicide. Further, it could increase the likelihood they will access support services in the future.

Preventing and reducing the impact of mental illness on Queenslanders

The QFCC recommends:

- the Strategic Plan gives special consideration to the mental health of children in youth detention, especially those who have lived in out-of-home care, and
- the QMHC advocates for more mental health interventions and therapeutic youth detention models.

1. What specific actions need to be taken for vulnerable groups?

1.1 The vulnerability of children in youth detention

Children in youth detention have comparatively poor mental and physical health.[6] Studies have consistently found they have disproportionately high rates of mental illness compared with other children.[7] A New South Wales Government study found 87 per cent of detainees had one psychological disorder and 73 per cent had two or more.[8]

Children in youth detention are also vulnerable to developing a mental illness. The majority of children in detention have one or more risk factors, such as problematic use of alcohol or illicit drugs.[9] Studies have shown the rate of illicit drug use for children in youth detention is substantially higher than other children.[10]

[4] Nicholas et al, 2004. "Help-seeking Behaviour and the Internet: An Investigation among Australian Adolescents," *Australian e-Journal for the Advancement of Mental Health*, vol. 3, issue 1, pp.1-8, p.1.
[5] Ibid, p.2.
[6] Indig, D. et al, 2011. "2009 NSW Young People in Custody Health Survey: Full Report," pp.14-15, accessed 10 April 2017, http://www.justicehealth.nsw.gov.au/publications/ypichs-full.pdf
[7] Ibid, p.143.
[8] Ibid, p.145.
[9] Ibid, p.143.
[10] Indig, D. et al, 2011, p.143.

Another risk factor for mental illness is abuse and neglect.[11] Studies have shown the majority of children in youth detention have experienced some form of abuse or neglect[12] or have lived in out-of-home care.[13] Children are often placed in out-of-home care due to abuse or neglect.[14] Mental illness is also more common in children who have lived in out-of-home care,[15] whether or not they have contact with the youth justice system.

1.2 System responses

The Strategic Plan acknowledges the relationship between mental illnesses, substance use disorders and criminal offending. However, it does not specifically recognise the heightened vulnerability of young detainees or the need for a whole-of-Government response to improve their mental health and wellbeing.

It is important to address the mental health needs of children in youth detention as that environment has the potential to exacerbate pre-existing mental illnesses or trigger the development of a mental illness.[16]

The age and immature brain development of children in youth detention provide a unique opportunity to prevent and reduce the future impact of mental illness. Adolescence is the second and last significant period of 'heightened [brain] malleability' during a person's lifetime.[17] This evidence highlights the importance of targeted mental health interventions which focus on creating new neural pathways.

The QFCC also recommends the QMHC use the youth justice system reform process currently underway to advocate for a more therapeutic model of youth detention. The Missouri Model is one example of a trauma-informed approach to youth detention. In Missouri, United States of America, children are detained in 'residential facilities' and attend daily group therapy sessions together. They are also able to access intensive individual and family therapy. This is a particularly effective model as children are supported when they return to the community.[18]

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[11] Australian Law Reform Commission, 2010."Family Violence: A National Legal Response," Sydney, p.973.
[12] Alltucker, K. et al, "Different Pathways to Juvenile Delinquency: Characteristics of Early and Late Starters in a Sample of Previously Incarcerated Youth," *Journal of Child and Family Studies* (2006), quoted in The State of Queensland (QFCC), 2017. "The Age of Criminal Responsibility in Queensland," p.19.
[13] Australian Law Reform Commission, "Family Violence: A National Legal Response," (2010), quoted in The State of Queensland (QFCC), 2017. "The Age of Criminal Responsibility in Queensland," p.19.
[14] Australian Institute of Family Studies, 2016. "Children in Care," accessed 21 April 2017, https://aifs.gov.au/cfca/publications/children-care
[15] Tarren-Sweeney, M., 2008. "The Mental Health of Children in Out-of-home Care," *Current Opinion in Psychiatry*, vol.21, no.4, pp.345-349, p.345.
[16] Holman, B. and Ziedenberg, J. "The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities," p.2, accessed 21 April 2017, http://www.justicepolicy.org/images/upload/06-11_rep_dangersofdetention_jj.pdf
[17] Steinberg, L., 2014. "Taking Advantage of Adolescent Brain Plasticity" (2014), quoted in The State of Queensland (QFCC), 2017. "The Age of Criminal Responsibility in Queensland," p.25.
[18] The Annie E. Casey Foundation (2010) "The Missouri Model: Reinventing the Practice of Rehabilitating Young Offenders," Baltimore, p.20.

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