The Royal Australasian College of Physicians

5 June 2014

Ms Megan Mitchell
National Children's Commissioner
Australian Human Rights Commission
Level 3
175 Pitt Street
Sydney NSW 2000

Dear Ms Mitchell

Re: National Children's Commissioner- Examination of intentional self-harm and suicidal behaviour in children, 2014

The Royal Australasian College of Physicians (RACP) acknowledges that intentional self-harm and suicidal behavior is a leading cause of morbidity amongst children and young people and, in 2012, was the leading cause of death in young people aged 15-24 years in Australia. This is a major issue for our whole community, and one made all the more disturbing given that many of the contributing factors are preventable.

In Australia, paediatricians have been at the forefront of advocacy efforts for public mental health policies and initiatives that focus on the needs of young people. They have promoted awareness that successful programs in childhood and adolescence lead to better outcomes in multiple domains, ranging from improved healthcare, enhanced learning and academic performance, to improved social skills and more successful relationships later in life (RACP Position statement *The Health and Wellbeing of Incarcerated Adolescents, 2011).*

Of particular interest to paediatricians and adolescent medicine specialists are the following six points.

1. **Why children and young people engage in intentional self-harm and suicidal behaviour**.

The RACP position statement, *Routine Adolescent Psychosocial Health Assessment (2008)* identifies a number of factors that contribute to the high risk of psychosocial and emotional problems in adolescents. These include:

- adolescents engaging in multiple risk factors simultaneously and at an increasingly younger age.
- a significant proportion of adult mental health problems originating during adolescence.

- lifelong mortality and morbidity due to chronic illness often starting with the initiation of risk behaviours, such as smoking, poor eating and alcohol and drug use during adolescence.

Learning and developmental problems can contribute to a young person's vulnerabilities to mental health problems such as depression, and to difficulties in engaging with complex health service systems and recommendations. Children, adolescents and young people with intellectual disabilities have higher rates of mental health problems[i] as do children with speech and language disorders.[ii]

The RACP position statement *Early Intervention for Children with Developmental Disabilities (2013)*[iii] recognises that children with developmental disabilities are at higher risk of a range of health problems, including mental health problems, and recommends an increased awareness of these problems and implementation of strategies to reduce the risk as part of early childhood intervention.

Any examination of self-harm in young people should take account the greater incidence in vulnerable groups, such as young people questioning their gender identity or sexuality, newly arrived immigrants, Aboriginal and Torres Strait Islander young people and homeless young people, among others.[iv]

ABS data 2001-2010 shows that suicide rates for Aboriginal and Torres Strait Islander females aged 15-19 were 5.9 times higher than for their non-Indigenous counterparts, while for males the ratio was 4.4. There are also estimates that across the Top End, suicide by children, mostly boys, aged between 10 and 14 accounts for as many as four in five of all indigenous deaths by suicide. The population-based and clinical approach to vulnerable groups may require more targeted efforts.

There are substantial and systematic health inequities in Australia, with fewer attempts to deal with these compared to other developed countries.[v] Socioeconomic adversities add to the risk and burden of mental health problems. Recommendations to address inequities include:

- a whole of government response.
- a universal approach to early childhood prevention and health promotion.
- explicit plans to reduce inequity be developed.
- improved cultural competencies.

Not all self-harm has suicidal intention

Recently, an understanding that not all self-harm is related to suicide risk has emerged. Non-suicidal self-injury has been acknowledged in the new psychiatric classification system Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as a condition that requires further research before being formally classified as a disorder.[vi] This condition is separate to the self-harm seen in patients with Borderline Personality Disorder. This is supported by Australian research that shows most self-harming behavior in adolescents resolves spontaneously. This research by Moran and colleagues reports eight per cent of adolescents reported self-harm, which decreased to 2.6 per cent of the sample when the survey respondents were in their 20s. The rate of young people reporting self-harm with suicidal intention was very low at 0.8 per cent. The paper states*: "However, young people who self-harm often have mental health problems that might not resolve without treatment, as evident in the strong relation between adolescent anxiety and depression and an increased risk of self-harm in young adulthood. Our findings suggest that the treatment of such problems might have additional benefits in terms of reducing the suffering and disability associated with self-harm in later years. Moreover, because of the association between self-harm and suicide, we suggest that the treatment of common mental disorders during*

adolescence could constitute an important and hitherto unrecognised component of suicide prevention in young adults".[vii]

Suicide and impulsivity
Previous research has postulated that suicide is often an impulsive act, particularly in adolescence, however the evidence is contentious. Although impulsivity is a significant risk factor for suicide, a compelling mechanism for the relationship between impulsivity and suicide has not been adequately documented. Further, Simon et al showed that the majority of all suicides were in fact, planned.[viii]

Witte and colleagues further showed that adolescents who were classified as more impulsive were more likely to plan for suicide attempts than those who were not considered impulsive.[ix] Both theoretically and practically, the notion of impulsivity needs to be used to refine risk assessment and clinical decision-making when seeing adolescents.

2. 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 media can play a powerful role in educating the public about suicide prevention and can highlight opportunities to prevent suicides, but this needs to be carefully balanced with the significant risk of causing harm through suicide contagion. Suicide contagion, or copycat suicide is a real phenomenon, historically referred to as the Werther effect, after a spate of copycat suicides which occurred after the publication of Goethe's *The Sorrows of Young Werther*.

SANE Australia (www.sane.org) has developed guidelines for media reporting of suicide, consistent with international guidelines developed in collaboration with various US-based organizations including the Centers for Disease Control and Prevention, the World Health Organization, National Swedish Centre for Suicide Research, New Zealand Youth Suicide Prevention Strategy and various US-based organizations including the Centers for Disease Control and Prevention.[x]

Principles for media reporting include the following:

- Consider whether the story needs to be run at all.
- Use language carefully. Use the term suicide sparingly, and ensure that language does not glamourise, sensationalise or present suicide as a solution to problems.
- Do not be explicit about the method.
- In reporting celebrity suicides, be careful not to describe the methods, try to provide comment on the wastefulness of the act.
- Always provide a helpline number or resource at the end of each report.

Stories to consider covering include issues such as trends in suicide rates (which have been decreasing in adolescence over the past twenty years), recent management advances, myths and warning signs, stories which show how treatment was life-saving or how people overcame adversity to thrive without attempting suicide.

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

Evidence suggests that concerns about confidentiality can act as a barrier to accessing healthcare services, particularly in relation to aspects of sexual health, mental health care and substance use. Nearly one in five adolescents report having foregone healthcare because of concerns about their parents finding out. Adolescents are also more likely to disclose information about behaviours that involve health risk and are

more likely to return for review if they know their concerns will not be revealed to their parents or others. The RACP position statement, *Confidential Healthcare for Adolescents and Young People (12-24 years)*, 2010, contains a number of recommendations for primary, secondary and tertiary healthcare physicians and paediatricians, but are equally applicable for all healthcare professionals who work with adolescents and young people.[xi]

The whole basis of seeing a mental health professional is to develop a sense of trust and a safe space to discuss issues that are personal and sensitive. Breaches in confidentiality betray that trust (Female, sixteen years).

4. The conditions necessary to collect comprehensive information.

Information 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.

Multiple strategies to inform ongoing data collection ought to be utilised, including formal health data bases such as those noted above. In addition, due to the likely under reporting of self-harm in adolescents, surveys and other methods that retain anonymity would contribute to a whole of community picture of the rates and contributing factors to inflicted self-harm in adolescents and young people.

The Australian Institute of Health and Welfare has been collecting indicators on children and young people's health and regularly reported them through their reports *A Picture of Australia's Children* and *Young Australians: their health and wellbeing*.[xii] [xiii] It is important that population data continue to be collected to inform national policy, program and practice planning, and development. For example, the recent National Health and Medical Research Council "Mental Health Targeted Call" grant supporting research into preventing suicide in Aboriginal and Torres Strait Islander youth is a positive step in growing the evidence base for this population who is at particular risk.

5. 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 RACP position statement, *Routine Adolescent Psychosocial Health Assessment (2008)* notes that research has found that adolescents wish to discuss a broad range of health concerns with health professionals but are reluctant to discuss sensitive issues unless asked directly and confidentially.[xiv] This position statement makes a number of recommendations including;

a. routine psychosocial health assessment.
b. a framework such as HEADSS (Home, Education and Employment (Eating and exercise) Activities and peer, Drugs, Sexuality, Suicide and depression, Safety and Spirituality).
c. Development of a comprehensive management plan.

Paediatricians often detect vulnerabilities in the patient and/or their family that may predispose them to mental health issues and self-harm, and identify early signs of mental health problems. Other healthcare providers such as GPs, emergency department medical specialists, Aboriginal and Torres Strait Islander Health Workers and nursing staff may also be involved in the early assessment of adolescents presenting with mental health problems, inflicted self-harm, or physical health concerns with underlying mental health problems.

Paediatricians are often the first port of call for children and young people with mental health conditions, often presenting either as a physical health issue (e.g. chronic or recurrent pain), problem behaviours (e.g. disruptive at school) or a physical manifestation of a mental health condition (e.g. fainting or shortness of breath due to panic attacks). Anecdotally, young people reporting self-harm is not uncommon, however there are no published rates in the literature. All paediatricians must complete a six-month rotation in community oriented paediatrics (which may include Community Child Health, Adolescent Health or Child Psychiatric training). Nevertheless, many still report a lack of confidence in dealing with young people with mental illness, self-harm and suicidal ideation.

Approaches to address this could include:

a. all healthcare professionals who treat adolescents and young people have a baseline level of training that encompasses issues such as comorbidity, confidentiality, consent.
b. adolescent physicians be utilized within the hospital and health care system to provide leadership for adolescent healthcare.
c. models of care be developed that integrate across paediatric and mental health care services to develop pathways for referral and collaborative management.

Particular concerns include a lack of youth mental health resources, a problem exacerbated in rural and regional areas, and also a lack of culturally safe services to support Aboriginal and Torres Strait Islander youth in regard to their social, emotional, cultural and spiritual health and well-being. Referring patients to child and adolescent area mental health services (CAMHS) or similar services is often difficult, with young people and their families often facing frustrating and potentially harmful delays. Because CAMHS are only able to accept the most severe cases, many children and young people are not accepted for care through CAMHS, thus having to rely on private Medicare-funded mental health (often through the Better Access initiative or through the relatively sparse community services like headspace).

Approaches to address this could include:

a. mapping of existing mental health services, especially those targeting adolescents and young people.
b. enhance availability of mental health services.
c. paediatricians are an important stakeholder and should be consulted in any mental health system planning.

Interagency engagement in prevention and intervention strategies is crucial to the early detection and intervention for self-harm and suicidal behaviours in adolescence. In addition to health care services, education and child protection services must be involved in strategic plans to identify and respond to risk and actual harms.

There's such little awareness (in schools) and the awareness that is there is so superficial. There is still a stigma and that leads people to act in harmful ways, and even insignificant comments can be powerful (female, seventeen years).

6. **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**.

Organisations such as the Young and Well Cooperative Research Centre and Reach Out have led the way in developing and promoting the potential benefits of digital

technologies in health promotion, suicide prevention and responding to suicide attempts. See www.youngandwellcrc.org.au and www.inspire.org.au for further details.

Conclusion

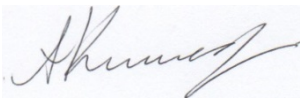
Paediatricians and adolescent medicine specialists share concerns about the high prevalence and substantial impact of inflicted self-harm and suicidal behaviours. Addressing this burden of disease must involve paediatric and adolescent medicine specialists, with increased emphases on training, identification of predisposing and risk factors and collaborative pathways to care.

The RACP thanks Commissioner Mitchell for instigating this inquiry, and looks forward to the 2014 Statutory Report.

Yours sincerely

Professor Nicholas J Talley
President

Dr Nicola Murdock
President – Paediatrics & Child Health Division



Dr Andrew Kennedy
Chair – Adolescent and Young Adult Medicine Committee

Further reading and references:

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2. Reporting on Suicide: Recommendations for the Media. CDC etc developed in collaboration with the WHO, National Swedish Centre for Suicide Research, New Zealand Youth Suicide Prevention Strategy
3. SANE Media Centre. Summary of Mindframe guidelines for media reporting of suicide

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[ii] Keating, D., Turrell, G., & Ozanne, A. (2001). Childhood speech disorders: Reported prevalence, comorbidity and socioeconomic profile. Journal of Paediatrics and Child Health, 37(5), 431-436.
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[viii] Simon GE, Rutter CM, Peterson D, Oliver M, Whiteside U, Operskalski B, Ludman EJ. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? Psychiatr Serv. 2013
[ix] Witte et al. J. *"Impulsive" youth suicide attempters are not necessarily all that impulsive.* Journal of Affective Disorders 2008. http://dx.doi.org/10.1016/j.jad.2007.08.010.)
[x] Centers for Disease Control and Prevention. *Reporting on Suicide: Recommendations for the media.* Available at: http://www.sprc.org/sites/sprc.org/files/library/sreporting.pdf
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[xiii] AIHW 2011. *Young Australians: their health and wellbeing* 2011. Cat. no. PHE 140. Canberra: AIHW.
[xiv] RACP. 2008. *Routine adolescent psychosocial health assessment – Position Statement.* RACP.