Grand Pacific
H E A L T H

medicare local
ILLAWARRA-SHOALHAVEN
Connecting health to meet local needs

2 June 2014

National Children's Commissioner
Australian Human Rights Commission

GPO Box 5218
SYDNEY NSW 2000

Dear Commissioner

I write in response to your call for submissions on 22 April 2014 regarding the need examine intentional self-harm and suicidal behaviour in children. This submission will focus on two of the areas you identified as being of particular interest to the Commission:

1) why children and young people engage in intentional self-harm and suicidal behaviour; and
2) 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.

The information in this submission is based on the work of the Illawarra-Shoalhaven Medicare Local (ISML) Suicide Prevention program, which is funded by the Department of Health under the Access to Allied Psychological Services (ATAPS) initiative. The Suicide Prevention program is run in partnership with headspace Wollongong and headspace Nowra, focusing on helping young people (12-25 years old) who are at risk of suicide or have engaged in self-harm behaviours.

As part of routine clinical care within the Suicide Prevention program, all clients complete a range of questionnaires and structured clinical interviews. These measures help staff to assess and monitor each client's level of risk over the course of treatment as well as inform treatment planning. One of the measures completed by clients focuses on the functions of self-harm, asking them directly what purpose(s) self-harming serves for them. We want to take this opportunity to share some of what we have learnt from this measure about how young Australians are engaging in self-harm behaviour.

When asked how many times they have ever self-harmed, the young people in our program report an average of 316 separate occasions, with some reporting as much as over 4,500 occasions of self-harm. In terms of ongoing self-harm behaviour, clients report an average of 27 occasions of self-harm per week as they enter our treatment program.

The main form of self-harming is cutting, with 59% of clients identifying this as their primary form of self-harm and over 82% reporting having cut themselves at least once. The mean age of onset for self-harming amongst our clients is 13.5 years old, but some report starting as young as 8 years old. The vast majority of clients (77%) self-harm when alone, making it more difficult for others to intervene.

It is also worth noting that, despite our clients voluntarily participating in a Suicide Prevention program, only 53% of clients report actually wanting to stop self-harming, with another 40% being ambivalent and 7% overtly stating they do *not* want to stop. Consistent with your question about why young people self-harm, we believe that understanding the functions of their self-harm is particularly crucial to helping those who are not yet committed to reducing their self-harm behaviour. Here, we outline what the clients of our treatment program are telling us regarding this question.

Why children and young people engage in intentional self-harm

The *Inventory of Statements About Self-injury* (ISAS; Klonsky & Olino, 2008) focuses on identifying the functions of a person's self-harm behaviour. To do this, it provides a list of 40 possible phrases to complete the sentence "When I harm myself, I am...". Examples of phrases are "calming myself down", "punishing myself", or "seeking care or help from others". Clients rate each phrase on a 3-point scale of *very relevant*, *somewhat relevant* and *not relevant*.

Client responses can be summarised using 2 scales – *intrapersonal functions* and *interpersonal functions*. If a client has endorsed intrapersonal functions strongly, it suggests that they use self-harm as a way of influencing their own internal experiences. If a client has endorsed interpersonal functions strongly, it suggests they use self-harm as a way of influencing their interactions with other people. To analyse the functions of self-harm even further, these two scales can be broken down into 13 sub-scales (see Table 1).

Table 1 - Mean score for functions of self-harm

	n	M	SD	Range
intrapersonal functions of NSSI	217	16.93	6.54	0 to 30
affect regulation	217	4.49	1.60	0 to 6
anti-dissociation	217	3.18	1.95	0 to 6
anti-suicide	217	3.10	2.02	0 to 6
marking distress	217	2.03	1.81	0 to 6
self-punishment	217	4.14	1.87	0 to 6
interpersonal functions of NSSI	217	6.31	6.47	0 to 48
autonomy	217	0.71	1.23	0 to 6
interpersonal boundaries	217	1.39	1.55	0 to 6
interpersonal influence	217	0.63	1.12	0 to 6
peer-bonding	217	0.18	0.70	0 to 6
revenge	217	0.29	0.93	0 to 6
self-care	217	1.41	1.45	0 to 6
sensation-seeking	217	0.64	1.14	0 to 6
toughness	217	1.07	1.53	0 to 6

The functions of self-harm most strongly endorsed by young Australians in our Suicide Prevention program are:

- *affect regulation* – minimising negative emotions (and perhaps triggering positive emotions)
- *self-punishment* – inflicting suffering upon oneself for perceived wrongdoing(s) or fault(s)
- *anti-dissociation* – causing physical pain to bring oneself mentally back to the present moment

It is also worth noting that *anti-suicide* is the fourth most endorsed function of self-harm by our clients (see Figure 1), which suggests many are using self-harm as a way of preventing their emotional distress from escalating to the point where they believe they may attempt suicide. For these young people, self-harm is clearly a protective behaviour and should only be reduced *after* alternative (more healthy) coping strategies have been successfully trialled and reinforced.

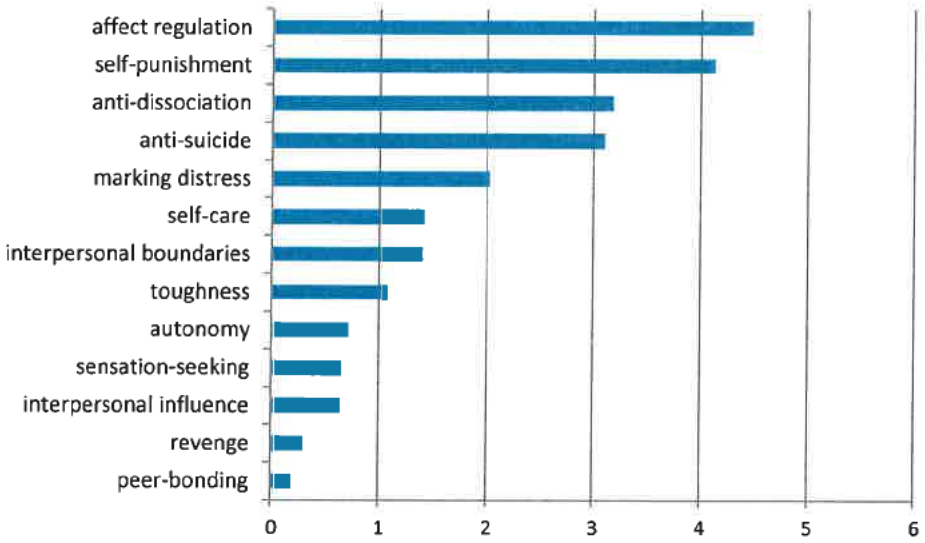

Figure 1 - Functions of self-harm, from most endorsed to least endorsed

Contrary to the common misconception that young people engage in self-harm behaviour as a way of identifying with their peers, the function of *peer bonding* was endorsed the least of all by our clients. Our findings highlight how important it is for families, service providers, teachers etc to avoid believing the myths about self-harm and instead show genuine interest in the underlying reasons for this behaviour.

We suspect that the 47% of our clients who are ambivalent about stopping or currently unmotivated to stop self-harming have genuine reasons for continuing to engage in self-harm behaviour. Therefore, our clinical staff work hard to explore the functions of their self-harm *before* looking to

reduce it. This is crucial for both therapeutic engagement with young clients and for preventing suicide.

Self-harm is one of the most significant predictors of a future suicide attempt and is, therefore, an important focus of our Suicide Prevention program. However, not all young people at risk of suicide are engaging in self-harm behaviours. In fact, 6% of our clients report experiencing active thoughts about suicide but never having self-harmed.

What types of programs and practices effectively target and support children and young people who are engaging in intentional self-harm and suicidal behaviours?

The evaluation framework that is embedded within the ISML Suicide Prevention program also enables us to analyse how young people are responding to treatment. This is important because our treatment is based on the requirements of ATAPS funding, a Federal Government initiative that every Medicare Local across Australia is mandated to use for suicide prevention work. The funding prescribed certain elements, and leaves others for the Medicare Local to shape based on local needs.

This ATAPS Suicide Prevention funding allows for 2 months of unlimited sessions of psychological treatment (or 3 months for Aboriginal or Torres Strait Islander Peoples). It incorporates a phone support service that is available 24-7, and Medicare Locals are expected to ensure clients are phoned within 24 hours of referral and seen face-to-face within 72 hours of referral. With this funding, we are able to provide short-term but flexible psychological treatments to people in crisis. We are able to increase the 'dosage' (by seeing clients more than once per week) if needed, and these sessions do not count against their quota of available sessions under other funding programs (e.g. Better Access).

Our results show that treatment provided under this funding is effective in significantly reducing clients' depressed mood, anxiety, hopelessness and general emotional distress (see Figure 2). And these improvements in mood are accompanied by significant reductions in self-harm behaviour (see Figure 3).

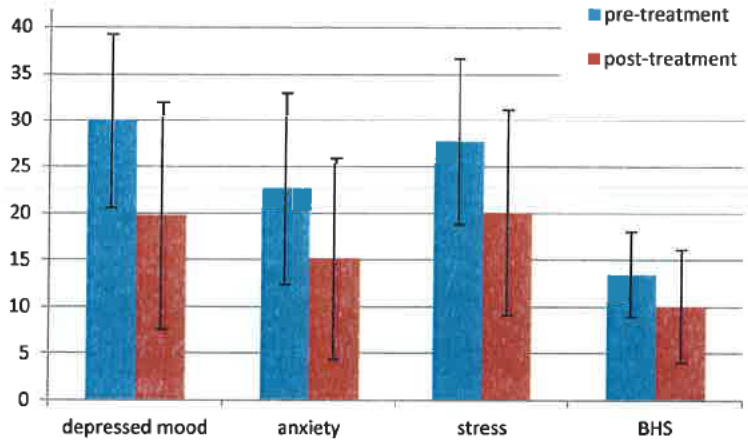

Figure 2 - Means scores from the *Depression Anxiety Stress Scale* ($DASS_{21}$) and the *Beck Hopelessness Scale* (BHS) pre- and post-treatment

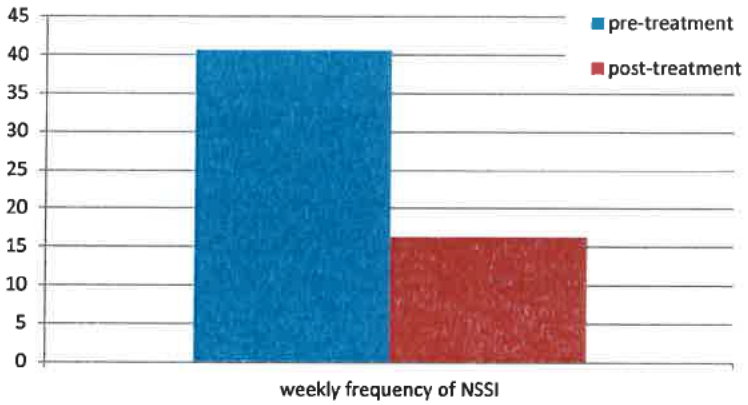

Figure 3 - Mean weekly frequency of non-suicidal self-injury (NSSI) behaviour pre- and post-treatment

To gain a more sophisticated understanding of a person's risk of suicide, the ISML Suicide Prevention program incorporates measures related to factors defined by the *Interpersonal Theory of Suicide* (Joiner, 2005). More specifically, we use two self-report questionnaires – the *Interpersonal Needs Questionnaire* (INQ) to measure *perceived burdensomeness* and *thwarted belongingness*; and the *Acquired Capacity for Suicide Scale* (ACSS) to measure *acquired capacity for suicide*. Joiner's theory posits that suicidal ideation occurs when a person feels that others would be better off if they were dead (i.e. perceived burdensomeness) and they experience a lack of meaningful and reciprocal relationships (i.e. thwarted belongingness). When they are hopeless about these factors changing for them, they are highly likely to have thoughts about death and possibly suicide. These thoughts

will not translate to suicidal behaviour without a certain level of fearlessness about dying and possibly an increased pain tolerance (i.e. acquired capacity for suicide). The role of these factors is illustrated in Figure 4.

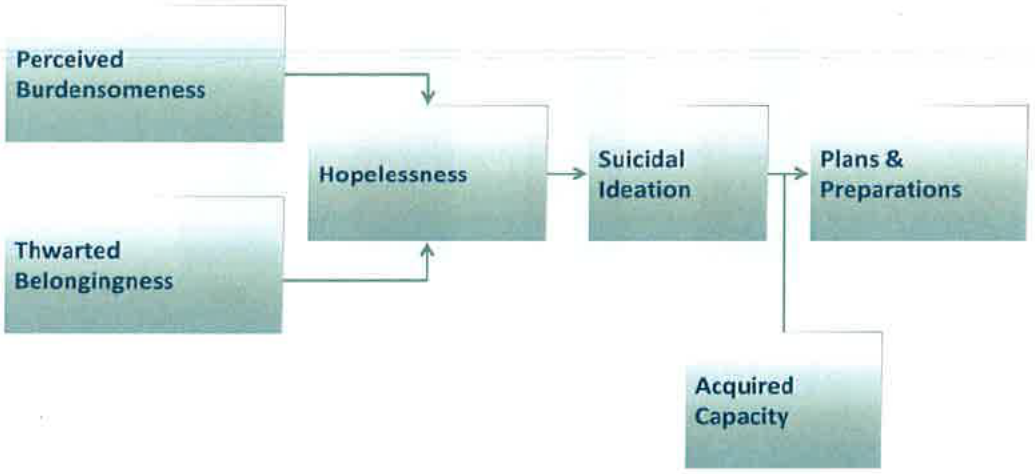

Figure 4 - Interpersonal Theory of Suicide (Joiner, 2005)

Pre- and post-treatment results on these factors show improvements in perceived burdensomeness, suicidal desire and ideation, and resolved plans and preparations (see Figure 5). The reduction in a sense of burdensomeness is consistent with anecdotal accounts – clients believe their struggles are a burden on their families, but when they do actually communicate their struggles with their parents, they experience a notable sense of relief and receive genuine support.

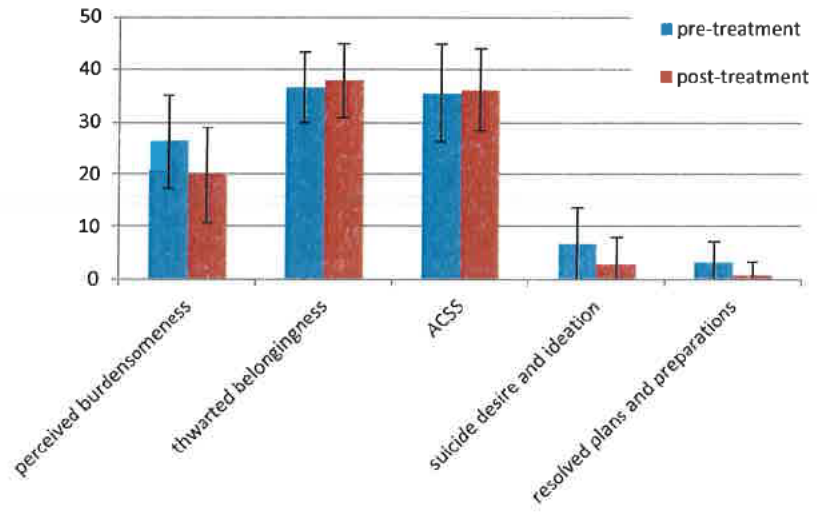

Figure 5 - Mean scores on the Interpersonal Needs Questionnaire (INQ), Acquired Capacity for Suicide Scale (ACSS), and the Modified Scale for Suicideal Ideation (MSSI) pre- and post-treatment

When averaging the scores of all clients together, thwarted belongingness and acquired capacity for suicide do not change significantly over the course of treatment. It is perhaps difficult for a short-term treatment to overcome the sense of disconnection and social isolation that has developed for clients prior to referral, and it is possible that treatment has in fact slowed down the rate at which their sense of isolation was increasing.

Joiner (2005) argues that acquired capacity for suicide consists of two elements – fearlessness towards death, and pain tolerance, both increased over time through a process of gradual desensitisation. As a result, acquired capacity for suicide does not fluctuate like perceived burdensomeness or thwarted belongingness. Instead, acquired capacity once cultivated, is either relatively static or further grows. Therefore, the finding that clients of the ISML Suicide Prevention program report no reductions in acquired capacity for suicide over the course of treatment is unsurprising. Again, it is possible that treatment has in fact slowed down the rate at which this factor would have increased if no treatment were provided.

In summary, a short-term psychological treatment for young Australians does appear to be an effective treatment in reducing risk of suicide and rates of self-harm behaviour. Two factors we consider essential for this positive finding are (1) the funding allows a psychological model (delivered by a multi-disciplinary team) rather than a purely medical model, and (2) the funding demands services ensure the capacity for a rapid response to engage the young people when in the midst of their crisis.

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We would like to take this opportunity to thank you for calling for submissions on this very important issue. We hope that communicating our experiences of providing suicide and self-harm prevention services with young people will help inform your recommendations.

Please do not hesitate to contact us if there is anything else we can help you with.

Kind regards,

Alex Hains
Mental Health Manager
Illawarra-Shoalhaven Medicare Local

Illawarra-Shoalhaven Medicare Local acknowledges support received from the Australian Government Department of Health.