**Submission to the National Children's Commissioner, Australian Human Rights Commission**
**"Self-harm and Suicidal Behaviour in children (under 18 years of age)"**

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## Preamble

*At low tide, from the shores of Bribie Island, Queensland, you can see the remains of the SS Avon sticking up from a sandbar in Pumicestone Passage. At high tide there is nothing to see, and buoys and markers are used to warn recreational boaties of the danger of possible shipwreck. Educated and wise sailors heed the warnings; risk-takers or the ignorant end up in trouble. As with all wrecks, the curious peer at a ship's skeleton and wonder how it happened, shaking their heads and counting the loss of human life. Now there are even kayak tours that can be taken to view our sandbar and wreck. Pumicestone Passage does not have gold or wealth at the top end, or much in the way of iconic sights to see. If it did, it would not just have markers to show the dangers; it would be dredged to allow the maximum traffic to benefit from easy and safe access through the passage.*

*Self-harm and suicide are like shipwrecks. They occur all around the world. Underlying causes and risk factors are each associated with multiple deaths, and the remains tell us there were hidden rocky outcrops or reefs or sandbars laying in wait. We look at the numbers of deaths, shake our heads, and feel sad; we set up marker buoys to help others avoid tragedy. The majority of dangers can be managed if you know they are there, are resourceful and confidant enough to plan your life's journey with care and caution, and get good advice from those who have gone before. The educated and wise heed the warnings; the ignorant and those who take risks, or the troubled who do not take due care, end up in trouble.*

*If we believe in Mental Wealth as underpinning the greatness of Australia, then we will provide better maps of how to attain it and better training for young people on how to avoid the shoals and reefs of life. We will make sure that the marker buoys are obvious and well-maintained to provide confidence to life navigators at each bend in their journey. Alternatively, we might also want to dredge out the 'help-seeking' passages to ensure that access to Mental Wealth is available without danger, and to all. Finally, we need to provide the very best maps on 'recovery' for those guiding others to avoid the shoals and reefs of life, particularly after they have once run aground.*

*Data is not necessarily Information*
*Information is not necessarily Knowledge*
*Knowledge is not necessarily Wisdom*
*And none of the above is Action*

*"When all is said and done, there is a lot more said than done"* (Aesop, 620-560 BC)

## Focus for this Submission

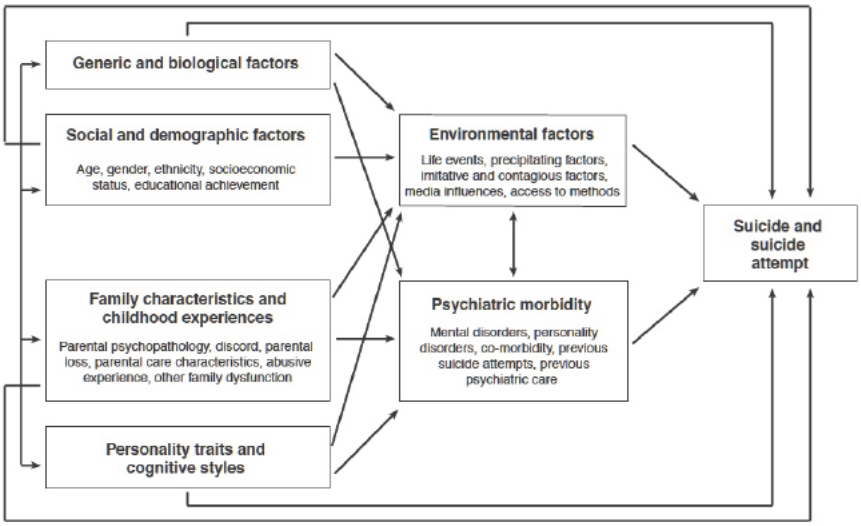
**"How children and young people under 18 years can be better protected from intentional self-harm and suicidal behaviour."**

The essence of this submission is that we should be very careful not to waste scarce public resources on setting up expensive systems to gain lots more Data and Information. Rather we should take what we know already, and use scarce public resources to provide the best possible practice in Prevention of Child and Adolescent Suicide, as well as improving the understanding, and the intervention and therapeutic skills, of professionals who come into contact with children who may be at risk for self-harm and suicide.

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

In an NHMRC literature review on Risk Factors for youth suicide (Commonwealth, 1999), Annette Beautrais explored risk factors for suicide and attempted suicide among young people, and provided a useful diagram (page 123) demonstrating the interplay of environmental, social and personal factors underpinning suicidal behaviours. While the NHMRC cautiously notes this is now a somewhat elderly document, and while it may miss some of the nuances deriving from more recent work, it still provides a sound basis to our considerations.

**Figure 1.2 Conceptual model of domains of risk factors for suicide and suicide attempt**




In our own research work we initially focused on suicidality and risks for suicide in adolescents, but have latterly shifted our focus to self-harming behaviour, particularly non-suicidal self-injury - which shows promise as a key warning sign for later suicidality, and is an obvious target for, and amenable to, intervention.

Overall in our research, we have been able to contribute information on

**parenting styles** (Martin & Waite, 1994; Allison, Pearce, Martin, et al., 1995; Martin, Rozanes, Allison, et al., 1995; Pearce, Martin, & Wood, 1995; Allison, Pearce, Martin, et al., 1996; Martin, Bergen, Allison, et al., 2004; Baetens et al., 2013; Baetens et al., 2014), from which we conclude that we CAN measure parental influence, and that relatively uncaring and overprotective or intrusive parents will increase the likelihood of depression and suicidal behaviour in their children.

In addition, **family style** CAN be measured and influences suicidality (Martin, Rozanes, Allison, et al., 1995; Martin, 1996), in that less structured and chaotic families, with poor communication styles, and low tolerance for emotion are likely to increase self-destructive behaviour.

We have been able to contribute to the literature that suggests **sexual abuse** in families is a key underpinning of later suicidality (Martin G., 1990; Martin, 1996; Beckinsale, Martin, & Clark, 1999; Bergen, Martin, Richardson et al., 2003. Bergen, Martin, Richardson et al., 2004; Martin, Bergen, Richardson et al., 2004; Swannell, Martin, Page et al., 2012).

We have examined the role of psychological factors such as **depression** (Martin, Rozanes, Allison, et al., 1995; Martin, 1995a; Martin, 1995b; Allison, Roeger, Martin, & Keeves, 2001; Roeger, Allison, Martin, et al., 2001; Martin, 2001), **rumination** and **optimism**, **resilience**, but also the place of **social supports** (eg Rotolone & Martin, 2012), and population attributable risks (Krysinska & Martin, 2009; Li, Page, Martin, et al., 2011)

We have investigated the **influence of media suicide** in young people (Martin, 1996; Martin & Koo, 1997; Martin, 1998.), but also the impact of suicide in a school (**see below under 2. Contagion and Clustering**)

A key to whether a young person needs to self-harm or attempt suicide appears to be **emotion regulation**, the ability to control whatever the level of negative emotion, from wherever that springs (Hasking, Coric, Swannell, Martin, et al., 2010; Voon, Hasking, & Martin, 2014a; Voon, Hasking, & Martin, 2014b). We believe that emotion regulation may be a key factor at what has been called the 'tipping point' to suicidal acts, in that if you have skills to contain emotion you may well turn aside from the act and survive.

In people who have given up self-harm activities, and moved on, through several studies we have now found that emotion regulation has improved. In addition, in some of our therapy studies, we find that emotion regulation seems to be a key factor that improves, alongside reduction in self-harming behaviours.

Overall, I believe we can conclude that a model such as the one portrayed above, not only informs how we understand the development of a pathway to suicide, but also provides a blueprint on which we can base preventive activities.

## 2. The incidence and factors contributing to contagion and clustering involving children and young people.

I have a core belief that in every high school in Australia we can identify a number of students who are troubled mentally, and at considerable risk for poor learning, but also for the development of mental health problems, which may later endanger their lives. I believe it is these young people who are more

likely to identify with a suicide, and therefore at risk of copycat, and contagion. Their rationale is often: "She has succeeded in killing herself; I have tried several times before, but this time I will succeed." (actual quote from a student).

**We should not be surprised at all when a suicide cluster occurs.**

Let me explain how I got to that conclusion.

In our early clinical experiences of suicide in young people in the late 1980s, we attended schools, by invitation, following a suicide of a student. The aim was to provide some 'grief work' and support to both surviving students and teachers. We were overwhelmed to find that amongst classmates, there were a number of students in each school who had been influenced to attempt suicide or self-harm. These experiences were published as three papers in an Australian journal, ***Youth Studies***, and later formed the basis for our attempts to understand **Early Intervention** (Martin, 1992a; Martin, 1992b; Martin, Kuller & Hazell, 1992). These findings spurred us to try to help schools to deal with the aftermath. I had the privilege to do numerous presentations to school staff groups over time to apprise 40 odd schools of something they did not appear to appreciate (and in some cases, actively tried to avoid). With some private money, we made a videotape "*Recognising the Signs*" which we showed to school staff in South Australia, and later to a large number of students – with permission of parents, and active support after the showing and discussion. We never had an adverse event from this – that is a copycat. We believe the video was salutogenic.

The video later formed the basis of a Commonwealth funded, videotape based, national training program to educate General Practitioners in Early Recognition and Intervention "*Keep Yourself Alive*". We ultimately trained 3,500 GPs and 5,000 community health works, seeding nearly 5,000 training kits in the community in a vain attempt to get a train-the-trainer process going.

The second outcome from our early experience was a belief that it is possible to identify young people with mental health problems in schools. A state-funded program "*Early Detection of Emotional Disorders*" led to us completing a three-wave program over three years with 3000 young adolescents (13.5 yrs at start) from 27 schools in South Australia. We believe our results prove that you can identify young people at risk for later suicidality, and we developed an algorithm to do this from our work. (see Martin, Roeger, Dadds, & Allison, 1997). A number of our publications derive from this program.

The problem with our results was that young people (or their parents, or the schools) did not want to follow through with deeper assessment and intervention from our very willing mental health service staff. Ultimately (maybe because of the fear of stigma) only 10% of those we deemed at risk (14%), attended. However, clinical assessment confirmed that they did need help – which we provided.

More recently we have changed the focus and methodology (but with the same intent – ie suicide prevention). We have had access to a program "*The Aussie Optimism Program"* devised by Professor Clare Roberts at Curtin University.

The program is in the majority of primary schools in WA, but uptake elsewhere in Australia has been slow. Rather than just 'run the program' in Queensland high schools, we evaluated it. That is we did short assessments of mental health prior to, and at the end of, the program (the Strengths and Difficulties Questionnaire (25 items), the CES-D (validated internationally to measure depression in adolescents, 20 items) and The Hospital Anxiety Scale (HADS; 5 items) Life Orientation Test (LOT-R; 6 items; measures optimism), and four questions on Delusions and Hallucinations (from the Diagnostic Interview Schedule for Children (DISC). We have found these latter 4 questions useful in confirming young people with altered cognition and loose associations (Swannell, Martin, Scott, et al., 2007; Scott, Welham, Martin, et al., 2008; Scott, Martin, Welham et al., 2009; Martin, Thomas, Andrews et al., 2014).

We have found that the program creates considerable change over the 20 weeks (one hour per week). But what has been of most interest is that we identify a number of young people who do NOT improve during the program despite attendance. We discuss all the information with school counselling staff and other senior staff, and help them to decide how to manage the students. Of note, about half of these 'difficult students' are well known already, but the others are discovered through the process. They are then put in touch with appropriate counselling programs or processes.

**Many of these 'difficult' students are also prone to self-harming behaviours. They are 'discovered' by a helpful program, and their relative lack of response to the program. They are then provided with relevant help.**

Unfortunately we have not been able to gain any money to do more than work with a handful of schools prepared to pay for the training materials (Curtin Uni), the assessment process, and the feedback and support program.

One of our schools in Queensland has built on this process to develop a **Wellness** focused program in their school (what they term 'The Well'). Over the last three years they have got to the point where they now report a large number of support and counselling sessions, but NO episodes of self-harm within a school year. I have encouraged the principal of the school to provide a submission to the Commission to describe in detail what they are doing.

**Nobody should be surprised or shocked that contagion occurs, when there is always a pool of troubled young people who feel they should be getting more emotional support, and are just waiting for a crisis to prompt them to actively seek help.**

What we should be doing in Australia is to have in-built Wellness programs for all students in every school. We should be measuring their progress in mental health, and actively intervening with those that need help – before some devastating and irrevocable disaster occurs.

Elsewhere on my 'blog', I have argued for a program parallel to the recently introduced NAPLAN program, and called WELLPLAN. (http://child2100.blogspot.com.au/2014/04/suicide-in-young-people-should-never_5.html)

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

(Having recently completed an editorial reviewing this area, I have taken the liberty of including the whole text (Martin, G., On Help-seeking. Editorial. Advances in Mental Health, 11:1, 2-6.)

In a recent Commonwealth funded review of international suicide prevention strategies (Martin & Page, 2009), we concluded that strategies in place for more than ten years appeared to significantly lower suicide rates (particularly for male rates). We suggested that: "the best strategies take a nation-wide approach. They aim to provide a communication program to the whole population, with education targeted at all relevant groups. In particular there is specific education for all groups defined as 'gatekeepers'. There is an attempt to both improve existing services that may have to deal with suicidal people, as well as the linkages with the community in general. In addition, there is an attempt to provide a critical mass of clinical services with relevant and sufficient highly trained professionals at all levels" (p. 75).

This critical mass of professionals trained in managing suicidal people is central, but exactly what it is they do to make a difference is somewhat unclear. If we consider admission of suicidal people to dedicated mental health services (as I did in my last editorial 'On Wisdom in Mental Health Care', Martin 2012), there is strong UK evidence that several key organisational strategies (removing 'hanging points' in wards, assertive outreach, 24-hour crisis teams, seven day follow-up, managing non-compliance, written policy on dual diagnosis management and sharing information with criminal justice agencies, multidisciplinary review and sharing of information with families after a suicide, and training of staff) *in combination* contribute significantly to saving lives (While et al., 2012). Of note, the type and quality of the individual's therapy were not discussed.

However, the majority of people with suicidal thinking will never be admitted to a mental hospital; they are managed by community based organisations or individual practitioners with relevant skill. The commonly accepted wisdom here is that it is the quality of the therapy that makes the difference, and this may be understood to be the type of interpersonal therapy provided, perhaps based in the therapeutic relationship or, in medical systems, the type of medication. The type, dosage and duration of specific talking therapies and the type, dosage and duration of particular medications have become the somewhat obsessive focus of research and clinical training in recent years. Recently, though, both have been called into question in the context of suicide prevention.

Again referring to our review of national strategies, we said: "we think we know that antidepressants (particularly Selective Serotonin Reuptake Inhibitors - SSRIs) not only improve depression, but also reduce the likelihood of suicide attempts (eg Simon et al., 2006). Increased SSRI prescribing appears to have reduced suicide rates in some countries (eg Isaacson, 2000).... However, more recent research has disputed the direct causal effect of increased prescribing on suicide rates, noting that rates began to fall *prior to* the onset of increased use of antidepressants (Reseland et al., 2006)". That is, something about 'putting the strategy in place' (in this case in Finland in 1992) began to reduce

the deaths from suicide. Could it have been the general increased awareness of suicide and its prevention that led to increased knowledge that help was possible, which in turn led to help-seeking and a *subsequent* increase in prescribing?

Similarly, as we noted in our review, "We think we know that Psychotherapy and psychosocial treatments (eg Cognitive Behavioural Therapy or Dialectical Behavioural Therapy) for mental disorders reduce suicidal behaviour (eg Brown et al., 2005). However, recent work suggests the impact of psychotherapy in a community or population could be simply the availability of psychotherapists (as a proxy for relevant healthcare services) in that community, as much as the actual therapy (Kapusta et al., 2009). Perhaps people have heard that increased or improved services are available, and are more likely to stop and think, and then possibly seek help rather than going through with an impulsive act. Could help-seeking be a crucial or perhaps even a central part of suicide prevention?

**What do we mean by help-seeking?**

A recent World Health Organisation review of adolescent help-seeking (Barker, 2007) suggests the following comprehensive definition: "Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff, traditional healers, religious leaders or youth programmes – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The 'help' provided might consist of a service (e.g. a medical consultation, clinical care, medical treatment or a counselling session), a referral for a service provided elsewhere or for follow- up care or talking to another person informally about the need in question." Barker's work focuses on adolescents, but it appears to me that the principles apply across the age range. Barker also goes on to distinguish positive forms of help-seeking from possibly negative ways of self-help such as drug use and abuse. Further, he distinguishes 'health-seeking' (for specific symptoms or illness) from 'help-seeking' (which might include personal stress or family crises, or perhaps financial problems). This latter distinction may be too detailed for the purposes of this editorial.

There are a number of issues that may encourage or discourage help-seeking.

**Illness awareness and public knowledge**

If you have an accident and break a bone, you will be whisked to relevant help whether you ask for it or not. If you have a lump or bump that is unsightly, or an itchy rash in an obvious place, you may be driven quickly by vanity to see your local doctor. If the itchy rash is in a non-obvious place, and even a little embarrassing, you may still seek help quickly. If you have recurrent heartburn or headaches or sleeplessness you will probably seek help after you have run out of remedies suggested by relatives or friends. If a lump ulcerates, or you pass blood in your urine, or you have sudden intolerable pain for no obvious reason you may be driven by fear to seek help. The ever-present fear of cancer

and its consequences is always in the news and social media.

But signs and symptoms of a mental illness may be more subtle, and creep up on you over time; you may continue to dismiss them as tiredness, overwork, or someone else's fault, and the full awareness that you have something serious may occur very late in the piece. We may all suffer from a sad mood from time to time, especially in the context of grief or loss of status or function, and this may be accompanied by loss of pleasure in life, a lack of energy and enthusiasm - but it is usually all self-limiting. We have sleepless nights when facing an exam, or an important interview, and our concentration may suffer. At the same time we may temporarily go off our food, and our weight can fluctuate. We all have reasons for some guilt and self-blame from the past, but most of us leave these *in* the past – they do not constantly intrude into, or consume, our thoughts. In clinical depression all these symptoms persist, may each be more troublesome, and the combination over time may get us to the point where life is no longer worth living.

The symptoms, combination of signs, and persistence of clinical depression (and other disorders) have all been well described and information about accessing help is freely available online at places like *beyondblue* and, for young people, *ReachOut* - to name only two of many useful sites. There is every reason to believe that public awareness of depression, and a wide range of other mental illnesses, may have improved over the last 12 years since Jorm's (2000) paper on mental health literacy. In fact, there may even be a problem emerging, in that some people are likely to have a few symptoms suggestive of disorder and, in the context of heightened anxiety, imagine they have the full blown serious mental illness. They may expect instant curative medication, when reassurance and minor modification of daily life may sufficiently change the problem. This is drawn from clinical practice, and there is little research to suggest what the impact is overall on help-seeking behaviour.

**Knowing there is a treatment or cure**

Part of this issue of awareness (or literacy) is not just about the capacity to put the symptoms and signs together, and realize you may have a problem that needs help. Rather, there is a need to know that your set of problems can be helped; there are treatments available, and they work. As mental health professionals we are not particularly good at getting this message across to the public. We are so busy critiquing the quality of other people's research work, so obsessed with needing the highest level of evidence before we recommend any treatment, so bound up in the ungenerous politics of our professional practice, we often forget to translate what we *do* know into simple terms for ordinary folk. Talking about mental health problems may be helpful, whatever the professional background of the clinician.

Therapeutic alliance may be a key to a positive outcome (Martin, D. et al., 2000). Various forms of cognitive behavioural therapy appear to work – especially when tailored to the particular condition (Butler et al., 2006). Psychodynamic psychotherapies work, when given time (Leichsenring & Rabung, 2011). Mindfulness based therapies work, though quality research is in its infancy (Tan & Martin, 2012), Even expressive therapies can be shown to work, though few randomised controlled studies have been completed (Martin, S. et al., 2012).

The issue here is that if we do not promote a variety of possible therapies for the full range of mental health disorders to the community, they may assume that their particular problem does not have a cure, and just not bother to seek help.

**Access to therapy**

There are a number of issues here needing to be explored. First, in Australia, one of the main barriers to care can be the geographic distance to any sort of professional help. New strategies are emerging to meet the need. For instance, videoconferencing to remote sites, to assist local primary clinicians, seems to be a powerful way to provide best available care (which also has inherent in it the extra training and supervision available to those rural clinicians). There is a long way to go before formal evaluation and research is possible, but early results are promising (Wood et al., 2012).

Even if systems like this exist, there can still be serious problems from the tyranny of distance. I have previously reported my clinical despair at having to manage a 7 year old boy (who had made a serious suicide attempt) and his family who had to travel over 150Kms into Mount Isa to be seen for a single session (Martin, 2007), with severely limited possibilities for follow-up.

But there are other problems in accessing care relevant to the problem. You may not have access to personal (or sometimes even) public transport. You may not have the finances to even consider paying for professional assessment and care, even with Medicare support.

Finally, there may be cultural constraints in terms of language, expectation, problem definition, and expectations of both the informal and formal systems of care. Even if some sort of care is available in geographical proximity, finding the help responsive and knowledgeable about how your symptoms and problems may fit within cultural norms, or may have been dealt with in the past using culturally appropriate methods, remains a problem in Australia today. How do we translate any of the therapies we know have reasonable research on efficacy or outcomes into a culturally acceptable frame? Conversely, how do we help other cultures to develop acceptable and effective interventions for some of our mental health diagnoses, or for mental health problems that seem to emerge from substance abuse like petrol sniffing?

**Stigma**

As a final issue I believe we have to consider how stigma and help-seeking may interact. Eisenberg et al., (2009) recently reported that 'personal stigma' (eg. "*I* would think less of someone who has received mental health treatment") was associated with lower help-seeking (perceived need and use of psychotropic medication, therapy, and nonclinical sources of support); 'perceived stigma' (eg. "*Most people* would think less of someone who has received mental health treatment") was not significantly associated with help-seeking. Subjects with high levels of personal stigma were less likely to decide on their own to seek help.

Elsewhere (Martin, 2010), I have commented that if we have a socially unacceptable behaviour driven by our mental health problems, we may be stigmatised. We may be as stigmatised by professionals as much as the members of the community. So, if you have self-injured and your wounds need medical care you may have to go to an Emergency Department of a local

hospital. If nursing and other staff do not understand the mechanism behind self-injury (ie control over emotion), they may see you as attention seeking, or just a nuisance. Because your wounds may be of less importance than road trauma or a coronary thrombosis, you may be left on a barouche in a quiet dark corner for a number of hours until they get around to dealing with you. I have now heard numerous recent reports of self-injurers being sewn up without anaesthetic, on the grounds that the original injury was self-inflicted, so the patient will not be worried by a little more pain. This is effectively a 'punishment' for seemingly 'wasting professional time'. In fact, it retraumatises people who already may have had a lifetime of trauma. How does that help us to prevent further self-injury? How is it therapeutic, when it can be seen as grossly inhumane? How does it help us to encourage people with mental health disorders to seek help?

Self-injury appears to be a common disorder, and may be somewhat more common that current studies have reported. People with mental disorders such as depression or anxiety may be *more* likely to answer research questionnaires, whereas those with health risk behaviours such as alcohol abuse may be *less* likely to do so, or only likely to respond with subsequent reminders (Said et al., 2012). This may be driven by personal stigma, and the authors suggest it may lead to underestimates of prevalence in large-scale studies, as well as less active help-seeking. So, the exact prevalence of behaviours like alcohol abuse, or drug abuse or self-injury may be in some doubt. Our own work suggested that 8.1% of the Australian population may have self-injured at some stage in their lives (Martin et al., 2009), and we thought this was surprisingly high. To gain the sample was complex, and we did have over 14,000 refusals to gain our final sample. Given the issue of personal stigma, perhaps self-injurers were a part of the group who refused; perhaps self-injury is a bigger problem than even we thought. Either way it demands considerable focus in terms of how we get sufferers to seek help and maintain their care.

The recent RU OK? Day (September 13th, 2012) in Australia was the fourth year of a national campaign to increase the likelihood of ordinary Australians reaching out to other Australians with a simple enquiry. With one in three Australians estimated to have taken some part in the day (up from 19% in 2011), an independent survey suggested that 67% of people asked someone face-to-face: "Are you OK?". However, older men were less aware of the campaign and less likely to participate than women of a similar age, and this reflects other issues for older men where stigma of having problems may be one of the issues stopping them seeking help. It remains to be seen with a national day of action such as RU OK? Day can ultimately lead not just to increased awareness, but also to active help-seeking, especially for at risk groups. If we can demonstrate that this occurs, then perhaps this kind of day of action needs to become part of a suite of programs within our national suicide prevention strategies.

## References for this section

Barker, G., 2007. Adolescents, social support and help-seeking behaviour: an international literature review and programme consultation with recommendations for action. ISBN 978 92 4 159571 1 World Health Organisation, Geneva.

beyondblue: the national depression initiative. http://www.beyondblue.org.au/index.aspx? Accessed 28.10.12.
Butler, A., Chapman, J., Forman, E. & Beck, A., 2006. The empirical status of cognitive-behavioral therapy: A review of meta-analyses. Clinical Psychology Review 26, 17–31.
Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. Medical Care Research and Review, 66(5), 522-541.
Isaacson, G., 2000. Suicide Prevention – A Medical Breakthrough? Acta Psychiatrica Scandinavica, 102: 113-117.
Jorm, A., 2000. Mental health literacy: Public knowledge and beliefs about mental disorders. The British Journal of Psychiatry. 177: 396-401.
Kapusta, N, Niederkrotenthaler, T, Etzersdorfer, E et al., 2009. Influence of psychotherapist density and antidepressant sales on suicide rates. Acta Psychiatrica Scandinavica, 119: 236-242.
Leichsenring F, Rabung S. (2011) Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. British Journal of Psychiatry. 199, 1, 15-22.
Martin, D., Garske, J. & Davis, M., 2000. Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. Journal of Consulting and Clinical Psychology. 68, 3, 438-50.
Martin, G. (2012). Editorial: On Wisdom in Mental Health Care. Advances in Mental Health. 10/3, 210–215. ISSN 1837-4905 ©2010 eContent Management http://amh.e-contentmanagement.com/
Martin, G., 2010. Editorial: On Self-injury. Advances in Mental Health, 9/2 ISSN 1837-4905 ©2010 eContent Management http://amh.e-contentmanagement.com/
Martin, G., Swannell, S., Hazell, P., Harrison, J., and Taylor, A., 2010. Self-Injury In Australia: a community survey. Medical Journal of Australia, 193: 9, 506-510.
Martin, G. & Page, A., 2009. National Suicide Prevention Strategies: a Comparison. Discipline of Psychiatry. The University of Queensland. ISBN 978-0-9808207-9-9. Commissioned review, DOHA, Canberra. PDF Download (accessed 24.10.2012) http://www.livingisforeveryone.com.au/Library-Item.html?id=82
Martin, G., 2007. Editorial: On Therapist Despair. Advances in Mental Health. 7, 1, 1-4. Accessed 28.10.12. http://amh.e-contentmanagement.com/archives/vol/7/issue/1/emotional--and-behavioural--problems-in-children
Martin, S., Martin, G., Lequertier, B., Swannell, S., Follent, A. & Choe, F. Voice Movement Therapy: Evaluation of a Group-based Expressive Therapy for Non-suicidal Self-injury in Young Adults. Music and Medicine. Accepted for publication (November 2012)
ReachOut Australia (Inspire Foundation). http://au.reachout.com/ Accessed 28.10.12.
Reseland, S., Bray, I., Gunnell, D., 2006. Relationship between antidepressant sales and secular trends in suicide rates in the Nordic countries. British Journal of Psychiatry, 188: 354-8.
RU OK? Day 2012. Accessed 28.10.12. http://www.ruokday.com/
Said, D., Kypri, K. & Bowman, J., 2012. Risk factors for mental disorder among university students in Australia: findings from a web-based cross-sectional survey. Social Psychiatry and Psychiatric Epidemiology. Published online September 2012. DOI 10.1007/s00127-012-0574-x Accessed 28.10.12.
Simon, G., Savarino, J., Operskalski, B. & Wang, P., 2006. Suicide Risk during antidepressant therapy. American Journal of Psychiatry, 163:41-47.
Tan, L. & Martin, G., 2012. Mind Full or Mindful: A report on mindfulness and psychological health in healthy adolescents. International Journal of Adolescence and Youth. Published online (September, 2012). Accessed 28.10.12. DOI:10.1080/02673843.2012.709174
While, D., Bickley, H., Roscoe, A., Windfuhr, K., Rahman,S., Shaw, J., Appleby, L., Kapur, N. (2012). Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *The Lancet*. www.thelancet.com. doi:10.1016/S0140-6736(11)61712-1 (published online February 2, 2012).
Wood, J., Stathis, S., Smith A. & Kraus, J. 2012. E-CYMHS: an expansion of a child and youth telepsychiatry model in Queensland. Australasian Psychiatry 20, 4, 333-337.

## 4. The conditions necessary to collect comprehensive information which 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.

The National Coronial Information System, and the Australian Bureau of Statistics already collect comprehensive data about suicides aged 15 year and over. The key to the validity of this data seems to reside not so much in method, but rather in 'Intent'. If it is clear, or if there is consensus agreement, that the intent behind the death was 'to die', then national bureaucracies are willing to report a death as 'suicide'. This then matches international data being collected by the World Health Organisation, on the basis of the International Classification of Disease (ICD).

The issue for children under the age of 15 becomes a problem for all concerned if we cannot agree about a child's ability to decide on life or death – ie 'intent'. The younger the child, the more abhorrent it is to us as adults that a child would choose to die.

**Brief Case Discussion**

I have had the privilege to be an appointed member of the Queensland Government Child Death Review Committee for the Children's Commissioner for 3 years from 2010-13. One of the cases assessed by that committee was a 9 year old boy who had been in and out of Department of Child Safety care, had been shuttled between rather inept parents over many years, had increasingly found himself in trouble at school. He had spoken to people of death, and given other signs that he was desperate, and wanted to die. Eventually, having 'warned' people on the day, he used his father's belt to hang himself in his father's wardrobe.

Our committee members were unanimous that this was a suicide. But at this stage it is not reported so at the national level in statistical reports. It is only through the good graces of the Queensland Children's Commission that the death has been counted as a suicide and reported as such (http://www.ccypcg.qld.gov.au/pdf/publications/papers/trends-and-issues/Child_deaths-prevalence_of_youth_suicide_in_Queensland.pdf)

I note that in the call for submissions, no mention was made of state-based organisations like Children's Commissions in each state and territory. Yet, I suspect that the Australian Human Rights Commission may have been influenced to call for submissions by the uproar which has greeted the suicides reported in children by state based entities. One of the problems of a federation, is that sometimes information held by one jurisdiction is not shared with other jurisdictions, or collated at a national level. This issue needs to be resolved to ensure that all suicides of children are included at the national level – surely just a bureaucratic endeavour.

## 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.

I have commented above on our emotional discomfort, as adults, when we realise that children can get to the point where they consider terminating their own lives. We cannot solve this serious problem if the problem is obscured.

## 6. The benefit of a national child death and injury database, and a national reporting function.

Great idea. We must make sure that this uses existing methodologies and databases (eg those used by the Australian Institute of Health and Welfare (AIHW)) to ensure costs are minimised and funding is predominantly channeled toward solutions for the problems.

## 7. 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. Submissions about specific groups are encouraged, including children and young people who are Aboriginal and Torres Strait Islanders, those who are living in regional and remote communities, those who are gender variant and sexuality diverse, those from culturally diverse backgrounds, those living with disabilities, and refugee children and young people seeking asylum. De-identified case studies are welcome.

'Effectively targeting and supporting children and young people who are engaging in the range of intentional self-harm and suicidal behaviours' is not to be taken lightly. It is a therapeutic endeavour demanding a high level of skill, persistence and fulfilment of duty of care, over whatever time frame is necessary to manage such complex and severe problems - which range across the spectrum demonstrated by Annette Beautrais' diagram. There are no short cuts or 'flip' solutions.

Having been Clinical Director of Royal Children's Hospital Child and Youth Mental Health Services (CYMHS) from 2001-2013, and having had the honour to supervise and mentor team members, as well as senior staff of all clinical backgrounds, I know the time and effort and collaboration with other services that goes into management of some of the most anxiety – provoking cases, providing a safety net to keep young people alive. At any one time we have 30-40 young people in our catchment with extreme and complex difficulties between our three community teams, our inpatient Child and Family Therapy Unit (CFTU), our inpatient adolescent ward (at RBWH), and our Extended Hours Support Teams. You need teams that are consistent in personnel, have

respect for colleagues from many disciplines both within and external to the service, and have a willingness to go the extra mile.

Once the acute phase of suicidality settles, then you need to do longer term work to prevent recurrence. This may involve family and extended family members, and brings its own complexities.

There are tiers to this work. Schools who have competent trained personnel will recognise the problems easily, and work with local services to ensure self-harm does not escalate. San Sisto College in Brisbane is an example of excellent practice in this regard, and it is my hope the principal (Ms Margaret Lee) will put in a submission, and give the Commission the opportunity to contest the issues).

Open door services (eg Headspace) may be able to attract otherwise nervous or suspicious young people into therapeutic contracts, but will need referral pathways other dedicated services to ensure the longer-term care is adequate.

**There are problems with exactly what therapy is most appropriate and effective for self-harming young people.**

This is addressed partly in the following editorial on self-injury published in 2012. Again, I believe it will have some utility to the Commission, and therefore have taken the liberty of including it all, with its references (Martin, G. 2012. 'On Self-Injury'. Advances in Mental Health, 9:2, 2-7).

"Three more stories have recently been contributed to the Australian Broadcasting Corporation's Special Broadcasting Service (SBS) "6 million stories and counting". These reflect on three quite different young women who self-injure, and are included as part of a new documentary in the SBS Science series to be launched in Adelaide at a public forum on 23rd November, and then publicly aired on SBS on the 12th December. As they note on their site: "*The Silent Epidemic: the Science of Self Harm"* lifts the veil on the widespread heath problem of the secret world of self-injury among young people in Australia and the emerging science behind the identification and treatment of these adolescents." (SBS, 2010a). The documentary was directed by Ili Bare, produced by Mark Hamlyn, Sue Clothier & Renee Kennedy, and lasts an hour with ad breaks, 52 minutes without. Other information is available from the Facebook site "The Silent Epidemic" (2010).

As you may imagine, working with media has been a complex, lengthy, but ultimately very satisfying endeavour. In particular, the issue of what to include to both provide an interesting and moving documentary, the human stories, but also the available science (such as it is) translated for the general public, was the subject of lengthy discussion. Including young adults who self-injure (and their families) in a television documentary is fraught with ethical issues, and we have had to work through these carefully and sensibly, while always having recourse to the basic tenet of 'first do no harm' (primum non nocere, attributed to Hippocrates, (460-370 BC)). One story tells about a personal ongoing struggle with self-injury, one focuses more on the ongoing family reactions to a young person self-injuring, and the final story tracks a young woman through a course of meditation - measuring on fMRI (functional magnetic resonance imaging) the changes that appear to occur over ten weeks,

but also tracking her reflections on her journey. Several international experts contribute their thoughts about the emerging science, and overall the program promotes a good understanding of the issues and some hope for the future.

So what is self-injury? Is it really in epidemic proportions? And what are some of the issues in the emerging science?

Self-injury is deliberate damage to the body *without* suicidal intent. This issue of the absence of suicidal intent is important. As we have noted elsewhere (Martin et al., 2010a), the first problem is that many studies combine self-injury and suicide attempts together as 'deliberate self-harm' (DSH). This clouds both the clinical and the research pictures. Consider the research issue first. The best available research concludes that the long-term outcome for 'deliberate self harm' is a higher risk for completed suicide. The best longitudinal study (Hawton and Zahl, 2003) reported that risk in the first year of follow-up was 0.7%, higher for men than women, increasing with age and, overall, 66 times the annual risk of suicide in the general UK population. Risk after 5 years was 1.7%, at 10 years 2.4% and at 15 years 3.0%. Another British study essentially agreed (Cooper et al., 2005) and US studies have similar emerging results (Claassen et al., 2006).

As clinicians we have to believe the research. So, not surprisingly, professionals in an emergency department have an immediate expectation that every person who self-injures must be suicidal. This leads to serious concern and, given our poor ability to predict exactly who may complete suicide, as caring professional people, we play it safe. We get into extensive questioning about suicidality and other possible underlying mental health issues.

When we find little other evidence of risks for suicide, we may be dismissive of what appear to be sometimes minor cuts or burns. We call it 'attention seeking', and may dismiss *the person* who self-injures – in part for supposedly misleading us. But in reality it is the research that has been misleading us. While there may be overlap, self-injury and a suicide attempt are essentially for different purposes. An attempt to suicide is most often for that purpose – to suicide (although we have to admit that some attempters may simply wish to escape their current circumstance 'for a time', and are often grateful when they survive the attempt).

From the clinical point of view, we have to consider a wide range of self-injury. If you interview young people at school who have cut themselves only once or twice, they may quickly admit they did it 'to be part of a group', or 'to feel what it was like', or even 'just for a laugh'. A few will say something more complex like: "I saw this person cutting their arm in the toilet, and asked them why they were doing it. They said they felt like crap, had all these awful memories they could not shake off, had a fight with their mum the night before, and cutting had made them feel better in the past. Well I've had some bad times and got bawled out the night before, so I thought I might give it a go…" This is in no way akin to suicidality, and appears to be about control over upsetting emotions. Yes, there is an element of imitation ('copycat' or even perhaps a case of 'contagion') that may cause us anxiety in a closed environment like a school. But the story allows us perhaps to empathise with the young person, engage them, and assist them with what they are telling us is the background problem, exploring with them some other way of

controlling their feelings. It provides us with an opportunity to prevent worse problems developing (to 'nip things in the bud'), and may also be a gateway to prevention in the wider community of the school, if there are others likely to be influenced in a similar way by the original cutter.

At the other end of the scale, there are people who are long past this. They have damaged their skin more times than they can remember, and the pathway from emotional overload to cutting is a single step. In addition, over time they may have had to injure themselves much more seriously to get the same effect of regaining control or feeling better. The story begins to sound much more like an addiction. Perhaps they only need a minimal current difficulty to re-evoke the need to self-injure, or the time since last self-injury may become important - with the interval, as it were, driving the need to damage ("I haven't cut for a week; no wonder I feel like crap!"). From a clinical perspective, the seriousness of the situation may be associated with a whole range of other psychological symptoms and begin to sound like a syndrome, or drive us to find a mental illness diagnosis to fit the picture. It may sound much more difficult for us to treat at the individual level, unless we have specific skills and prior experience. Perhaps if we thought of this level of self-injury as an addiction, then we might gain by considering what the field of addiction has in terms of successful evidence-based treatment programs from which we could borrow (Glasner-Edwards et al., 2010). Again though, it needs to be said that even at this level the primary purpose is not suicide-related.

Matthew Nock (2010) reminds us that "People have engaged in self-injury… in the absence of suicidal intent … for thousands of years; however, systematic research on this behavior has been lacking." Despite this, recent research has clarified differences between self-injury and suicide attempts - in their correlates, response to therapy, and long-term outcomes (Klonsky, 2007; Muehlenkamp & Gutierrez, 2007). This has led to discussion that non-suicidal self-injury should be recognised as a unique syndrome within the planned 5th edition of the DSM (American Psychiatric Association, 2010).

So, self-injury is more about control over inner states of emotion for which other cognitive skills seem to have failed, or perhaps not been well-developed – for instance in adolescents (Jacobsen & Gould, 2007; Hasking et al., 2010; Swannell et al., 2007). This builds on the earliest work in this field of study (Favazza & Conterio, 1989). Recent work of ours (based on the Australian National Epidemiological Study of Self-Injury –ANESSI (Martin et al., 2010b)) confirms 'to manage emotions' as the most commonly reported motivation for self-injury reported *across the life span*, with the exception of the 10-17 yr age band where 'to punish oneself' is more common (Hazell et al.). Our nationally representative study also confirms that much self-injury occurs in the absence of suicidal thoughts (51.9%) and in the absence of a lifetime history of suicide attempts (73.7%).

Many studies have reported self-injury in hospital samples, as well as community cohorts, often with widely differing rates. Among high school students, lifetime prevalence rates have been reported to range from 14% to 47% (Ross & Heath, 2002; Muehlenkamp & Gutierrez, 2004; Laye-Gindhu et al., 2005; Lloyd-Richardson et al, 2007; Muehlenkamp & Gutierrez, 2007; Yates et al., 2008). Our equivalent lifetime figures for 15–19-year olds were 16.6% for females and 11.6% for males. Similarly, studies among university students

have reported lifetime prevalence rates ranging from 17% to 41% (Gratz et al., 2002; Whitlock et al., 2006; Gollust et al., 2008; Hasking et al., 2008). Our equivalent value was 13.1% for the age range for Australian university students (Martin et al., 2010b).

Only one previous nationally representative study has been conducted (Briere & Gill, 1998). This was a postal survey (response rate 64%) of 927 US adults (range 18–90; mean age 46). "Self-mutilation behavior" was based on Item 48 from the Trauma Symptom Inventory — 'intentionally hurting yourself in the absence of suicidal intent'. Occasional instances were reported by 4% of participants, and 0.3% reported *often* self-mutilating in the previous 6 months. There were no gender differences in frequency, but those reporting self-mutilation were younger (mean age 35). Our equivalent 6-month prevalence of 1.8% may relate to greater specificity of our survey questions (Martin et al., 2010b).

Just to complete the picture, our overall lifetime rate ("Have you ever…") was 8.1%, and the rate for the previous month was 1.1%. In all of this morass of figures can we discern 'an epidemic'? Probably not. There does not appear to have been a rise in frequencies over the last 10 years, and any differences are probably related to the style of questions. But the rates *are* surprising and concerning, and we could say that self-injury appears to be *endemic*; that is it may well be at a maintained rate in the Australian and other populations. It is little acknowledged publicly, but is a serious problem for health and other services, and there appears to be a good deal of stigma surrounding the problem (perhaps related to fear and ignorance) both in the community and in health services. We believe that our survey is representative of the Australian population, and if we just consider the rate of 1.1% over the month previous to survey, this translates to about 200,000 people (Martin et al., 2010b). This is not a small number, and suggests an enormous possible impost on health services, and a large cost to the public purse.

Self-injury, in fact, has a 12-month prevalence very similar to a wide range of other mental health problems. Yet because it goes unrecognized as a serious problem, or perhaps because it is more stigmatized, there is little attention or funding made available to address issues of therapy or prevention. This has to change.

So what are the areas of research endeavour? Early work reported on the influence of childhood sexual abuse in developing reduced pain perception and dissociation (van der Kolk et al, 1991). More recent work has shifted the focus away from early sexual abuse (Klonsky & Moyer, 2008) perhaps more toward physical abuse (Swannell et al, submitted). Low levels of serotonin have been investigated as important (Crowell et al., 2008), and may be of genetic origin (Pooley et al., 2003). Dietary lipids may be implicated in depression and impulsivity (Garland et al., 2007), and improvements in some aspects of deliberate self-harm may occur from Omega-3 supplementation (Hallahan et al., 2007). James Harris (2003), and Glen Gabbard (2005) have broadened our view of how the brain may work, and raised possibilities for further work – perhaps to do with mirror neurons and their implications in self-injury.

A particular issue for further research is that we struggle to find therapies that work well for self-injury, particularly in young people. Despite early promise

in the UK (Wood et al., 2001), results from group-based brief Cognitive Behavioural Therapy of adolescents could not be replicated in Australia (Hazell et al., 2009). Dialectical behaviour therapy with its inclusion of mindfulness training, may well be the treatment of choice for adults (Linehan et al., 2006), but its length and intensity may not suit younger people. Despite some progress, we still have a way to go to get the best available therapies for any given individual (Muehlenkamp, 2006). Perhaps mindfulness training (Gratz, 2007; Nock et al., 2007; Tan & Martin, 2012) may prove to be the core of future therapies for self-injury. But, as with all therapies for self-injury, we need a large number of trials to confirm what works well, for which people, at what stage in their therapy.

As for preventive approaches and programs, one might simply ask: "What prevention?" Where suicide has had vast amounts of money applied to its prevention in national strategies, using comprehensive models of prevention that are now tried and true (for instance the Mrazek and Haggerty (1994) model so central to the conceptualization of the Australian Living is for Everyone (LiFe) strategies), at this point, this level of thinking or funding has not been applied to Self-Injury.

All of these new frontiers suggest areas for further research in which Australia could and should be involved. But this will not occur unless self-injury, as an entity, is taken more seriously by the community, clinicians, politicians and our research funding bodies.

## References for this section


American Psychiatric Association. DSM 5 development. Proposed revision: non-suicidal self-injury. (accessed 1st November 2010). http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=443#

Briere J, Gil E., 1998. Self-mutilation in clinical and general population samples: prevalence, correlates, and functions. American Journal of Orthopsychiatry, 68:609-620.

Claassen, C., Madhuka, T., Shimizu, I., Sunita, S., Larkin, G. & Litovitz, T. (2006). Epidemiology of Nonfatal Deliberate Self-Harm in the United States as Described in Three Medical Databases. Suicide and Life-Threatening Behavior. 36:2, 192-212.

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K. & Appleby, L. (2005). Suicide After Deliberate Self-Harm: A 4-Year Cohort Study. American Journal of Psychiatry, 162:297-303.

Crowell, S., Beauchaine, T., McCauley, E., Smith, C., Vasilev, C. & Stevens, A., (2008). Parent–Child Interactions, Peripheral Serotonin, and Self-Inflicted Injury in Adolescents. Journal of Consulting and Clinical Psychology, 76,1:15-21.

Favazza, A. R. & Conterio, K. (1989). Female habitual self-mutilators. Acta Psychiatrica Scandinavica, 79:3, 283–289.

Gabbard, G., (2005). Mind, Brain, and Personality Disorders. American Journal of Psychiatry, 162:648-655.

Garland, M., Hallahan, B., McNamara, M., Carney, P., Grimes, H., Hibbeln, J., Harkin, A. & Conroy, R., (2007). Lipids and essential fatty acids in patients presenting with self-harm. British Journal of Psychiatry, 190:112-117.

Glasner-Edwards S, Rawson R. (2010) Evidence-based practices in addiction treatment: review and recommendations for public policy. Health Policy. Oct; 97(2-3):93-104. Epub 2010 Jun 16.

Gratz KL, Conrad SD, Roemer L., (2002). Risk factors for deliberate self-harm among college students. American Journal of Orthopsychiatry, 72:128-140.

Gratz, K., (2007). Targeting emotion dysregulation in the treatment of self-injury. Journal of Clinical Psychology (Special Issue: Non-Suicidal Self-Injury), 63:11, 1091–1103.

Gollust SE, Eisenberg D, Golberstein E., (2008). Prevalence and correlates of self-injury among university students. Journal of American College Health, 56:491-499.

Hallahan, B., Hibbeln, J., Davis, J. & Garland, M., (2007). Omega-3 fatty acid supplementation in patients with recurrent self-harm: Single-centre double-blind randomised controlled trial. The British Journal of Psychiatry, 190:118-122.
Harris JC., (2003). Social neuroscience, empathy, brain integration, and neurodevelopmental disorders. Physiology & Behavior, 79:3, 525-31.
Hasking P, Momeni R, Swannell S, Chia S., 2008. The nature and extent of non-suicidal self-injury in a non-clinical sample of young adults. Archives of Suicide Research, 12:208-218.
Hasking, P.A., Coric, S.J., Swannell, S., Martin, G., Anderson, H.A. & Frost, A.D.J., 2010. Emotion regulation and coping as moderators in the relationship between personality and self-injury. Journal of Adolescence. 33:767–773.
Hawton, K. & Zahl, D. (2003). Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. British Journal of Psychiatry, 182: 537-542.
Hazell, P., Martin, G., McGill, K., Kay, T., Wood, A., Trainor, G. & Harrington, R., 2009. Group therapy for repeated deliberate self-harm in adolescents: Failure of replication of a randomized trial. Journal of American Academy of Child and Adolescent Psychiatry, Jun; 48(6):662-70.
Hazell P, Martin G, Swannell S, Harrison J, Taylor AW. Methods and motivations for self-injury in a community sample according to sex and age. Australian and New Zealand Journal of Psychiatry. Unpublished.
Jacobson CM. & Gould M., (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. Archives of Suicide Research, 11(2):129-47.
Klonsky, ED., (2007). The functions of deliberate self-injury: A review of the evidence. Clinical Psychology Review, 27:2, 226-239.
Klonsky, ED. & Moyer, A., (2008). Childhood sexual abuse and non-suicidal self-injury: meta-analysis. The British Journal of Psychiatry,192:166-170.
Laye-Gindhu A, Schonert-Reichl KA., (2005). Nonsuicidal self-harm among community adolescents: understanding the "whats" and "whys" of self-harm. Journal of Youth & Adolescence, 34:447-457.
Linehan, M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., Korslund, K., Tutek, D., Reynolds, S. & Lindenboim, N., (2006). Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder. Archives of General Psychiatry, 63:757-766.
Lloyd-Richardson E, Perrine N, Dierker L, Kelley ML., (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. Psychological Medicine, 37:1183-1192.
Martin, G., Swannell, S., Hazell, P., Harrison, J., and Taylor, A. (2010a). Self-Injury In Australia: a community survey. Medical Journal of Australia, 193: 9, 506-510.
Martin, G., Swannell, S., Harrison, J., Hazell, P. & Taylor, A. (2010b). The Australian National Epidemiological Study of Self-Injury (ANESSI). Centre for Suicide Prevention Studies, Brisbane, Australia. ISBN 978-0-9808207-0-6. Available in .pdf format from http://www.suicidepreventionstudies.com
Mrazek P.J., & Haggerty, R.J. (1994). Reducing Risks for Mental Disorders: Frontiers for preventive intervention research. Washington, DC: National Academy Press.
Muehlenkamp J, Gutierrez PM., (2004). An investigation of differences between self-injurious behavior and suicide attempts in a sample of adolescents. Suicide & Life-Threatening Behavior, 34:12-23.
Muehlenkamp, J., (2006). Empirically Supported Treatments and General Therapy Guidelines for Non-Suicidal Self-Injury. Journal of Mental Health Counseling, 28: 2,166 - 185
Muehlenkamp JJ, Gutierrez PM. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. Archives of Suicide Research, 11: 69-82.
Nock, MK., Teper, R. & Hollander, M. (2007). Psychological treatment of self-injury among adolescents. Journal of Clinical Psychology (Special Issue: Non-Suicidal Self-Injury), 63:11, 1081–1089.
Nock M.K. (2010). Self-injury. Annual Review of Clinical Psychology, 6: 339-363.
Pooley, E., Houston, K., Hawton, K. & Harrison, P., (2003). Deliberate self-harm is associated with allelic variation in the tryptophan hydroxylase gene (TPH A779C), but not with polymorphisms in five other serotonergic genes. Psychological Medicine, 33:5,775-783.

Ross S, Heath N., (2002). A study of the frequency of Self-mutilation in a community sample of adolescents. Journal of Youth & Adolescence, 31:67-77.
Special Broadcasting Service, (2010). *The Silent Epidemic: the Science of Self Harm.* Accessed 31st October, 2010. http://www.sbs.com.au/contentsales/programs/view/id/627/t/Silent-Epidemic
Swannell, S., Martin, G., Scott, J., Gibbons, M. & Gifford, S., 2007. Motivations for self-injury in an adolescent inpatient population: development of a self-report measure. Australasian Psychiatry, 2:98-103.
Swannell, S., Martin, G., Page, A., Hasking, P., Hazell, P., Taylor, A., Harrison, J. & Protani. Child maltreatment, subsequent non-suicidal self-injury and the mediating role of self-blame. Psychological Medicine. Submitted.
Tan, L. & Martin, G., 2012. Taming the Adolescent Mind: Preliminary report of a mindfulness-based psychological intervention for adolescents with clinical heterogeneous mental health diagnoses. *Clinical Child Psychology and Psychiatry*. 18:2, 300-312. DOI 1359104512455182.
The Silent Epidemic, 2010. Facebook site. Accessed 31st October, 2010. http://www.facebook.com/group.php?gid=277924664732
van der Kolk, B., Perry, J. & Herman, J., (1991). Childhood origins of self-destructive behavior. *The American Journal of Psychiatry, 148*(12), 1665-1671.
Whitlock J, Eckenrode J, Silverman D., (2006). Self-injurious behaviors in a college population. Pediatrics, 117:1939-1948.
Wood, A., Trainor, G., Rothwell, J., Moore, A., & Harrington, R. (2001). Randomised trial of group therapy for repeated deliberate self harm in adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 40, 1246-1253.
Yates TM, Tracy AJ, Luthar SS., (2008). Nonsuicidal selfinjury among "privileged" youths: longitudinal and cross-sectional approaches to developmental process. Journal of Consulting & Clinical Psychology, 76: 52-62.

## Our Current Research Direction at The University of Queensland "Those young people who have successfully given up self-harming behaviours" (largely UNFUNDED)

We became intrigued by this approach during an Honours research study (Rotolone, C. & Martin, G., 2012. Giving up Self-Injury: A Comparison of Everyday Social and Personal Resources in Past Versus Current Self-Injurers. *Archives of Suicide Research*. 16: 2, 147-158. IF 1.530.)

Essentially what became clear is that those who had given up self-harm successfully for more than a year, and were convinced they could continue not to self harm, were substantially different on a wide range of personal factors and social resources. We have continued to follow this trail, asking different questions, and assessing different issues which reflect the literature on self-harm.

Horgan, M. & Martin, G., 2014. Differences between current and past self-injurers: How and why do people stop? Archives of Suicide Research. Impact Factor 2.219. Corrections submitted (March).
Caltabiano, G. & Martin, G., 2014. Mindless Suffering: The Relationship Between Mindfulness and Non-Suicidal Self-Injury. Journal of Clinical Psychology. Impact Factor 1.668. Submitted.
Palmer, B. & Martin, G., 2014. Self-harm in intellectually normal children: A comparison of inpatients who self-harm with those who do not. Submitted

A similar idea was used in part of a PHD study a longitudinal study of 2500 Australian school based adolescents (Andrews, T., Martin, G., Hasking, P., & Page, A. (2013). Predictors of continuation and cessation of non-suicidal self-

injury in a longitudinal sample of community-based adolescents. *Journal of Adolescent Health*. 1:40-6. doi:10.1016/j.jadohealth.2013.01.009. Epub 2013 Apr 19. Impact Factor 3.334)

and (Andrews, T., Rotolone, C., Martin, G., Hasking, P. & Page, A. (being revised). Cessation of non-suicidal self-injury: A qualitative study using interpretative phenomenological analysis.)

## Self-harm in other populations

### Aboriginal and Torres Strait Islander populations

I draw the attention of the Commission to a collaborative work completed by our team with an Aboriginal academic, Dr. Norm Sheehan.

This research reviewed all of the available research, literature, and relevant available unpublished materials across a range of fields in an attempt to find solutions that might work for Aboriginal and Torres Strait Islander communities. We also discussed the issues and took advice from a large number of key informants both in Australia, but also in New Zealand, Canada and the United States. The intent was to devise a framework for Indigenous suicide prevention in Australia that might be relevant, acceptable, fundable, manageable, and successful. As with many before us, we concluded that social, cultural, emotional, and spiritual wellbeing as building blocks toward overall mental wellbeing are likely to be crucial in reducing suicide in Indigenous Australians, and that social reform to help rediscover Identity, Voice and Place, is likely to be more important than measures taken to improve pathways to care.

Point 8 of our Executive Summary noted:

"Of serious concern is the high and increasing rate of suicide among Indigenous Australian children and adolescents (Commission for Children and Young People and Child Guardian Queensland, 2007). In 2006-07, Aboriginal and Torres Strait Islander Australian children and adolescents accounted for 39% youth suicide victims in Queensland, despite comprising only 6% of the youth population."

We made 15 major recommendations for action related to suicide prevention. I would urge the commission to have access to the document which can be downloaded as a pdf. (Krysinska, K., Martin G. & Sheehan N., 2009. *Identity, Voice, Place: A Framework for Suicide Prevention for Indigenous Australians based on a Social and Emotional Wellbeing Approach*. Centre for Suicide Prevention Studies, Discipline of Psychiatry. The University of Queensland, Brisbane. ISBN 978-0-9808207-1-3.) Available in Soft Cover, or downloadable in pdf format from http://www.suicidepreventionstudies.org/uploads/Identity%20Voice%20Place%20Dec%202009.pdf

## 8. 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.

I would like to draw the attention of the Commission to a series of books we have prepared for specific audiences – based on a synthesis of all of our research studies. We address issues of non-suicidal self-injury, self-harm, and suicidality in each. There is some duplication of content across the five books.

Martin, G., Hasking, P., Swannell, S., McAllister, M. & Kay, T., 2013). ***Seeking Solutions to Self-injury: A Guide for Young People*** SECOND EDITION. Child and Adolescent Psychiatry, The University of Queensland, Brisbane, Australia. ISBN 978-0-9875603-3-9

Martin, G., Hasking, P., Swannell, S. & McAllister, M., (2013). ***Seeking solutions to self-injury: A guide for parents and families***. SECOND EDITION. Child and Adolescent Psychiatry, The University of Queensland, Brisbane, Australia. ISBN 978-0-9875603-4-6

Martin, G., Hasking, P., Swannell, S., Lee, M., McAllister, M., Griesbach, K., 2013. ***Seeking Solutions to Self-injury: A Guide for School Staff***. 'What can you do if you are not the Counsellor? SECOND EDITION. Centre for Suicide Prevention Studies. Discipline of Psychiatry. The University of Queensland. ISBN 978-0-9875603-1-5.

In the last 6 months, these three books have been sent from our Centre at The University of Queensland, **free of charge, to every high school in Australia and New Zealand**, including multiple copies of the 'school staff' book. Schools have been surprised and pleased, for the most part very complimentary. Many schools have subsequently ordered multiple copies in either book form, or as a .pdf download.

Martin, G., Swannell, S., McAllister, M., & Hasking, P., 2014. ***Seeking Solutions to Self-injury: A Guide for Emergency Staff.*** Centre for Suicide Prevention Studies. Discipline of Psychiatry. The University of Queensland. ISBN 978-0-9808207-6-8.

In the last 6 months, three copies of this book have been sent from our Centre at The University of Queensland, **free of charge, to every Emergency Centre in Australia and New Zealand.** We have had no feedback (as might be expected from busy professionals). None of the books were returned. A second tranche of 3 books has been sent to act as a reminder. Further copies are available in either book form, or as a .pdf download.

Martin, G., Swannell, S., Hasking, P. & McAllister, M., 2014. ***Seeking Solutions to Self-injury: A Guide for Family Doctors.*** Centre for Suicide Prevention Studies. Discipline of Psychiatry. The University of Queensland. ISBN 978-0-9875603-6-0.

In the last 6 months, 50 copies of this book have been sent from our Centre at The University of Queensland, **free of charge, to every Medicare Local**

**organisation in Australia.** None of the books were returned. Many of the Medicare Locals have contacted us to arrange for large quantities of the books to be made available to the GPs under their care.

We have no way of knowing what impact our books will have, or whether they will influence practice in the management of self-harming behaviours. We had no funding from any government or commercial source to publish the books. Funding for our research programs has now run out, and we have no available funding to investigate impact and outcomes. I will complete my current contract at the University of Queensland on 31st August 2014, and will not be developing new research programs.

## 9. The role, management and utilisation of digital technologies and media in preventing and responding to intentional self-harm.

When we began our work with the media to develop a number of television programs, we devised a Facebook page "Therapy for Self-injury" to enable access to young people who self-injure. We also accessed, and have a presence on a number of other relevant Facebook pages.

As we began work on a new therapy for Self-harming behaviours (Martin, S., Martin, G., Lequertier, B., Swannell, S., Follent, A. & Choe, F., 2013. Voice Movement Therapy: Evaluation of a Group-based Expressive Therapy for Non-suicidal Self-injury in Young Adults. *Music and Medicine*. 5:1, 31-38. doi: 10.1177/1943862112467649), we again sought to use social media to assist development, but also to engage young people in our work.

Subsequently we have used Facebook groups to assist access to self-harming young people who might agree to complete a series of Honours research programs at The University of Queensland. To date we do not appear to have caused difficulties or upset any young people who have contributed to our work.

As new work is published we have apprised our contacts of the work, and where possible provided access.

**I believe there is immense utility in having a mix of approaches to young people – face to face, telephone, text, on line.**

**I am wary of any technology (for instance an app on an iPhone) being used alone in the absence of a program of direct face to face therapeutic care.**

# Additional References mentioned in the text


**Background**

Commonwealth, 1999. National Youth Suicide Prevention Strategy – Setting the evidence-based research agenda for Australia (A literature review), Department of Health and Aged Care, Commonwealth of Australia, Canberra, 1999. Accessed 27th May 2014. http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/mh12.pdf

**Parenting**

Martin, G. & Waite, S., 1994. Parental bonding and vulnerability to adolescent suicide. Acta Psychiatrica Scand., 89:246-254.

Allison, S., Pearce, C. & Martin, G., Miller, K., & Long, R., 1995. Parental Influence, Pessimism and Adolescent Suicidality. Archives of Suicide Research, 1:4, 229-242.

Martin, G., Rozanes, P., Allison, S. & Pearce, C., 1995. Adolescent Suicide, Depression and Family Dysfunction. Acta Psych. Scand., 92:336-344.

Pearce, C., Martin, G., & Wood, K., 1995. The Significance of Touch for Perceptions of Parenting and Psychological Adjustment among Adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 34:2, 160–167.

Allison, S., Pearce, C. & Martin, G., Miller, K., & Long, R., 1995. Parental Influence, Pessimism and Adolescent Suicidality. Archives of Suicide Research, 1:4, 229-242.

Martin, G., Bergen, H., Allison, S. & Roeger, L., 2004. Depression in young adolescents: Investigations using 2 and 3 factor versions of the Parental Bonding Instrument (PBI). The Journal of Nervous and Mental Disease. 192:10, 650-657.

Baetens, I., Claes, L., Onghena, P., Grietens, H., Van Leeuwen, K., Pieters, C., Wiersema, J. & Martin, G., 2013. Is non-suicidal self-injury associated with parenting and family factors? *Journal of Early Adolescence*. Impact Factor 2.303 0272431613494006, first published on July 15, 2013

Baetens, I., Claes, L., Hasking, P., Smits, D., Grietens, H., Onghena, P., & Martin, G. 2013. The Relationship Between Parental Expressed Emotions and Non-suicidal Self-injury: The Mediating Roles of Self-criticism and Depression. *Journal of Child and Family Studies*. Impact Factor 0.291. Published online first, November 2013. (DOI) 10.1007/s10826-013-9861-8

**Family**

Martin, G., 1996. Reported family dynamics, sexual abuse and suicidal behaviors in community adolescents. Archives of Suicide Research, 2:3, 183-195.

Martin, G., Rozanes, P., Allison, S. & Pearce, C., 1995. Adolescent Suicide, Depression and Family Dysfunction. Acta Psych. Scand., 92:336-344.

**Abuse**

Martin G., 1990. On Child Sexual Abuse. In 'The Impact of Society on the Child'. Martin G. (Ed.) Proceedings of the Faculty of Child Psychiatry (1988 conference), R.A.N.Z.C.P.

Martin, G., 1996. Reported family dynamics, sexual abuse and suicidal behaviors in community adolescents. Archives of Suicide Research, 2:3, 183-195.

Beckinsale, P., Martin, G. & Clark, S., 1999. Sexual abuse and suicidal issues in Australian young people: An interim report. Australian Family Physician, 28:12, 1298-1303.

Bergen, H., Martin, G., Richardson, A., Allison, S. & Roeger, L., 2003. Sexual Abuse and Suicidal Behavior: A model constructed from a large community sample of adolescents. Journal of the American Academy of Child and Adolescent Psychiatry. 42:11, 1301-1309.

Bergen, H., Martin, G., Richardson, A., Allison, S. & Roeger, L., 2004. Sexual Abuse, Antisocial Behaviour and Substance Abuse: Gender and Age Differences in Young Community Adolescents. Australian and New Zealand Journal of Psychiatry, 38:34–41.

Martin, G., Bergen, H., Richardson, A., Allison, S. & Roeger, L., 2004. Sexual Abuse and Suicidality: Gender Differences in a Community Sample of Adolescents. Child Abuse and Neglect, 28:5, 491-503.

Swannell, S., Martin, G., Page, A., Hasking, P., Hazell, P., Taylor, A., Protani, M. (2012). Child maltreatment, subsequent non-suicidal self-injury (NSSI) and the mediating roles of dissociation, alexithymia, and self-blame. *Child Abuse and Neglect*, 36(7–8), 572–584. IF: 2.471

**Depression**

Martin, G., Rozanes, P., Allison, S. & Pearce, C., 1995. Adolescent Suicide, Depression and Family Dysfunction. Acta Psych. Scand., 92:336-344.

Martin, G., 1995a. The effectiveness of prevention strategies for adolescent depression; a literature review. Quality Of Care And Health Outcomes Committee, National Health & Medical Research Council.

Martin, G., 1995b. The effectiveness of treatment for adolescent depression; a literature review. Quality Of Care And Health Outcomes Committee, National Health & Medical Research Council.

Allison, S., Roeger, L., Martin, G., & Keeves, J., 2001. Gender Differences in the relationship between depression and suicidal ideation in young adolescents. Australian and New Zealand Journal of Psychiatry, 35, 498-503

Roeger, L., Allison, S., Martin, G., Dadds, V., & Keeves, J., 2001. Adolescent Depressive Symptomatology: Improve Schools or Help Students? Australian Journal of Psychology, 53: 134-139.

Martin, G., 2001. Management of depression and suicide in general practice. Stephen Lee and Cathy Sanders (Eds) In The Missing Link: adolescent mental health in general practice. Alpha Biomedical Communications, Sydney, ISBN 1-876101-08-3.

**Media and Suicide**

Martin, G., 1996. The Influence of Television Suicide in a Normal Adolescent Population. Archives of Suicide Research, 2:2, 103-117.

Martin, G. & Koo, L., 1997. Celebrity Suicide: Did the death of Kurt Cobain influence young suicide in Australia? Archives of Suicide Research, 3:3, 187-198.

Martin G., 1998. Media Influence to Suicide; the search for solutions. Archives of Suicide Research, 4:1,1-12.

**Population Attributable Risk**

Krysinska, K. & Martin, G., 2009. Balancing the struggle to prevent and evaluate; application of population attributable fraction and preventable fraction to suicide prevention research. *Suicide and Life-threatening behavior*. 39:5, 548-557.

Li, Zhuoyang, Page, A., Martin, G. & Taylor, R. 2011. Attributable Risk of Psychiatric and Socio-economic Factors for Suicide from Individual-level and Population-based Studies. *Social Science and Medicine*. 72:4, 608-16.

**Emotion Regulation**

Hasking, P.A., Coric, S.J., Swannell, S., Martin, G., Anderson, H.A. & Frost, A.D.J., 2010. Emotion regulation and coping as moderators in the relationship between personality and self-injury. *Journal of Adolescence*. 33:767–773.

Voon, D., Hasking, P., & Martin, G., 2014. Change in emotion regulation strategy use and its impact on adolescent non-suicidal self-injury: A three-year longitudinal analysis using latent growth modelling. Journal of Abnormal Psychology. Impact Factor 4.646. Accepted (April).

Voon, D., Hasking, P., & Martin, G., 2014. The roles of emotion regulation and ruminative thoughts in non-suicidal self-injury. *British Journal of Clinical Psychology*. Impact Factor 1.90. EPub ahead of print. DOI: 10.1111/bjc.12030

**Schools and Contagion**

Martin, G., 1992a. Adolescent Suicide 3: Imitation and the clustering phenomenon. Youth Studies Australia, 11, 1:28-32.

Martin, G., 1992b. Adolescent Suicide 2: Postvention in a school. Youth Studies Australia, 11, 1:24-27.

Martin, G., Kuller, N. & Hazell, P., 1992c. Adolescent Suicide 1: The effect on adolescents of the completed suicide of another student. Youth Studies Australia, 11, 1:21-23.

Martin, G., Roeger, L., Dadds, V., & Allison, S., 1997. Early Detection of Emotional Disorders in South Australia; the first two years. Adelaide, Southern Child and Adolescent Mental Health Service. ISBN 0 646 31337 1.

Hasking, P., Martin, G., Berger, E., Andrews, V. & Swannell, S., 2014. ***Adolescents Coping with Emotional Problems (Final Research Report for Schools)*** Monash University and the University of Queensland, Australia. ISBN: 978-0-9875603-5-3.

**On Delusions and Self-harm**

Swannell, S., Martin, G., Scott, J., Gibbons, M. & Gifford, S., 2007. Motivations for self-injury in an adolescent inpatient population: development of a self-report measure. Australasian Psychiatry, 2:98-103.

Scott, J., Welham, J., Martin, G., Bor, W., Najman, J., O'Callaghan, M., Williams, G., Aird, R., McGrath., J., 2008. Demographic correlates of psychotic-like experiences in young Australian adults. Acta Psychiatrica Scandinavica, 118: 230-237.

Scott, J., Martin, G., Welham, J., Bor, W., Najman, J., O' Callaghan, M., Williams, G., Aird, R., McGrath, J., 2009. Psychopathology during childhood and adolescence predicts delusional-like experiences in adults: A 21-year birth cohort study. The American Journal of Psychiatry, 166(5):567-74.

Martin, G., Thomas, H., Andrews, T., Hasking, P. & Scott, J. (2014). Psychological distress and psychotic experiences predict contemporaneous and future non-suicidal self-injury and suicide attempts in a sample of Australian school-based adolescents. Psychological Medicine. Impact Factor 5.587. Corrections submitted (May).