The Royal Australian & New Zealand College of Psychiatrists

28 May 2014

Ms Megan Mitchell
National Children's Commissioner
Australian Human Rights Commission
GPO Box 5218
Sydney NSW 2000

By email to: nccsubmissions@humanrights.gov.au

Dear Ms Mitchell

Re: National examination into intentional self-harm and suicidal behaviour among children and young people

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback into the National Children's Commissioner's examination into intentional self-harm and suicidal behaviour among children and young people under 18 years. The RANZCP welcomes this inquiry particularly in view of the release of recent statistics that suicide continues to be a leading cause of death among children and young people.

In 2010 the RANZCP made a submission to the House of Representatives Standing Committee on Health and Ageing Inquiry into Youth Suicide Prevention (available via https://www.ranzcp.org/Files/Resources/Submissions/sub33-pdf.aspx), and also published a report on Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents (available via https://www.ranzcp.org/Files/Resources/peips_report-pdf.aspx)

A key principle outlined in these documents is that addressing the incidence of child and adolescent self-harm and suicide in Australia requires strategies to address the factors that contribute to and perpetuate such behaviours. There is consistent evidence to support the finding that people who self-harm or die by suicide have a much higher prevalence of mental illness than the general population. Prevention and early intervention of mental illness in childhood and adolescence is therefore particularly important.

The enclosed submission expands on these documents and provides further specific feedback to inform the Children's Commissioner's current inquiry.

To discuss any of the issues raised in this submission, please contact Dr Anne Ellison, General Manager, Practice, Policy and Projects via anne.ellison@ranzcp.org or by phone on (03) 9601 4918.

Yours sincerely

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National Children's Commissioner examination into intentional self-harm and suicidal behaviour in children

RANZCP Submission – June 2014

The Royal Australian & New Zealand College of Psychiatrists

Background

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback into the National Children's Commissioner's examination into intentional self-harm and suicidal behaviour among children and young people under 18 years. The RANZCP welcomes this inquiry particularly in view of the release of recent statistics, both from States and the Australian Bureau of Statistics, that suicide continues to be a leading cause of death among children and young people.

The RANZCP submission has focused its attention on the key areas identified by the Commissioner to look into why children engage in intentional-self harm and suicidal behaviour, as well the barriers which prevent them from seeking help by responding to the questions outlined in the call for submissions document.

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A key principle outlined in these documents is that addressing the incidence of child and adolescent self-harm and suicide in Australia requires strategies to address the factors that contribute to and perpetuate such behaviours. There is consistent evidence to support the finding that people who self-harm or die by suicide have a much higher prevalence of mental illness than the general population. Prevention and early intervention of mental illness in childhood and adolescence is therefore particularly important. The RANZCP made a number of recommendations in its submission on youth suicide prevention which it draws to the attention of the Children's Commissioner.

The Royal Australian and New Zealand College of Psychiatrists (RANCZP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. The RANZCP has more than 5000 members, including around 3700 fully qualified psychiatrists.

Responses to key areas outlined by the National Children's Commissioner

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

The majority of children and adolescents never engage in self-harm, but a significant proportion do; a systematic review of community based studies suggested that 26% of adolescents had self-harmed (regardless of intent) in the previous year (Evans et al., 2005b). Swannell et al.,(Swannell, 2014) reported nonsuicidal self-injury (NSSI) prevalence of 17.2% in a recent meta-analysis. A large Australian study of self-injury found a mean age of onset of 17 years, peaking for males slightly earlier (10-19 years) compared with females (15-24 years) (Martin et al., 2010). A study of adolescents in 11 European countries found a lifetime prevalence of 27.6% for NSSI; 19.7% occasionally and 7.8% repetitively (Brunner et al., 2013). Cutting, scratching, hitting and burning were the most frequently reported methods of self-injury in these studies. Most self-injury episodes (Martin et al., 2010) and around seven out of eight episodes of self-harm *do not* lead to a hospital presentation (Hawton et al., 2002).

Among adolescents who do present for hospital treatment, the majority have harmed themselves by taking an overdose, self-poisoning with analgesics being particularly common and dangerous due to the risk of

liver failure (Hawton et al., 2002). The estimated risk of repetition is between 5 – 25% per year (Bridge et al., 2006, Muehlenkamp et al., 2012). The risk being highest in the first year, but remaining high for many years after an episode of self-harm (Gibb et al., 2005, Reith et al., 2003). Self-harm is associated with an elevated risk of overall mortality (Carter et al., 2005, Suominen et al., 2004, Gibb et al., 2005). Young people have a poor understanding of the potential lethality of methods of self-harm and also switch between methods (Fortune and Hawton, 2005), so interventions to prevent further episodes of self-harm is one approach to reducing both the morbidity and mortality associated with these acts.

None of these data reflect the small but resource intensive group of young people who repeatedly self harm in medically damaging ways and who have severe impairment. Such young people typically cannot attend school, and may no longer be able to live with their families. Youth accommodation agencies also struggle to maintain their safety, leading sometimes to longer term institutionalisation. Exposure to physical and psychological trauma is a common experience for these young people, and sadly the system response when they are in crisis can be retraumatising.

Family factors are particularly important risk factors associated with both non-fatal and fatal self-harm among children and adolescents (Ougrin et al., 2012). Difficulties in parent-child relationships, including those related to early attachment problems, perceived low levels of parental caring and communication are related to increased risk of self-harm and suicide (Fergusson et al., 2000). A family history of self-harm is associated with increased risk of self-harm by adolescents (Johnson et al., 1998, Hawton et al., 2002). Parental mental illness and substance abuse (Bridge et al., 2006), childhood sexual abuse, physical abuse (Evans et al., 2005a) and exposure to recent stressful life events such as rejection, conflict or loss following the break-up of a relationship, conflicts, and disciplinary or legal crises are important risk factors (Hawton et al., 2003). The nature of the stressors vary according to age; children and younger adolescents describe familial stress, whereas older adolescents typically describe peer-related stressors (Gould et al., 2003, Hawton et al., 2003).

In adults the most common proximal motivation for self harm is to manage one's emotions, but for those aged 10-17 years the most common proximal motivation is to punish oneself (Hazell et al. Submitted).

Given that family factors are particularly important risk factors, reducing exposure to long term risk factors arising in early life, collectively referred to as adverse childhood experiences, is an important factor to consider in reducing risk of self-harm and suicidal behaviours. This would form part of a public health approach with benefits for a range of other outcomes including educational performance, and physical health e.g. cardiovascular disease. Some evidence of this is presented in the RANZCP report Cost Effectiveness of Prevention and Early Intervention Strategies in Infants, Children and Adolescents (2011). The RANZCP would be pleased to provide further information as required.

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

Empirical evidence is lacking for the incidence and mechanisms leading to clustering of adolescent self harm. An unpublished study (Hazell et al.) found self harm occurred more frequently amongst the friends of self harming adolescents than the friends of non self harming psychiatric controls. The self harming in friends however both preceded and followed the self harm event in the index adolescent, pointing to assortive friendships as the mechanism, rather than copycat or contagion. In examining a cluster of intentional self-harm from a clinical perspective, assortive friendships were also found to be contributing factor to sustaining intentional self-harm risk after suicide in the index adolescent (Kowalenko et al, submitted).

Case reports suggest self harm occurs more frequently in confined settings such as psychiatric inpatient units, juvenile detention centres and immigration detention (Proctor et al., 2012). Self harm also occurs more commonly in certain adolescent subcultures such as 'Goths'.

There has been awareness of a spate or cluster of youth suicides in Melbourne over the last two years and there was a previous smaller grouping of suicides in the Geelong area. It is likely that the Coroner will produce a broader report around the cluster beyond just the individual findings which may be of interest to the Children's Commissioner when published. Similar clusters are reported in other States including, most recently, Hobart. *Headspace* has a particular engagement with schools and it is likely to have an arrangement to assist schools following of death of a student thought to be due to suicide. The RANCZP understands this arrangement is being developed currently. It is likely in time that *Headspace* will have figures around students within schools. However, obviously, this will not include those young people not attending school.

Professionals engaging with local youth services to address the cluster, who provide clinical response or a population health, policy and strategic response to youth issues, report that while lots of good work is being done, there is often no-one with capacity to look at this cluster as a whole, track it and take responsibility for how services and community response should be directed. The Coroner's office is most likely to be able to do this, but that response is far from timely and not likely to prevent further death as part of the existing cluster.

Media reporting of suicide is also an important factor in managing contagion and clustering. The RANZCP has a position statement on Suicide report in the media which outlines the level of care and caution which must be taken in portraying suicide. Particularly in the case of children and young people simplification of cases (for example anti-bullying messages) run the risk of being misleading but also glorifying or idealising a suicide death as a solution to a problem that can seem intractable to young people at critical times in their lives. Compliance with media recommendations in covering self-harm is important.

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

Anecdotally, many people who self harm do not want help. The self harm serves a purpose (usually self regulation) and once the need has gone the behaviour is abandoned.

Of those for whom the self harm is a concern, or who have important associated problems barriers to help seeking include: embarrassment, shame, fear of punishment, not wanting to distress parents, fear parents will overreact, lack of knowledge of available resources, suspicion available resources will be unhelpful, concerns about stigmatisation, concerns about confidentiality.

Many adolescents seek help from their peers, or if not seeking help, communicate with their peers about their intentional self-harm intent or behaviour. Some communicate with their peers about intentional self-harm behaviour under the condition that this is not communicated more widely.

Access to help can be problematic although the situation is improving. Most adolescents can access e-headspace for example, and there are other online resources.

Except where medical treatment is required, hospital emergency departments are a poor environment to engage and assess young people who self harm. Prompt review by community teams or assertive outreach teams is preferable.

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

Australia has a well developed paediatric surveillance system to monitor trends in certain conditions. With sufficient resources this could be adapted to capture data on individuals who self harm. The limitation is that the system will only detect cases that attend medical services.

5. **The impediments to the accurate identification and recording of intentional self-harm and suicide in children and young people, the consequences of this, and suggestions for reform**

The International Classification of Diseases (ICD) is used to code all hospital discharges and is the main instrument for gathering hospital statistics. ICD codes T36 – T50, T71, X60 – X84 cover Poisoning, Asphyxiation, Intentional self-poisoning and Intentional self-harm. Self battery is inconsistently recorded as self harm as it is often not considered a self harm act e.g. the adolescent who fractures his metacarpals from punching a wall. Yet self battery has the same correlates and associations as self cutting (Hazell et al, submitted). ICD codes are not helpful for recording self harm ideators, and near miss suicide attempts (e.g. the young person found close to the edge of a train platform or railway bridge, contemplating jumping to their death). There are Centre for Disease Control (CDC) standardised definitions for describing and recording non-suicidal self injury and suicide to allow for international and national comparisons of suicide data. This is not routinely applied in Australia. International comparisons can inform prevention strategies and other effective interventions.

In regard to suicide figures, states and territories across Australia collect information in various ways, including through coroners reports and health department statistics. The Coroners Court probably has the most official figures but these are likely to be an underestimation as some suicides will be returned with an open finding. There is also a considerable delay in these figures becoming available because of the process.

It is unfortunate that there is no clear national surveillance mechanism for child and youth suicide and that it is not easy to integrate the various data and figures from states and territories. The RANZCP supports the establishment of such national surveillance.

Furthermore the issue of 'intent' in children is a complex one, and underlies the fact that the National Coronial Information System (NCIS) and the ABS are reluctant to report child suicides (particularly those under 14) because the public finds it difficult to accept that a young child would 'want to die'. What this has created is a 'hidden' group of child suicides, only just now coming to our knowledge through state based databases (e.g. Queensland and WA). The dilemma is that if a problem is hidden and not publicly acknowledged, then there is no public will to find and fund strategies to prevent such suicides.

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

All states and territories have bodies which review child deaths. Some also review severe injury. It should require only a small administrative resource to bring together the data in a uniform national database. There is benefit in doing this however, only if there is a federal government commitment to action based on the findings.

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.]

Disappointingly most interventions developed to prevent the recurrence of self harm have been no more effective than treatment as usual (which is of itself often limited). The evidence is as follows:

There are four systematic reviews (Newton et al., 2010, Hawton et al., 2000, Ougrin et al., 2012, Robinson et al., 2011). The most recent of these reviews (Ougrin et al., 2012) included 11 relevant randomised control trials (RCTs). A more recent narrative review (Brent et al., 2013) included two further relevant RCTs, leading to a total of thirteen relevant trials involving 1888 participants. For the following there was no statistically significant difference in rates of self harm repetition between groups randomised to an experimental intervention and those randomised to 'treatment as usual' (TAU): family intervention for suicide prevention, token allowing readmission, home-based family intervention, compliance enhancement in hospital, skills based treatment, youth nominated support team, therapeutic assessment at point of presentation (Ougrin et al., 2012). One trial found fewer multiple (more than one) repetitions of self harm with developmental group psychotherapy than TAU, but two larger multicentre trials were unable to replicate the finding (Ougrin et al., 2012). The narrative review reported one RCT of integrated cognitive behaviour therapy plus TAU versus TAU for suicidal alcohol or substance abusing inpatients. Fewer participants receiving the experimental treatment than those receiving TAU made suicide attempts (5.3% versus 35.3%, $p = .023$) during 18 months follow up (Brent et al., 2013). The narrative review reported one RCT of mentalization based therapy versus TAU. Fewer participants receiving the experimental treatment than those receiving TAU reported self harm (56% versus 83%, $p = .01$) during 12 months follow up (Brent et al., 2013). While data suggest integrated cognitive behaviour therapy and mentalization based therapy may be effective, replication is required before they can be recommended.

TAU, the most studied of interventions, performs as well or as poorly as most alternative interventions. TAU was not standardized across or within studies, and it is difficult therefore to distil its essential components. That said, Brent et al (Brent et al., 2013) proposed five factors that should be considered for interventions designed to prevent recurrence of self harm in children and adolescents: motivation to change, maintenance of sobriety, familial or non-familial support, promotion of positive affect, and healthy sleep. Timeliness of intervention is important, as the individual is most likely to repeat self harm within one to four weeks of an index self harm event. During this period intervention may not have commenced, or may not be of sufficient intensity to protect against recurrent self harm (Brent et al., 2013). Objectives of treatment need also to be realistic. Attenuation of self harm can be a more achievable goal for the individual than immediate abstinence.

A study of 10-12 yr olds in regional NSW (Hawke et al. in preparation) found 11.2% (n=38/339) of the adolescents reported self-harming actions or behaviours during the year prior to survey, with an even gender distribution (11.3% of females and 11.2% of males). Cutting was the most commonly reported method by females (n=5) and both head banging and jumping from a height by males (each n = 5). Approximately one-third (n=7/20) of the males who self-harmed had received treatment compared with only 5.9% of the females, a statistically significant difference (FET $p < 0.05$ or $p = 0.048$). The gender parity in the study contrasts with a ratio of 3:1 for an Australian community sample of 10-14 year olds (n = 12) reporting non-suicidal self-injury (Martin et al., 2010). Differences may be accounted for by sampling, and by differing definitions of self-harm.

Australian government agencies have supported the evaluation of programs and practice in the prevention, intervention and post-suicide phases for suicide and self-harm prevention. The Department of Health and state governments have funded innovative practice to reduce suicide, and sometimes funded evaluation of this practice (Penrose-Wall and Kowalenko, 2000). There is a need for high level review and planning of supports and trauma focused interventions. These responses need to be proactive to prevent deteriorating function and escalating self-harm.

It is appropriate for the Children's Commissioner to seek narrative responses from Aboriginal and Torres Strait Islander peoples, 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 as none are likely to be the subject of systematic data collection. Specific programs need to be developed for particularly high-risk groups including

victims of child sexual abuse and asylum seekers and refugees, particularly unaccompanied minors and those who have had significant traumatic exposure.

It should be noted the report *A last resort? The national inquiry into children in immigration detention* found rates of self harm among child detainees at various locations ranged from 25-100% (Human Rights and Equal Opportunities Commission, 2004). Self-harm and suicidal behavior is common in immigration detention and there is a contagion effect among distressed young people. As outlined in its position statement a position statement on Children in Immigration Detention, the RANZCP opposes detention of children and young people and believes community housing and support is required to prevent distress and self-harm. There is a need to have better access to culturally appropriate torture and trauma recovery programs for young refugees and school based supports for those in education.

Similar support is required for Aboriginal and Torres Strait Islander peoples, where the development of resilience is particularly important given the ongoing impact of serious disadvantage and poorer health outcomes. This is covered to some extent in the previous RANZCP submission on youth suicide prevention and the report on prevention and early intervention (page 15). There is need for adequate access to professional expertise needed to diagnose and treat mental disorders in a culturally appropriate manner. A mixture of universal and targeted approaches are therefore appropriate, including both adapted mainstream and Indigenous specific programs, all of which require rigorous evaluation. Access to adapted mainstream programs should be introduced cautiously and only where there is evidence. Further dialogue with Indigenous communities is appropriate.

A further group for consideration should be children in out-of-home care. These children are found to have high rates of developmental and mental health problems, and higher rates of suicide attempts than reported for adolescents in the general community (Sawyer et al., 2007). Many do not receive professional help and there is a need for a greater focus on services for this population, as outlined in RANZCP position statement The mental health care needs of children in out-of-home care.

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

A first step would be to consult with young people, including those who self harm, to canvas their views and attitudes about the value, and best vehicle, for public education campaigns.

9. The role, management and utilisation of digital technologies and media in preventing and responding to intentional self-harm and suicidal behaviour among children and young people

Many such digital technologies and media already exist. A helpful strategy would be to rate the material already available on agreed criteria, and publicize recommendations or endorsements for the highest performing material. Young people should be engaged in the rating process.

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