National Children's Commissioner
Self harm and suicidal behaviour in children and young people
GPO Box 5218 Sydney NSW 2000

31 May 2014

Dear Sir/Madam,

Thank you for the opportunity to make a submission into the very important enquiry into self harm and suicidal behaviour in children and young people in Australia. I am making this submission as both a parent of a child who has suffered in this way and as a medical practitioner with professional experience in dealing with this issue.

I am a general practitioner, a graduate of and a I work principally in a medium sized multidisciplinary practice in and am also a medical member of the newly constituted My previous clinical experience includes work at with youth aged between 12 and 25, and at the The latter is a primary health care service that caters to persons experiencing homelessness and IV drug use, many of whom have co-morbid mental illness. In all of these varying domains of my clinical work I encounter young people who engage in self harm and suicidal behaviours as well as children and young persons who have completed suicide.

I am also a parent of 3 children, aged 18, 16 and 14 years. My 16 year old son, has experienced severe and debilitating anxiety and depression over the past 18 months. His illness has been punctuated by 2 suicide attempts and by multiple episodes of deliberate self harm. The experience of being a parent in this circumstance has been incredibly difficult and has provided me with insights into the causes and the responses to childhood self harm that were not possible from my professional position.

I would like to draw on both my personal and my professional experience in responding to the key areas of interest of your enquiry. Inevitably, some parts of my submission draw on very personal (and clinical) anecdote and I am aware that this is by no means the standard upon which good policy should be made. Nevertheless, I feel that the experience of people dealing with these issues on a daily basis, whether professionally or personally, ought be heard and understood if we are to learn how to better respond to the needs of young people and their families.

Why do children and young people engage in Self harm and Suicide?

Self harm and suicide are not unrelated and may, in fact, represent a continuum. However, they are also sufficiently different that I feel they need to be considered separately.

Self Harm

Children and young people who engage in self harm will often report that this behaviour is not suicidal in intent. Rather, they often report intense feelings of distress or else a complete absence of feeling, or numbness, that leads them to self harm.

Some of the feelings that have been reported to myself include:

-Self loathing
-a persistent and distressing feeling emptiness or numbness
-Despair and an inability to articulate this
-Worthlessness and self reproach with a desire to inflict pain or punishment upon oneself.
-Feelings of being abnormal

Many young people will report that the act of self harm causes pain but that this pain is seen as a relief to their otherwise distressing feelings. In a sense, they describe using this behaviour as a type of diversion therapy. Some also report that after the initial pain there is an intense sense of abatement of pain which is interpreted as a positive feeling or a feeling of relief - again, preferable to the previous distressing feelings.

Other young people report that self harm is associated with suicidal feelings, and the act of self harm is taken to try to drive away suicidality. In other words, the act of self harm itself is a measure taken to prevent or alleviate suicidal thoughts. In the words of one 17 year old boy:

"I cut to live, not to die."

This notion that self harm might be an act of self preservation is promoted in written material provided (to children and their families) by some community youth mental health services. This material can seem to normalize the behaviour, down playing its dangerousness and emphasizing the 'feel good' endorphins that self harm might release. These are concerning messages to be giving to young people and may promote harmful behaviours without appropriate underpinning evidence. This message gives credence to the use of self harm as a strategy to manage negative emotions, which seems dubious at best to me. Would we encourage purging when the person with an eating disorder told us that it helped to manage their distress? No, instead we would recognize the wrong thinking of the mentally ill person and encourage alternative solutions.

As a parent I have been advised by mental health professionals that I should allow my son to continue to self harm, because to do otherwise might result in his taking his own life. This is a difficult position to put forward without adequate evidence to support it. As a parent, to stand idly by whilst your child inflicts injuries upon their body, some causing permanent scarring or impairment, is absolutely counter to every parenting decision that you have made before. I feel that material which promotes this approach needs to be withdrawn until there is sufficient high level evidence to indicate that these messages are in fact accurate, that they do not cause harm and that they are in some way helpful to the young person and his/her family.

Whilst self harm and suicidal behaviours may be separate entities (and for some young people who self harm there may be no suicidal thinking or intent at all), they are not unrelated and I feel that health professionals need to be very mindful of his and not to take, or to give, false reassurance in this regard. In

particular, I feel that families of young people who engage in self harm should be aware that their young person is in fact at increased risk of suicide compared to a young person who is not self harming (an increased risk of 100 fold in the year after an episode of self harm) and that continuation of self harm, as advocated by some services, will not negate that risk.

Of course, some acts of self harm can lead to inadvertent suicide even if this was not the primary intent. Most notably this is the case with medication overdose, particularly where the person's understanding of the likely effect of overdose is incorrect (e.g. A common misconception is that Paracetamol in overdose is relatively harmless, whereas in fact it is potentially fatal).

Suicide and Suicidal behaviours

My experience suggests to me that suicidal behaviour in young people is not particularly different to that in adults. In particular, I believe that most (but not all) children and young people who attempt or complete suicide are suffering from a mental illness, most usually depression or anxiety. Other factors that are common amongst young people and adults who engage in suicidal behaviour are social isolation and the co morbid use of drugs or alcohol. Young people are perhaps more prone to impulsive acts of suicide due to their poorly developed frontal lobes and increased propensity to impulsiveness. Anxiety may also be a more common precipitant than in the adult population, and can easily be missed as young people may present with irritability or difficult behaviours, and often do not have he language to articulate their distress.

Underlying causes of both self harm and suicide

Common themes that contribute to depression and anxiety in young people (and therefore to risk of self harm and suicide) are identity, gender and role confusion, trauma - including bullying, family breakdown, physical, psychological and sexual abuse, poor social connectedness and even a fear of failure.

I wish to make some specific comments about bullying.

Bullying

Bullying is a widely under estimated issue for children and one which we, as a society, need to take much more seriously. In my experience, very many of the young people who present to general practice with mental illness have experienced significant trauma in the form of bullying, either at school or via online forums. Often, incidents of bullying have been reported to school leaders and their response has been wholly inadequate. Schools need to be acutely aware of their responsibility to their students whilst at school. They need to protect the children in their care from harm and must do this prudently and without bias. All members of a school community need to have a very clear understanding of what behaviours constitute bullying. There are certainly some schools who manage the issue of bullying well, whereas others do not. I feel that the key elements of a good response to bullying are:

-A preparedness to accept that bullying can and will occur in every school (i.e. No school is exempt)
-A zero-tolerance approach that results in clear and strong action at the very first sign of bullying-type behaviour. This requires that schools act before behaviours have technically reached the threshold of what might be defined as bullying. In other words, on the very first occasion that a student vilifies, abuses, taunts, etc another student he/she needs to be identified and disciplined.
Schools need to be less concerned about being seen to be harsh in this instance,

and more concerned about not being responsive enough. Such a response does not need to be (and should not be) humiliating to the offender, but should provide a positive opportunity for development and learning.
-Prompt and consistent responses to behaviours that might harm others should be opportunities to reinforce to the wider student body the standard of behaviour that is expected and moreover, what is not acceptable.
-Engagement with parents : Parents need to take responsibility for the way they role model and also for backing up schools when their child has behaved badly. Schools need to have the tact and the professionalism to enable parents and students to accept responsibility without losing respect and the ongoing opportunity to be seen as valued members of the school community.
-In relation to cyber-bullying, schools need to accept that this is also part of their domain. In other words, the school yard no longer stops at the school gate. When I was growing up, problems with peers at school could be left behind at 3:30pm, with a period of reprieve and safety in the family home at least until the following day. For today's students this is no longer the case. Whilst this is a complex area of overlapping responsibilities, we must start to accept its truth and to work together to provide the appropriate safeguards as well as effective responses to protect out young people.

Contagion and Clustering: Self harm

There is a growing awareness amongst children and young people of self harm as a possible response to stress and distress that was not nearly as prevalent 20-30 years ago. Young people will very often know of a person who engages in self harm and/or will encounter discussions and even images portraying self harm on social media sites. This exposure, for some people, may be the catalyst to 'try out' such behaviours to manage their own psychological distress. It is important for us to remember, though, that even in this context, self harm will occur secondary to some some of psychological distress and is not mere experimentation on its own.

Whilst exposure to self harm in one's peers may trigger similar behaviours, it is my observation that most young people who self harm do so very privately and with no desire to have their self injury discovered by others. Whilst of course there are exceptions to this, I feel that there is a significant misunderstanding amongst health professionals about attention seeking as the motivation to self harm. More specifically, I believe that any attention seeking aspect of this behaviour is overstated and viewed in an overly harsh manner. By way of comparison, many people might 'seek attention' when distressed, by acting out in particular ways. So long as their distress is recognised we are willing to suspend judgement - that is, we do not take a punitive approach to their seeking for help. Rather, we are more likely to offer assistance. Any attention seeking that may attend self harm should be viewed as a legitimate call for help from the child or young person. There may also be an aspect of attempting to create some sort of connection to peers by copying self harming behaviours. As health professionals we must respond to this with empathy and concern.

Given the clear increase in self harm as a coping strategy by young people it may be important to try to limit exposure of young people to self harm. In practice this may mean, for example, that policies need to be adopted (in schools, etc) to reduce exposure to evidence of self harm. Management of social media in this respect is yet another challenge. On the other hand, open discussion with young people about self harm also needs to considered, and we should be cautious not to avoid this out of fear that such discussion might trigger further episodes of self harm. It is possible that engendering better understanding amongst young people themselves might allow for improved empathy and support for those

suffering emotional distress.

Contagion and Clustering: Suicide

It is widely recognised that there have been clusters of suicides where exposure to the news of another young persons suicide seems to trigger suicide in other young people. Indeed this is the prime reason for the media moratorium on reporting of suicide. This is, of course, somewhat ineffectual in this day and age where social media sites allow each and every one of use to be a journalist without regard to the ethical standards that apply to traditional media.

Social media sites may, therefore, exacerbate the phenomenon of copycat suicides, although I am not aware of specific studies which either prove or disprove this. Alternatively, they may provide a forum for discourse on the occurrence and the catastrophic effects of suicide in young people, and perhaps this is helpful.

In my own local area there is a high rate of youth suicide. The completed suicide of a 14 year old girl in resulted in an enormous ripple effect throughout the community where it seemed that an enormous proportion of the youth aged between 12 and 18 had some connection to . This connection was made, often, through social media, where young people were either 'friends' with or had friends or siblings who were in turn 'friends' of or her 2 teenaged siblings (who each attended different local schools). Most of these 'friends' had never met as such, but either before (and often after) her death, they were able to access a glimpse at her life through access to her Facebook/Myspace/other social media profile. This created a sense of closeness and connection that was not real, in the way that we adults would see it. But for young people, these connections do feel real and indeed, in many ways they are real. The distress at death and the widespread sharing of her means of suicide may have triggered suicidal thoughts or sharpened suicidal plans in others. On the other hand death did generate enormous community discussion, at both formal and informal levels, about the causes of her death, the presentation of mental illness in youth, possible triggers and of course the catastrophic impact on her family and her friends. The ubiquitous use of social media platforms means that this will always be a challenge when a young person suicides. We need to work with young people to understand what opportunities might exist via these fora to help young people and to protect them from harm.

Another aspect to this is that social media platforms are also used at times by young people to post messages of farewell prior to their final act. A modern day equivalent of the suicide note. In my experience such use of social media can result in an opportunity to intervene and potentially save the life of a young person.

Barriers to accessing help

Thee are many obstacles that will prevent young people who self harm or are contemplating suicide from seeking help. Some of these rest with the child, whilst others lie with the responses of care givers and health professionals or with the health care system itself.

<u>Confidentiality</u>
Young people often report fear that their confidentiality will be breached if they report self harm or suicidal thoughts. Health professionals, particularly GPs and school counsellors, should make greater efforts to ensure that young people

attending them are aware of the protections and limitations of confidentiality.

Parental reaction

They also fear what they perceive to be an over-reaction from their parents. Parents, meanwhile, probably do react poorly as they, in turn, are distressed and their understanding of these thoughts and behaviours is likely to be poor. Increased community dialogue about these issues might allow young people to have more confidence in seeking help as well as supporting parents to respond in a way that promotes trust and ongoing engagement with their child.

Cultural and religious barriers are also important, particularly for example where a child might belong to a family whose religious tradition frowns upon suicide. Whilst such beliefs might afford some protection from suicide, they might equally prevent a young person from seeking help when needed. Those providing Pastoral care in schools need to be mindful of this possibility.

Stigma

Young people and their families also fear the stigma that attends mental illness, and this too is a barrier to their seeking help. Again, increased community dialogue about the prevalence of mental illness and the many presentations of mental illness may reduce this barrier. In Australia there are additional challenges for many young people navigating these issues across cultures.

This stigma also impacts the experience of families of young people who self harm or attempt or commit suicide. It has occurred to me that it would be easier to have a child with leukemia than one with a mental illness. Leukemia, like so many other diseases, is patently physical. There is a clear evidence base to guide treatment and it is an illness that is blameless. Such illness in children elicits sympathy and support. People (even strangers) can engage with it - they have a language that allows discussion and they have some sense of how they can help. This is not the case when a child self harms or suicides. As the parent of a child with a mental illness I have experienced isolation, little support and the very obvious silence of people who, in different circumstances, would likely have provided enormous practical and emotional support.

Health services responses

Mental health services might be expected to be the best placed to respond well to these issues, but in fact this is not necessarily the case. When a young person engages in self harm we need to adopt an empathic and concerned response. Too often, in health services, I do not see this. Rather than asking what is actually wrong with this child, what has led him/her to this behaviour, I see the service approach the person with blame, reproach and annoyance.

The confronting nature of self harm in a child or young person no doubt drives this emotional response even from health professionals, as does the anxiety that such presentations cause us. This is unfortunate and unhelpful. As health professionals we need to make a greater effort to understand the person's distress, to acknowledge that distress, and to help them to find better (less harmful) ways of managing this. When mental health services do this poorly they may cause disengagement of the young person as well as missing important opportunities to provide a useful model to support distressed parents at such times - indeed adding to their distress.

Labeling a young person who has engaged in self harm as having a 'personality disorder' is one potentially very harmful and yet common response by health services. Such labeling confers a sense of hopelessness on both the child/teenager and the treating team, is diagnostically incorrect (as personality is

still developing in this cohort) and also contributes to significant iatrogenic harm. This latter occurs because of the persistent and quite specific stigma that attaches to such a label and is manifest is the apportioning of blame, denial of access to further services, and poor risk assessment.

Health service resources

Finally, the poor resourcing of mental health services are a significant barrier to young people and their families accessing help when facing psychological distress, self harm and risk of suicide. In the public health system, patients need to present in extreme circumstances in order to receive assistance. Even as a general practitioner with extensive experience in mental health, it is very difficult to get timely assessment and treatment for young people in significant distress. Presentations to emergency departments (by no means the ideal pathway to mental health services), even with explicit suicidal intent, are also no guarantee to appropriate assessment and support. In the private sector there is no capacity whatsoever to deal with acutely suicidal patients (young or old) and assessment and effective ongoing treatment is so financially inaccessible as to preclude access to all but the most financially secure families. Whilst psychological services are now funded under Medicare, the limitations of this funding do not enable young people to get sufficient longitudinal support.

In my own experience a combination of the barriers mentioned above resulted in very poor treatment of my son, with near catastrophic results. was taken to ED by police following an attempted suicide. This was his first presentation to hospital. In the ED he was noted to have engaged in self harm and was almost immediately labelled 'borderline personality disorder.' This assessment was made after a 15 minute interview by a mental health worker.

Admission to hospital only followed at our insistence, despite reporting ongoing, unchanged suicidal intent . At the time of discharge some 2 weeks later still reported high suicidality. At this point, we (his parents, and both doctors) had not been provided with any opportunity to meet his treating doctor. This, in itself, was remarkable and would certainly not have been the case had he been admitted with a life threatening physical illness. The central advice we were given by his allied health team was that we should not prevent him from self harming, as this may cause him to attempt suicide again. There was, in this statement, a very clear inference that we had contributed to his initial suicide attempt by restricting his access to means of self harm (knowing that he had suicidal thoughts we had locked away all medications and sharp implements and had attended to all possible hanging points in our home). Meanwhile, we were unable to secure any private psychiatric support, as there was no psychiatrist available to take on a new patient at that time.

Soon after this discharge attempted again to take his own life. He did this following a 2 week period of intensifying self harm (which he did not disclose to us or to others). He had been discharged with no real support other than that able to be provided by his family. His ability to engage in self harm did nothing to mitigate his suicide risk, but it has left him with very extensive scarring which will have significant impacts on him throughout his life. His suicide attempt on this occasion was by poly pharmacy overdose and very nearly caused his death. He was admitted to intensive care and fortunately made a full physical recovery following a prolonged hospital admission. I was with on the day that this occurred and, aware as I was of his mental illness and relative suicidality, I had no clue to his actual suicidal intent on that day.

What can we learn from this? For me, the most important lessons are that (a) we should never underestimate the risk of suicide in a young person who engages in

self harm, (b) that suicide prevention is difficult and will never be 100% possible because risk is so difficult to measure, (c) that health professionals need to mindful of the dictum to 'first do no harm.' And finally (d) that suicide prevention rests as much with family members and with society as a whole as it does with medical professionals.

Features of programs and practices that more effectively target and support children and young people who engage intentional self-harm and suicidal behaviours

The important features of effective support for children and young people with these difficulties seem to me to be:
- A capacity for early intervention
- Consistent and continued care providers
- Engagement with family
- Respect for family decisions and an understanding of the impact of self harm and suicide on the broader family

My own experience does not add greatly to this list, as it has been more one of frustration and despair than of satisfaction. In recent times my son has engaged with a private psychiatrist and psychologist, and enjoys a great rapport with both. Extensive work with these health professionals has been of benefit, but self harm and suicide are still an ever present concern. Financial barriers to accessing these services have been mitigated partially by the Better Access to Mental Health program and the Medicare Safety Net. These programs would not be sufficient mitigation for most families in our situation, however, and I despair for the many young people who are denied adequate assistance.

The role of public education campaigns aimed at reducing the number of children who engage in intentional self-harm and suicidal behaviour

To my knowledge public education campaigns aimed at reducing self harm and suicidal behaviour in young people have not been trialled in Australia. Given the high rates of self harm and suicide, and particularly as these are the leading cause if death in our youth, I feel that we need to take bold and courageous steps to try to effect change. Undoubtedly there would be opposition to media campaigns on these issues, but this opposition in and of itself should not deter us in our efforts to help young people. Clearly we need to look to the evidence from other jurisdictions in order to understand the effectiveness of such approaches and, in particular, to ensure that they do not cause further harm.

Media guidelines limiting reporting of suicides is aimed at minimizing copycat behaviours, but do we know whether the supposed benefit of this outweighs the negative effect of creating further silence around the issues of mental illness, self harm and suicide? Such silence has proven futile (and even harmful) in other domains such as education about sexuality and fortunately we now understand that education and information equates to power and improved sexual health. We must be carful not to be paralyzed by fear of what might be, when it is possible that in this case also, information may equal better outcomes.

Can digital technologies and media assist in preventing and responding to intentional self-harm and suicidal behaviour among children and young people?

Online media and digital technologies provide forums where young people can connect with others and find support and shared experiences. This may be

helpful but might also reinforce negative feelings and experiences rather than providing actual support. Moderation my be important. I feel that we must respect young peoples' choices in this regard whilst remaining vigilant. Some (perhaps few) digital technologies might promote competitive self harming behaviours when unmoderated, however this phenomenon, when it does occur, seems to be confined to a very small minority of young people who engage in self harm or suicidal behaviours.

There is also the capacity for digital technologies (whether online or not) to provide useful alternative diversionary strategies for young people in distress. I am aware of young people who have found engagement in an intense activity has been able to alleviate distress and allow delay/deferral from self harm. Such activities have included building Lego models, playing Play Station games, and engaging in creative pursuits such as drawing or musical performance.

Research into these modalities would be helpful to better appraise their usefulness in this area.

Again, I thank you for the opportunity to make this submission.
This enquiry is very welcome because it seems to me that there is a significant evidence void in the area of child and youth self harm and suicide, resulting in inconsistent practices and messages. These factors diminish our capacity to recognise the problem and to respond adequately. They also add to the stigma that attends mental illness in general and to self harm in particular.

I acknowledge that much of what I have to say is based on anecdote and hope that you will, nevertheless, give it your due consideration. I am very hopeful that this enquiry will lead to improved understanding and management of these challenging issues for our young people.

In the interests of protecting my son's privacy I would be grateful if you would not publish mine or his names. In every other respect I am happy for this submission to be made public.

Your faithfully,