The Royal Australian & New Zealand College of Psychiatrists

ACT Legislative Assembly Standing Committee on Health, Ageing, Community and Social Services inquiry into youth suicide and self-harm

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promoting the role of psychiatrists as leaders in mental health care

309 La Trobe Street, Melbourne VIC 3000 Australia
T +61 3 9640 0646 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation responsible for training, educating and representing psychiatrists in Australia and New Zealand. Psychiatrists must be accredited by the RANZCP before they can practise.

Psychiatrists are medical doctors who are specialists in the treatment of mental illness, substance abuse and addiction. Psychiatrists play a crucial role in the provision of evidence-based mental healthcare in the community using a range of therapies, including medication and psychotherapy.

The RANZCP has over 5,500 members including 4,000 fully qualified psychiatrists and 1,400 doctors who are training to qualify as psychiatrists. The RANZCP is guided on policy issues by a range of expert committees whose membership is made up of preeminent psychiatrists with relevant expertise, and consumer, carer and community representatives.

In developing this submission, the RANZCP worked closely with its expert members, to ensure that the recommendations made reflect clinical excellence, community experience and insight, in particular the Faculty of Child and Adolescent Psychiatry.

Key messages and recommendations

- Psychiatrists have a critical role supporting children and adolescents who present with self-harm or suicidality, both in the education of other professions about mental illness and risk factors that may lead to suicide, as well as in direct service provision.
- Primary Health Networks (PHNs) should link with high quality child and adolescent mental health specialist practice to ensure vulnerable children are able to access the care they need in the most timely and coordinated manner.
- More information is required regarding how the PHNs will interact with ACT-funded mental health services, and where children and adolescents with self-harm behaviours will fit along the stepped care model.
- Mental healthcare, including early intervention in self-harm and suicide needs to be delivered across all age groups, from children to adolescents. There are currently significant service gaps in the availability of services for children, and this is indicated in the Terms of Reference which show a sharp increase in the numbers of deaths in early teens due to self-harm.
- Evidence-based interventions for children and adolescents with persisting self-harm behaviours should be delivered by specialist child and adolescent mental health teams. The ACT should investigate how these services can be funded and how this could be supported by via the PHNs.
- The RANZCP is finalising a new resource, *Clinical practice guideline for the management of deliberate self-harm*, to be released later in 2016. We would welcome the opportunity to discuss how the guideline could be disseminated and implemented in ACT-funded health services, to promote evidence-based service and policy design.

a. ACT Government and Commonwealth Government roles and responsibilities in regard to youth mental health and suicide prevention, particularly in relation to the recently announced Commonwealth response to the National Mental Health Commission Report and the mental health and suicide commissioning role for the Primary Health Networks as it affects the ACT.

Primary Health Networks

Early indications from the PHNs are that their policies and procedures will include a system for following up with consumers after a suicide attempt and/or discharge from an inpatient unit. The RANZCP welcomes this development, however we emphasise that for this to be implemented successfully the system needs to be easy to use, accurate and enabling of cross-sector communication.

While the PHNs' responsiveness to suicide risk is promising, more information is required as to how the PHNs' stepped-care model will be operationalised with regards to deliberate self-harm, and how the approach of the PHNs will fit alongside that of ACT-funded services.

The RANZCP is concerned that the PHNs' focus on youth mental health risks missing an opportunity for identifying children with significant risk factors. Data from the Australian Institute of Health and Welfare shows that there were 18,277 hospitalisations for intentional self-harm involving children and young people aged 3-17 years between 2007-2008 and 2012-2013, and over one fifth of this number (22%) were aged 14 or under (AHRC, 2014). The Terms of Reference further illustrate the unacceptably high, and rapidly increasing, rates of self-harm and suicide in children in the ACT, however this vulnerable group tends to be overlooked in service design and delivery.

The RANZCP emphasises that, for the potential of the PHNs to be realised, there needs to be a coordinated, transparent and consultative development and implementation process. Currently there is a uncertainty in the mental health sector with regards to how the PHNs will impact on and interact with services. Localised mental health plans will need to be drafted in close consultation with local services and groups, so that they accurately represent the needs of the population. PHNs will need to carefully establish roles with regards to their interactions with ACT-funded child and adolescent mental health services.

Need for improved reporting

The development of a cross sector suicide reporting system that is easy to use and allows accurate data reporting will be an essential step in establishing effective prevention and early intervention mechanisms. The PHNs offer an effective platform for coordinating and implementing this, and the RANZCP welcomes early indications that the Government is looking to take this approach.

Accurate statistics provide the foundation for appropriately targeted programs and strategies. Reliable data also enables more accurate monitoring and evaluation of approaches, contributing to a clearer picture of the efficacy of the various approaches.

Need for improved integration and reach of services

The RANZCP was alarmed by the statistics in the Terms of Reference, including those showing that suicide was the leading cause of death of children aged five to 17 years of age in 2013; and that there has been a 650% increase in deaths from self-harm when comparing 12 to 13 year olds with 14 to 15 year olds from 2007 to 2012. These figures illustrate the urgency of the need to develop better integrated and more accessible services for at risk children and adolescents. Currently, access and workforce familiarity and skill in working with children and young adolescents with deliberate self-harm is lacking. This needs to be addressed as a matter of urgency.

An adequate and holistic response to childhood mental illness and risk of suicide and self-harm, mental health treatment specialising in the management of the sequalae of trauma needs to be readily available, along with a robust and responsive child protection system. All services involved need to have the capability and skills to respond adequately and quickly to family violence, abuse and neglect of children. Evidence shows that self-harm in children is often used as an attempt to control difficulty and overwhelming feelings, to express anger and communicate a need for help. Intervening early for children at risk of trauma is essential for preventing the development of more serious and acute mental health issues down the track, including self-harm (AHRC, 2014).

The Australian Human Rights Commission's *Children's Report 2014* emphasises the importance of recognising and responding to deliberate self-harm in children, given the significance of children's mental health for future suicide risk. Children's mental health needs to be targeted in a comprehensive approach to preventing and managing self-harm and suicide.

Overall, effective management of child and adolescent suicide and self-harm, requires investment in the prevention, identification and appropriate treatment of mental illness. This should include increased and improved workforce, research, consumer involvement, and funding. Services should be accessible and easy to navigate, and if a young person attends an agency that cannot service their needs directly, effective referral and follow-up mechanisms need to be in place.

There is a need for greater public education regarding the personal and financial costs of untreated mental illness in children and adolescents, particularly as this relates to suicide. Affected children, and their parents, often delay in presenting symptoms for professional assessment. This delay in assessment could potentially be addressed through greater public awareness of symptom expression, destigmatisation, promotion of help-seeking behaviours, greater coordination and communication between healthcare and educational services, and reducing practical barriers to accessing services.

Recommendations

- More information is required regarding how the PHNs will interact with state-funded services, and how the stepped care approach will be operationalised in the context of children and adolescents with self-harm behaviours.
- More information is required however as to how the PHNs' stepped-care model will apply to children and adolescents with deliberate self-harm.
- A comprehensive approach to self-harm and suicide in ACT must incorporate services targeting children, not just young people. This should be central to the preventative strategy, as well as treatment and management.
- More information is required regarding how the PHNs will interact with ACT-funded child and adolescent mental health services. In particular, clarity is required regarding whether acute service system responses will primarily be through the PHNs or not, and how this will be managed.
- The PHNs offer an important opportunity to establish more accurate, nationally coordinated recording of data on suicide and self-harm in Australia. As above, the RANZCP would welcome more information on how this will be rolled out.
- Central to preventing self-harm in children and adolescents is ensuring services are responsive and effective at intervening early in child abuse, family violence, neglect and other risk factors.
- Self-harm in children is a significant risk factor in future suicide risk. Any approach to addressing youth suicide and self-harm needs to incorporate a focus on the mental health of children, to ensure early intervention and prevention mechanisms are strong.

- The effective management of child and adolescent suicide and self-harm requires:
    - adequate funding for child and adolescent mental health services, relative to the proportion of the population experiencing disorders
    - increased capacity and competence of the workforce to engage in prevention and early intervention work
    - coordinated and integrated care between health and other sectors to deliver prevention and early intervention programs to target high-risk groups
    - continued strategies to reduce stigma associated with mental illness in children and adolescents.
- Universal screening for infants, children and adolescents to identify early symptoms of mental disorders and illness. Early identification improves effectiveness of clinical interventions and reduces disease burden on both the individual and society. The ACT should consider how this might best be implemented.

b. Any gaps or duplicate roles and responsibilities.

Gaps in mental healthcare availability

The RANZCP is concerned that there are significant service gaps, and these should be addressed as a matter of priority. Children and adolescents who present with deliberate self-harm and other serious mental health issues require ready access to specialist mental healthcare.

The Australian Government's *Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing* (the Report) found that 186,000 (10.9%) young people aged 12-17 had deliberately injured themselves in their lifetime, including 73.5% of this number in the previous 12 months. Further, 560,000 (13.9%) four to 17 year olds were assessed as having a clinically significant mental disorder in the previous 12 months yet only 56% of this group had accessed services (Lawrence et al., 2015). These figures show that 44% of Australian children and adolescents with a clinically significant mental disorder had not recently accessed supports. This indicates that there continues to be significant gaps in the availability and accessibility of mental health services for children and adolescents.

The Report also found that mental disorders are having significant impact on the overall functioning of four to 17 year olds. 50.5% of this group reported moderate to severe impacts on their attendance and engagement with school or work, 43.8% reported moderate to severe impact on their relationship with friends and 50.3% with family (Lawrence et al., 2015). Disruptions to education, social development and relationships are a consequence of failed early intervention and evidence of the need for comprehensive, coordinated specialist management at home, school and in the life of the young person.

Overall, the Report illustrates in several ways why more specialist children and adolescent psychiatric oversight and management is needed in ACT, and Australia wide. Research shows that, for adolescents with persisting deliberate self-harm behaviours, structured, intensive medium term treatments are effective. These interventions, delivered by specialist, multidisciplinary child and adolescent mental healthcare services, have an evidence base for reducing risk of suicide into the long term (Mehlum et al., 2016). The ACT needs to investigate how these services can be funded at a level commensurate with need, and how the PHNs can support this.

Need for improved follow up

Suicide attempt survivors are can be misunderstood, isolated and neglected. Engagement, follow-up and maintaining contact with suicide attempt survivors after emergency room contact is critical. Positive results have emerged from recent studies showing that maintaining contact with suicide attempt survivors or those who self-harm after discharge can significantly reduce their risk of subsequent attempts and death (Carter et al., 2005; Motto and Bostrom, 2001; Fleischman et al., 2008). Continuing support can be as simple as sending postcards or letters four or five times a year (Carter et al., 2005). Dual intervention of a one-hour information session, referral options and follow-up contacts (phone or in person) over a period of 18 months is also effective (Fleischman et al., 2008). Studies suggest that when contact is reduced or ceased, the preventative effect also disappeared (Motto and Bostrom, 2001).

These successful interventions are relatively inexpensive and work through enhancing social connection and sense of personal value. Allowing for appropriate cultural and age adaptation, these programs deserve further research and implementation in local settings.

Recommendations

- Service gaps need to be addressed by ensuring the child and adolescent mental health workforce is adequately resourced and supported to meet the level of need in the community, with a particular focus on those most at risk.
- Evidence-based interventions for children and adolescents with persisting self-harm behaviours should be delivered by specialist child and adolescent mental health teams. The ACT should investigate how these services can be funded and how this could be supported by via the PHNs.
- A clear process should be established for following up with children and adolescents who have engaged in self-harm or suicide attempts. These programs can be simple and inexpensive to implement. They should be continually evaluated for clinical outcomes, and be based on the most up-to-date evidence base.
- Programs to engage and follow up with suicide attempt survivors can be relatively inexpensive and simple. These should be prioritised for further research and implementation.

c. Whether there are unique factors contributing to youth suicide in the ACT, taking into account the small number of young people who have died by suicide in the ACT in recent years, and the impact public investigation may have on families and close friends, that can be identified through submissions and expert witnesses.

The RANZCP has no response to this question.

d. ACT government-funded services, agencies and institutions, including schools, youth centres, and specialist housing service providers' role in promoting resilience and responding to mental health issues in children and young people.

Forthcoming RANZCP *Clinical practice guidelines for the management of deliberate self-ham*

The RANZCP will be releasing a new *Clinical practice guideline for the management of deliberate self-harm* later in 2016. We anticipate that this resource will provide essential information for psychiatrists

and other health professionals working with people who have self-harmed. The guideline addresses all age groups, and includes a specific section on the treatment of self-harm in children and adolescents.

The guideline reviews and synthesises current evidence about the management of self-harm, provides guidance on assessment, clinical treatment, aftercare, and organisation of services. Where possible it makes evidence-based recommendations for clinical practice. The RANZCP would welcome the opportunity to discuss how the guidelines could be disseminated and implemented in ACT government-funded services, agencies and institutions, particularly health services, to promote evidence-based service and policy design.

Improved education and training for gatekeepers

Improved community and practitioner mental health literacy through the use of education programs aimed at identifying and supporting those at suicide risk is essential. Suicide prevention is not limited to health services, and rather includes a range of interventions focused on community or organisational gatekeepers whose contact with potentially vulnerable children and adolescents provides an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment. Gatekeepers include those employed in institutional settings, such as schools or after school activity coordinators (Mann et al., 2005), general practitioners and other health professionals, as well as parents and peers.

Improving gatekeepers' knowledge of mental illness can lead to a greater recognition and understanding of mental health, increased help-seeking, more timely provision of support, leading to early intervention and prevention (Mann et al., 2005).

Gatekeeper education should include awareness of risk factors, ways of encouraging help-seeking, availability of resources, and efforts to reduce stigma. All relevant programs and institutions should also be required to promote organisation-wide awareness of mental health and suicide, and facilitate access to mental health services.

To date, systematic evaluation of gatekeeper training on suicidal behaviour has largely been limited to multilevel programs conducted in institutional settings, such as the military (Mann et al., 2005). Much of the focus of these evaluation has been on the training process rather than the clinical outcomes. Whilst it is useful to demonstrate information can be learnt, further research into the translation of training to the actual outcome of preventing suicide is necessary.

Recommendations

- Investigate ways the RANZCP's forthcoming *Clinical practice guideline for the management of deliberate self-harm* could be disseminated to ACT-funded health services, and used to inform service design and clinical decision-making.
- Training, education and support should be provided for gatekeeper staff to recognise and assist children and adolescents who are at risk of self-harm and suicide.
- School-based programs, focusing on suicide awareness, skills training, screening, peer support and gatekeeper training. The RANZCP supports gatekeeper training in particular, given the evidence to show that teachers are particularly well-placed to recognise early indicators.
- Evaluation of gatekeeper training should be expanded to examine outcomes for children and adolescents.

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